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CROSSING IDIOMAS[1]: NEGOTIATING TRANSLINGUAL RHETORIC WITHIN GLOBAL HEALTH PUBLICS

By

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Submitted to the Department of English and the Faculty of the Graduate School of the University of Kansas in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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[1] Tr. Languages

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Abstract

Increasing numbers of U.S. students and practitioners in the health professions travel annually to developing countries with global health programs. In these programs, visiting practitioners and local residents often work side-by-side to serve marginalized communities in need of better access to medical and dental care. This transnational public engagement in global health requires collaborative work among individuals with varied backgrounds of language, culture, class, and status. Health teams must develop communicative strategies to negotiate these differences and connect with their patients. This qualitative study examines these strategies for cross-cultural communication with two groups of volunteers that ran temporary health clinics in the Dominican Republic. Drawing from ethnographic methods (interviews and participant observation) and a methodology of rhetorical engagement, I examine how Dominican volunteers and visiting health practitioners assembled to form "emergent collectives" that collaborated across linguistic and cultural differences. I also analyze how individuals developed translingual rhetorical strategies that negotiated languages, dialects, and non-verbal gestures to support performances in the clinics.

Using grounded practical theory, this study analyzes the communicative problems that volunteers encountered with varied proficiencies in English, varieties of Spanish, and medical terminology. It then examines the rhetorical strategies participants developed in response to those problems to interpret across English-Spanish, Spanish-Spanish, and non-verbal tactics. Although U.S. participants noted that the rural, Dominican dialect of Spanish of the local community was stigmatized, globally, I argue that it was considered the most "useful" form of Spanish to connect with patients and support performances in these clinics. By recognizing the integral support of the local volunteers' use of Spanish-Spanish interpretation and how U.S.

participants performed language in ways to "sound more Dominican," I assert that vernacular language use was crucial to assembling as a collective and effectively caring for patients. This dissertation demonstrates how a situated health context outside of the U.S. can illuminate the complex "messiness" of translingual rhetoric in practice for transnational publics. Ultimately, this project encourages a collective approach to translingual rhetoric and advocates for more narratives that incorporate the vernacular voices of local volunteers working "on the ground" of global health.

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Chapter 1: Exploring Translingual Rhetoric in Transnational Public Health

It was "muy Caribe[2]" in the hot sun one afternoon in a rural Dominican town about 45 minutes away from the Haitian border. I was working for the second summer in a row as a coordinator with a temporary health team from the United States (U.S.) that was running medical and dental clinics with local residents in the town for one month. On this particular day, our medical team walked along the gravel road only a few houses away from our clinic to make a house visit for a patient who was bedridden and in need of a consultation. I was there to help interpret and facilitate the visit. The patient was an older male, maybe 70 "y pico[3]" who had various health issues, the names of which I do not remember. What I do remember is that there were about six people, including the patient's wife, crowded around his double bed in a fairly small room with little light. After the patient explained his symptoms, the physician, medical students, and nursing student began to deliberate about the case—discussing what could be done to help ease his pain and how his future might span out with these health issues.

As the medical team conversed in English in a small huddled circle, the patient, his wife, and I quietly waited, left out of what was going on until I would begin to interpret again. I felt compelled to do something to break the barrier of silence that had been set up between the patient and the providers for that moment. Since our purpose was to spend time with him, I sat down on the side of his bed and began asking questions about his family: how many children he had, how many grandchildren, how long he had lived in the area, et cetera. I began interpreting my conversation with the patient into English, and one by one the medical team turned around and joined in the conversation, alternating between discussing his family life and possible

[2] Tr. literally "Very Caribbean," this was a term that local residents used to describe the hot heat of the afternoon.
[3] Tr. "and a little" referring to a bit more than 70 years old.

treatments for his pain. I do not remember the medications that we later brought him or the instructions that I translated for his wife to take care of him, but what I do remember is the light that emerged from his eyes as we switched from talking *about* him to talking *with* him—sitting, accompanying, and "being" with him as a whole person and not just a medical case study.

As we interacted with other patients and community members during our month-long stay, I began to notice how a rhetorical approach to health care could benefit our work and interactions in this summer program. This rhetorical approach would recognize patients as an audience, learn their motivations, and adjust speech habits to communicate in a way that respected their values and needs. As the visiting health providers encountered the complexity of language varieties and cultural differences in this program, they began to collectively develop new communicative strategies that were integral to the care they would deliver. In their daily interactions, clinic volunteers developed strategies that represented a type of negotiation of differences as local residents helped their visitors run the medical and dental clinics. After seeing how central the role of language negotiation was to carrying out the goals of this program the summer before, I began the second summer by setting up the clinic in a way that would support a collaborative and rhetorical approach to conducting patient intake, dental procedures, and medical consultations.

The following chapters serve to describe and report on a qualitative research project that emerged from questions I had about the potential for communication between local and visiting volunteers who worked in these health clinics. This research draws from ethnographic research methods (interviewing and participant observation) to explore communication strategies in the context of two different clinics within the same transnational health program. The program is run by a non-profit organization based in Santiago, Dominican Republic (D.R.), called El Centro

para la Salud Rural (CSR)[4]. Each summer, CSR works with a private, Midwestern university to host a five-week trip for U.S.-based health care students and professionals to the D.R. The summer program's purpose is to provide accessible medical and dental services to rural communities while fostering cross-cultural relationships with local volunteers who help run the clinics and host the visiting participants. The CSR board of directors chooses six communities from over 150 each year to host summer program clinics. Communities that have the opportunity to host a clinic often do so for a maximum of two to three years in a row. Throughout the remainder of the year, CSR receives different local and foreign physicians who follow up on the referrals made by the summer program doctors and the cooperadores de salud[5] for each community. During the summers of 2011 and 2012, I served as a coordinator for the program, and all interviewees for this project worked in some capacity with my groups during those years. As a coordinator, I worked with an assistant coordinator to plan homestays and activities for participants, serve as an interpreter in and outside of the clinic, and act as the primary liaison between the host community and visiting participants.

By examining a rural health program that brings together individuals from different nations to run temporary clinics, this study explores how the participants formed a type of transnational public that collaborates across linguistic and cultural differences. Drawing connections among public engagement, global health, and translingual rhetoric, this project aims to provide insight into translingual communication practices for global health programs that bring together providers and patients from different nations. The research design and analysis of this project are guided by the following research questions: RQ1) *What strategies do*

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[4] Tr. The Center for Rural Health. (The name of the organization has been changed for this study).

[5] Tr. Health promoters (These are leaders in each affiliated community chosen and trained by the organization to serve as the point person for health-related concerns of local residents).

transnational health program participants and local volunteers develop to negotiate meaning and develop mutual understanding with varied levels of proficiency in different languages? and RQ2) *How can the study of communication within these specific transnational health clinics inform understanding of collaboration across cultural and linguistic differences?*

Research on issues of public engagement in global communities, collaboration across difference, and the emergence of translingual practices in these spaces can contribute to understanding about the intersections of global health communication and translingual rhetoric for scholars within the field of Rhetoric and Composition. The specific program and qualitative data that I will analyze in this study provide one example of the potential case studies that rhetorical scholars could explore with regard to these topics, if willing to move our scope of research outside of English-dominant settings and "local" U.S. publics. As an introduction to the project, this chapter outlines the major theoretical tenets that have guided my investigation of communication practices within this transnational health program in the D.R. I will demonstrate how a move to "transnationalize" public engagement should also encourage interrogation into translingual rhetoric, since it is clear that any transnational public is inherently a multilingual public. My aim for this project is to enrich understanding of transnational publics and translingual rhetoric in a way that foregrounds the voices of my participants and their experiences with negotiating language, culture, and difference. Ultimately, this study provides practical recommendations for communication and collaboration between transnational health program participants and host community volunteers.

Public Engagement

The first component of relevant literature guiding the inquiry of this study is public sphere theory. Any discussion of rhetoric and public sphere theory has historically begun with a

nod toward Jürgen Habermas and his book *The Structural Transformation of the Public Sphere: An Inquiry into a Category of Bourgeois Society.* Extending initial inquiries (Kant, Hegel, Arendt, Lippmann, Dewey) into public discourse and social action, Habermas set out to define the terms public and private in a way that examined an ideal public sphere that could host rational deliberation among its members. He specifically examined the eighteenth century bourgeois public sphere, which he describes as "an early public sphere in the world of letters whose institutions were the coffee houses, the *salons*, and the *Tischgesellschaften* (table societies)" (Habermas 30). As long as participants were "propertied and educated," they could participate in public discourse on topics of concern for the larger group of "private" citizens. These people, whom Habermas refers to as "private" initially, gathered to use the "social" sphere as a place where the private realm became publicly relevant. Even though the middle of the nineteenth century came with a transformation of the public sphere through non-owners and an enlarged public, Habermas maintains that this initial bourgeois public sphere set up an ideal that can motivate democracy and public discourse objectives today.

Following Habermas's work emerged a series of objections, critiques, and re-articulations of the notion of publics. In "Rethinking the Public Sphere: A Contribution to the Critique of Actually Existing Democracy," Nancy Fraser criticizes Habermas's idealization of the liberal public sphere and failure to acknowledge other competing publics that emerged in the same time period because of exclusion and marginalization. This idea of a multiplicity of publics has influenced further work in public sphere theory tremendously. Fraser examines how "virtually contemporaneous with the bourgeois public there arose a host of competing counterpublics, including nationalist publics, popular peasant publics, elite women's publics, and working class publics" (Rethinking 61). Her explanation of multiple publics in relation to their group identity—

whether by gender, race, class, or nation—initiates an important discussion among scholars about how people define and organize themselves according to shared identity and interests as they develop in opposition to dominant identity and interests.

Similar to Fraser's assertions to pay attention to multiplicity in public engagement, Gerard Hauser challenges public sphere scholars to consider multiple, overlapping publics, and the vernacular discourses which guide public discourse in his book *Vernacular Voices: the Rhetoric of Publics and Public Spheres.* Hauser explains,

> Members of pluralistic societies belong to several, perhaps many, overlapping discursive arenas in which they experience the polyphony of concurrent conversations as vernacular languages that rub against one another, instigating dialogues…on the questions raised by their intersections and leading us to consider possibilities that might encompass their political, social, cultural, and linguistic differences. (67)

A deeper investigation into how vernacular voices instigate dialogues and rub against one another can provide insight into the ways that individuals respond to, and communicate within, their various differences. Extending this idea of communicating across differences, Fraser updates her approach to public sphere theory in her article, "Transnationalizing the Public Sphere: on the Legitimacy and Efficacy of Public Opinion in a Post-Westphalian World." With this article, and the more recently published book, *Transnationalizing the Public Sphere,* scholars in political theory, media studies, women and gender studies, and sociology have considered challenges to the existing body of public sphere theory to re-consider definitions of citizen, nation, and public opinion in light of the increasingly transnational nature of the public sphere.

Re-framing discussions of citizenship and public discourse in light of a transnational public sphere requires an acknowledgement of the increasingly mixed citizenry and identities of rhetors today. In her article, Fraser explains that

> the equation of citizenship, nationality and territorial residence is belied by such phenomena as migrations, diasporas, dual and triple citizenship arrangements, indigenous community membership and patterns of multiple residency. Every state now has non-citizens on its territory; most are multicultural and/or multinational; and every nationality is territorially dispersed (Transnationalizing 10).

With the traditional notions of citizenship and civic engagement often accompanying discussions of publics and counterpublics, these material realities of residence and citizenship provide an imperative for updating definitions of public opinion, the public sphere, and public engagement in Rhetoric and Composition. Since Fraser's call for transnationalizing our conception of publics and critical theory on public engagement, much of the public sphere research in this field has still remained in U.S. local communities that are predominantly English speaking. Even though researchers have explored diverse publics that collaborate across, or interact amid, difference (Jeffrey Grabill, Linda Flower, and Candace Rai to name just a few), the national and linguistic boundaries have yet to expand fully into other territories, which could be fruitful for our investigation into public engagement and the diverse vernacular voices of publics today.

In 2006, Wendy Hesford described what she saw as the *global turn* of Rhetoric and Composition in her piece, "Global Turns and Cautions in Rhetoric and Composition Studies." Hesford argues that "an understanding of the intertextuality of local and global cultures" is crucial to this global turn and, "More and more, scholars across the disciplines join rhetorical and ethnographic methods to study the role of persuasion in the formation of transnational publics"

(792). The interdisciplinary work that Hesford mentions is crucial to a global turn, which identifies the need for comparisons across contexts for the topics that we study today. While existing research that utilizes rhetorical and ethnographic methods is fitting for the study of transnational publics, I argue that some of the traditional notions of citizens and civic engagement still have inhibited a larger movement toward transnational research in the field. Much of the field's scholarship has made major strides toward including a more globalized look at the composition classroom and the U.S. university system. However, examples of citizen-scholars and public intellectuals most often remain close to "home," with a heavier emphasis on the "local" in order to be relevant to the field's pedagogical roots.

This research near our institutional "homes" has benefitted our knowledge and understanding about collective action, public writing, and public engagement. Examining geographically local publics is important for public sphere scholars and can enhance our theory on how "local" publics are simultaneously transnational with the movement of people, goods, and resources in and out of those locations. In their edited collection *The Public Work of Rhetoric: Citizen-Scholars and Civic Engagement*, John Ackerman and David Coogan state, "Globalization and new distributions of wealth and human communities provide us with rhetorical scenes as civic engagement with the imperative to learn how to comprehend them. This imperative gathers momentum and 'expertise' through local communities" (11). Their description reflects what seems to be the driving factor to study "local" publics: that one's existing comfort levels and potential for expertise will be strongest with those publics that are in close proximity to his or her workplace. Additionally, they seem to argue that since rhetoric is locally situated, studies of rhetoric must be local. If our rhetorical scenes emerge from globalization, we must investigate how studying "local" and situated rhetorics outside of the U.S.

can illuminate new findings for civic engagement in global contexts, and thus work to explore transnational public engagement. Therefore, studies that consider the "on the ground" situated locales of rhetoric in transnational publics can benefit our understanding of both global and local communities. These studies can further map out what "transnational" moves look like for our public turn. They might encourage discussions of what other binaries on the borders of publics illuminate for us about discourse, such as *formal* versus *vernacular, public* versus *private,* and *local* versus *transnational.* This research may also help us to respond to Hesford's call for "a global citizenship that gives substance to human rights and encourages intercultural and transnational dialogue" (795).

Themes of citizenship and intercultural dialogue have remained relevant to our current notions of how people engage in public discourse, a "public life," and organizing across differences. At times, the various emerging publics have been counterpublics, subaltern counterpublics, rogue publics, and more. For my purposes in this study, I recognized that the assembly of a multicultural health team and the discursive work of running a clinic represented a type of public engagement, but I had trouble identifying the team as a "counterpublic" since they functioned differently than how existing literature described marginalized populations forming around a shared identity. Many of the definitions of counterpublics distinctly note identification with one type of positionality, in opposition to the majority or Public in power, making it difficult to envision participants from both marginalized and privileged groups engaging in public discourse together. With this temporary health program, local residents from the patient population in rural Dominican towns worked alongside visiting health practitioners from privileged communities in the U.S. The purpose of the program was to serve marginalized groups of patients who could not easily access medical and/or dental services by bringing

individuals who had the means to volunteer their time and services in the D.R. The combined group of clinical volunteers represented a variety of racial, cultural, socioeconomic, and educational backgrounds. Additionally, the identities and discourses associated with counterpublics often endure over time or represent a lifelong struggle. I began to wonder, how might scholarship on publics account for temporary bursts of engagement like summer health programs? What about publics that emerge across lines of privilege and exist for a set amount of time in the effort of making small steps toward more immediate goals?

I investigate public engagement in a temporary health program by considering how the groups that form in this program are what Robert Asen calls "emergent collectives." In his article "Seeking the 'Counter' in Counterpublics," Asen introduces the term "emergent collectives" to describe counterpublics and explains that "not all members of a historically excluded group may affiliate with counterpublics. Additionally, emergent collectives are not necessarily composed of persons excluded from wider public spheres. This quality facilitates critical attention to coalitions built across difference" (439). If individuals build these coalitions across difference, their members must also develop common codes and rhetorical tactics to learn from each other and share information. Broadening our scope of research to include emergent collectives may open up perspectives on how individuals in both privileged and marginalized communities cross borders (national, cultural, linguistic, or otherwise) to work together in addressing public concerns such as health disparities.

Global Health

Health care practitioners and students of "first world" nations are travelling across national borders each year for global health programs, and the complicated, temporary relationships that are established between people from different backgrounds in these programs

warrant further research and reflection. In their article "Global Health is Public Health," Linda Fried, Margaret Bentley, Pierre Buekens, Donald Burke, Julio Frenk, Michael Klag, and Harrison Spencer state:

> [G]lobal health is still often perceived as international aid, technologies, and interventions flowing from the wealthier countries of the global north to the poorer countries of the global south. A more nuanced and contemporary perspective emphasises interdependence and recognises the many contributions of both resource-rich and resource scarce nations. (536)

Critical theory and investigation into the communication practices that develop in spaces of transnational public health are critical to providing a more comprehensive look at the *collaborative* relationships established between emergent collectives in global health. For programs that do not emphasize collaboration, investigation into successful models of communication tactics can help encourage administrators to ensure that host communities contribute to the dialogues about these programs as much as their foreign visitors do. Learning from host communities about their experiences and opening more spaces for their voices in the dialogue about global health may encourage visiting practitioners to recognize the language practices of their patients as resources in expanding their own health literacies.

First world, English-speaking voices often dominate public discourse about international immersion trips. These voices can give helpful, yet always only partial, insight into transnational public engagement today. Whether sharing stories with family and friends or encouraging other health providers to engage in global health, these narratives structure the "first world" view of health and illness in developing countries. This circulation of discourse about "other" nations and global health reflects the history of tropical medicine and physician-explorers. In their chapter

"Colonial Medicine and its Legacies," Jeremy Greene, Marguerite Thorp Basilico, Heidi Kim, and Paul Farmer explain,

> Just as missionaries were frequently the first point of contact between Europeans and non-Western peoples, the news and writings the missionaries sent back home were commonly Europeans' main source of information about the colonies…The medical missionaries themselves became iconic figures in Western understandings of the colonies. The heroic image of physician-explorer…popularized the idea of a 'civilizing mission' and the role of a clinician in that process. (48)

Greene, et al. add that this "iconography of Western physicians in developing countries persists, as those familiar with the global health movement can attest" (48). This historical connection of iconic images of Western physicians in developing countries, and the narratives of global health dominated by them, are cause for concern about whether our understanding of public engagement in global health is accounting for the experiences of all individuals involved. From the start of this project, I wanted to incorporate the experiences of both Spanish- and English-speaking participants to contribute to the consistently growing narrative of "global health" and transnational projects. This contribution from the various stakeholders is crucial for challenging "colonizing" narratives of global health programs and incorporating feedback from various perspectives of the many individuals that "do" this work and help run clinics in their local communities.

Understanding transnational public engagement in global health requires a look at why participants engage in these types of programs. In the preface to the edited collection, *Reimagining Global Health,* Paul Farmer explains,

> Disparities of wealth, like epidemics, transcend national and other administrative borders

> and remind us of links, rather than disjunctures, between settings of affluence and privation. But many of our students want to follow the economic gradient down to some of the poorest and most disrupted places on the face of the earth. They want to learn how to work in the places that are in greatest need of modern medicine and public health. A new generation of students and trainees has been explicit about the importance of equity (xv).

This increased interest in global health and transnational engagement requires health communication scholars to study and question how to best facilitate communication about health and illness across lines of difference. Furthermore, to examine transnational programs as emergent collectives illuminates how time and context can affect the potential for building relationships and communicating across cultures. The term "emergent collective" more accurately describes how members come together across differences in wealth, status, language, and culture to work toward a common cause. This can also lead to recognizing how people assemble as collectives to discuss issues of health disparity and how these collectives communicate across cultural differences.

If emergent collectives in global health encounter these differences, questions of language and culture come into play with how these collectives communicate and work together. Fraser reminds us about the challenges with

> the presupposition of a single national language, which was supposed to constitute the linguistic medium of public sphere communication. As a result of the population mixing already noted, national languages do not map onto states…[and] existing states are de facto multilingual, while language groups are territorially dispersed, and many more speakers are multilingual. (Transnationalizing 12)

The idea that a single national language can constitute the linguistic medium for communicating in publics does not stand as a viable option in the increasingly transnational and multilingual nature of existing global citizenry. Thus, if health practitioners are engaging in communities that are inherently multilingual, a rhetorical approach to health communication must reflect the translingual moves necessary for the work carried out in these communities.

Knowledge of how people engage in multilingual global health programs can also enhance practitioners' understanding of how to learn about patients' vernacular voices, or "personal languages." In her chapter "Time and Ethics," from *Stories Matter: The Role of Narrative in Medical Ethics,* Rita Charon explains argues, "Our task as doctors, nurses, therapists, and ethicists is to learn each patient's personal language in its tenses, its images, its silences, and its tensions. That these narratives must unfold in time grants us the time to hear them, to provisionally understand them, and perhaps, thereby, to be of help" (67). While it seems like arduous work to learn each patient's personal language, Charon is right to note that the hope to "help" patients can only be fulfilled through understanding their languages through narratives of health and illness. Even if the provider and patient seem to share the same language, they may encounter layers of differences among dialect, specialized vocabulary, and "health literacy" that can influence how they tell and listen to narratives.

Taking into account the variety of stakeholders involved in global health programs acknowledges that organizing across differences is inherent in this type of work. In the preface to the special issue of *Literature and Medicine,* "Narrative Medicine, or a Sense of a Story," Charon and Sayantani DasGupta describe the rhetorical scene that health care providers enter to engage across lines of difference:

> Health care world-wide is a stage on which are enacted profound and high-stakes struggles across lines of class, race, gender, and power. By receiving all the voices engaged in the work of health and recognizing their often contradicting perspectives, we think we can move health care toward a more effective, more egalitarian, more respectful, and ultimately more just practice. (x)

Similar to what Paul Farmer explained about the goals of the new generation of practitioners in global health, Charon and DasGupta emphasize efforts toward more just health care in the world today. This project will examine the voices engaged in the work of health on a transnational scale, and explore how individuals negotiate communication across differences. Similar to Charon and DasGupta's intention for moving health care toward a more effective, egalitarian, respectful, and just practice, this project aims to explore how health communication research across cultures and languages can also promote this movement. While they acknowledge that there are many different perspectives when crossing the lines of class, race, gender, and power, it is important to note that those border crossings also always include language varieties among dialects, symbolic action, and lay terminology for health and illness. In order to listen to those contradicting perspectives and improve doctor-patient relationships on a global scale, I argue for a translingual rhetorical approach to cross-cultural health communication.

Translingual Rhetoric

A growing number of scholars in the field of Rhetoric and Composition argue for a translingual approach to literacy practices in relation to teaching writing. Scholars such as Bruce Horner, Min-Zhan Lu, Jacqueline Jones Royster, John Trimbur, and Suresh Canagarajah have established the term "translingual" as more fitting than "multilingual" to describe literacies that incorporate cross-language relations in a way that reflects the fluidity and movement among

dialects and languages in literacy today. For example, when talking about translingual literacy, rather than multilingual literacy, the emphasis is on the movement and interactive relationship between languages rather than a collection of separate languages. Translingual literacy scholars also work to dismantle the idea that being multilingual, or presenting language difference, is a quality that inhibits students from success in writing and speaking.

According to Horner, Lu, Royster, and Trimbur in their piece "Language Difference in Writing: Toward a Translingual Approach," a translingual approach to writing "sees difference in language not as a barrier to overcome or as a problem to manage, but as a resource for producing meaning in writing, speaking, reading, and listening" (303). The U.S. composition classroom has proven to be an important space to study this translingual approach, especially with the field's history of positioning first year composition as a "gatekeeper" class at universities and its association with nationalistic English-only politics (Trimbur). However, examining language difference as a resource in the field of Rhetoric and Composition might be more multi-faceted if situated outside of the classroom, English departments, and the institutional confines of U.S. universities. Until now, research on a translingual approach to rhetoric and research on transnational public engagement have yet to be intertwined, and I argue that by doing so, we can positively inform both translingual and publics research in various ways.

This move toward transnational publics and translingual rhetoric will further contribute to moving our theory and practice from a monolingual paradigm to a translingual one. In his book *Translingual Practice: Global Englishes and Cosmopolitan Relations,* A. Suresh Canagarajah explains that the term "monolingual" may be nothing more than something with academic and ideological significance because communities and communication have "always been heterogeneous. Those who are considered monolingual are typically proficient in multiple

registers, dialects, and discourses of a given language" (8). Since communities are already engaging in multiple discourses, theory on translingual literacy should develop from detailed study of those communities' social practices. Additionally, in their article, "Translingual Literacy, Language Difference, and Matters of Agency," Min-Zhan Lu and Bruce Horner explain that a translingual approach "recognizes difference *as* the norm, to be found not only in utterances that dominant ideology has marked as different but also in utterances that dominant definitions of language, language relations, and language users would identify as 'standard'" (585). Understanding language difference as the norm thus requires that translingual scholarship focus on discursive interactions representing a variety of languages and dialects to better integrate theory and practice.

While the term "translingual" has recently picked up speed within the field as an area of interest for research, it has mostly been associated with writing in order to inform composition pedagogy and theory. Proponents of multiliteracies (Cope, Kalantzis, and New London Group) in addition to scholars such as Shirley Brice Heath, Brian Street, and Juan Guerra have demonstrated in their research that speaking and writing, reading and listening, creating and composing are all intertwined as literate acts that are mutually informative in the ways users translate from one medium to another. They also connect their research on literacy in communities to literacy learning and education. This broader understanding has encouraged literacy scholars to investigate the interplay between different acts of speech, writing, and composing. While this study examines a process of developing translingual literacy skills, the focus of my analysis is on translingual rhetoric, and not explicitly translingual literacy, in order to examine strategies used to respond to communicative differences and accomplish certain goals. For this project, I utilize *translingual rhetoric* to refer to cross-language rhetorical acts that

move back and forth between languages by negotiating dialectical and cultural differences in order to achieve a mutual understanding. I argue that translingual rhetoric is inherently a public rhetorical act, and by moving across languages, or dialects of a language, this rhetorical act negotiates private and public concerns. Individuals constantly interpret and re-articulate these concerns by negotiating meaning between the language users in conversation with each other. In this situated use of “public,” I do not necessarily mean shared with a large group of people, but rather the transfer of information that was initially closed off from the health provider (thus private) and has now been made visible through the negotiation of language and interpretation of meaning. Just as I examine this process within the same “language” but across varieties of Spanish, so too does this translingual rhetorical approach apply to interactions between providers and patients who both speak English or other languages. A translingual paradigm disrupts the traditional notion of a “language” being a static and unified code to examine the nuances of dialect, pronunciation, and specialized terminology—all of which are important for examining health communication today.

In this project, I apply a “translingual approach” to investigate translingual negotiation as a public rhetorical act utilized in oral literate practices by volunteers in a cross-cultural health care setting. I hope to demonstrate how examining translingual rhetoric in situated, oral practice can allow space for interrogation of concepts that are often limited by a U.S., English-dominant setting such as the composition classroom. In doing so, I hope to further what Bruce Horner, Samantha NeCamp, and Christiane Donahue call for in “Toward a Multilingual Composition Scholarship: From English Only to a Translingual Norm” by contributing a translingual research project which helps “in shifting our focus away from the confines of national borders toward transnational connectivities, and away from treating ‘local’ language practices of teaching and

learning writing as discrete toward recognizing all language use as acts of translation" (287). Additionally, not only is the subject matter of this project an attempt to expand the translingual approach to rhetorical scholarship, the project itself also serves as an example of translingual scholarship. The choices I made in representing my research subjects' words, when and where to translate, and how I designed and analyzed the data consistently required considerations of language difference and audience.

Taking a translingual approach to transnational health care with this qualitative project also reflects how Horner, NeCamp, and Donahue hope that this notion of multilingualism "shifts our focus away from individuals, located on a fixed scale of competence toward 'mastery' of a reified 'target' language, and toward groups of people working in collaboration to use all available linguistic resources" (288). This shift can benefit our investigation into emergent collectives and transnational public engagement by understanding how people collaborate and utilize their collective resources to encourage translingual negotiation in conversations. Additionally, inquiry into translingual rhetoric as a public rhetorical act can illuminate new findings when situated in various vernacular discourses. Hauser reminds us, "We belong to a community insofar as we are able to participate in its conversations. We must acquire its *vernacular language* in order to share rhetorically salient meanings" (67). Thus, if multilingualism is the norm for emergent collectives today, understanding how to use translingual rhetoric to acquire vernacular language is crucial for research on public engagement. Finally, listening to vernacular voices in global health programs can open up space for more ethical interaction across differences of class and power and encourage more collaborative relationships through discursive strategies in daily interactions.

Outline of Project

Drawing on the theoretical framework that I have outlined in this chapter, the following chapters will explore other aspects of the project's design and analysis. In *Chapter 2: Research Design,* I elaborate on my own role as a researcher-as-participant in this program and the qualitative methods that I used to design and conduct this project. I outline how I moved from a participant with this transnational program to a researcher who utilized a methodology of engagement (Grabill) to design a study that investigates translingual rhetoric in a transnational health program. This chapter explains the qualitative approach I took to focus on two groups working with this summer program in the two towns from 2011 and 2012: Buena Vista and Rancho de la Vaca[6]. Finally, it demonstrates how Robert T. Craig and Karen Tracy's analytic framework of grounded practical theory informed my analysis of interviews, participant observation notes, and other relevant documents.

Chapter 3: Engaging the "Messy": Interpreting the Public Work of Translingual Rhetoric explores the analysis and results from my findings to answer my first research question. It lays out the first two levels of grounded practical theory, technical and problem, through the methodological framing of Jeffrey Grabill's rhetorical engagement. In describing how each level helped identify interpretive strategies to work with linguistic difference for these participants, the discussion focuses on how assembling this collective influenced the development of translingual practices used to support performances in the clinics. Drawing from the unique experiences of various language users, I examine hybrid interpretive strategies across English-Spanish, varieties of Spanish, and non-verbal tactics, and how various members of the group drew from vernacular discourses of their fellow companions to forge connections across differences.

[6] The names of the towns have been changed for this study.

In *Chapter 4: Considerations for Collaboration in Cross-Cultural Health Care*, I answer my second research question through an examination of the third level of grounded practical theory: philosophical. This chapter demonstrates how the situated ideals of language learning and emotional connections influenced the decision-making of participants as to whether or not they wanted to engage in translingual negotiation. It also examines how participants used verbal and nonverbal vernacular performances to make connections across differences. This chapter also examines the moments of disconnect between individuals that further emphasized their differences and, at times, were caused by the U.S. participants feeling especially "foreign" or "othered" by interactions with local residents. By examining the negative and positive factors influencing translingual negotiation in this program, this chapter explores what this study contributes to an understanding of collaboration across difference.

Chapter 5: Taking a Translingual Approach to Health Communication examines the theoretical and practical implications of this study. I discuss how the results from this study can inform future transnational collaborations and future inquiry into translingual rhetoric. Acknowledging the limitations of this study, I identify areas for future inquiry for the organization (CSR), the field of Rhetoric and Composition, and health practitioners involved in global health.

Chapter 2: Research Design

I arrived at Rancho de la Vaca in June 2012 with a familiarity with the region and an excitement to see familiar faces from the previous year. I reassured my assistant coordinator, Alexis[7], that even though our campo would probably be one of the hottest out of all six groups in the summer program, the hospitality of the people and the beauty of the region would more than make up for it. Alexis and I spent a weekend in the town before the group from the U.S. arrived, and from the start of the program, we tried to think ahead about potential issues that might arise. We talked about discomforts participants might experience with different food, the heat, using latrines, sleeping under mosquito nets, and having less privacy than at home. We discussed ways to help build good relationships between the visitors and the host families. Among many other topics, we discussed how to best facilitate conversations by encouraging Spanish use as much as possible and working alongside the community leaders whenever making decisions. The community had two cooperadoras de salud[8], both of whom I had met briefly the year before when they visited the clinic I was helping coordinate in Buena Vista, another town about fifteen minutes away. Throughout our month in Rancho de la Vaca, local residents often introduced me as "the coordinator from last year in Buena Vista," and I was able to connect with many residents whom I had met the year before in the other clinic. Generally, they seemed to have had a positive experience in that clinic, and thus I was able to build rapport as the coordinator for this summer's clinic in the region.

My positioning as a researcher was at the forefront of my mind when re-visiting the region. I was nervous and excited about the possibilities for a qualitative project centered on our

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[7] All names of participants have been changed.
[8] Tr. Health promoters (female)

work in Rancho de la Vaca, but knew that, above all else, taking an ethical approach to my data collection and analysis was crucial. Since I already had developed a relationship with, and affection for, the people in this region, those relationships would take priority over any research goals I might have. This was risky, professionally, since I knew that my job with the program and rapport with the community would come before the project if I worried that it would cause any harm. I decided to get to know people as a coordinator for the program first, and, over time, I began to introduce my identity as a researcher who was looking to utilize feedback to share with the summer program and similar programs in other countries. Without developing rapport with my participants, I would not have gathered as detailed and helpful of data. Thus, through this critical analysis of ethnographic data, I set out to describe a series of approaches to translingual rhetoric and collaboration in one specific transnational health context.

This project was developed from questions I had about how communication across difference works and what practical strategies translingual rhetors take to achieve mutual understanding. I wanted to know why language and information transfer happened certain ways, or why things went wrong, and how we could contribute to existing theories on border crossings of language, culture, and nation. Thus, I designed a qualitative research project that would examine public engagement in transnational health communication across boundaries of language and culture in one specific setting. As I stated in Chapter 1, this project is guided by the following research questions: RQ1) *What strategies do transnational health program participants and local volunteers develop to negotiate meaning and develop mutual understanding with varied levels of proficiency in different languages?* and RQ2) *How can the study of communication within these specific transnational health clinics inform understanding of collaboration across cultural and linguistic differences?*

Engaged Scholarship

Underlying the motivations for this project is a desire to build connections between theory and practice in a form of engaged scholarship. In their article, "Engaged Scholarship and the Creation of Useful Organizational Knowledge," J. Kevin Barge and Pamela Shockley-Zalabak explain how putting theory and practice in relationship with each other

> is an embodied relational activity that necessitates bringing members of scholarly and practitioner communities into conversation with one another. Engaged scholarship privileges the diversity of perspectives that theorists and practitioners bring to making sense of a problem and honors their unique knowledge and expertise as valid. (253)

This notion of bringing together both theorists' and practitioners' perspectives in making sense of problems is similar to Ellen Cushman's approach to *activist ethnographic research* in her book *The Struggle and the Tools*. Cushman presents this approach as one that can avoid the "liberal savior" or "do-gooder" mentality that often accompanies service learning and public engagement projects. She explains that an activist methodology "insures that, at every level of the ethnographic enterprise—from data collection through interpretation to write-up—the researcher and participants engage in openly negotiated, reciprocal, mutually beneficial relations" (Cushman 332). This is an effort to avoid reproducing an oppressive relationship between the researcher and those studied, which I believe is crucial for ethnographers to keep in mind when conducting cross-cultural research. However, when discussing a collaborative approach that privileges "mutually beneficial relations," a researcher must simultaneously design a rigorous project while building relationships before, during, and after the project's work is complete.

To frame my own approach to this type of collaboration, I use Jeffrey Grabill's methodology of rhetorical engagement to demonstrate how this project takes an *engaged* approach that recognizes rhetoric as a practical tool to enable the work of others. In his piece "On Being Useful: Rhetoric and the Work of Engagement," Grabill introduces a methodology of rhetorical engagement that examines two methods: "assembling a public and supporting performances—[which] are essential to effective public rhetoric and fundamental to the notion that rhetoric might more usefully be understood as enabling the work of others" (Being 193). This methodology, when situated in a diverse, transnational environment, can allow for useful rhetorical engagement in cross-cultural health care settings. The first step, assembling a public, is crucial to becoming an engaged partner. Similar to Grabill's description, the group that I worked with in this study could be described as "a 'public,' which in this case we understood as a 'community'" (Being 197). The term community will be used throughout this study to identify the group of people that came together to work and visit the clinics. Since "comunidad" (community) and "campo" (rural area) were most often used when research participants described this group of people or town as a whole, I will also use those terms to describe the public and local residents. Additionally, the terms are fitting with the sense of community the health care teams felt as they moved into the town for four weeks and developed relationships with families and each other over that time.

Living with host families and participating in local activities led to a process of assembling a public through the visiting participants' engagement with local community members. Understanding the process of "assembling" a public means acknowledging that groups, relationships, and activities were very much in existence, and will continue to exist, outside of the time of engagement with this specific public. Assembling a public was more than

simply choosing the participants and campos for this program. There needed to be a conscious effort from all participants to acknowledge and respect each other as members of our public. Additionally, any service or outreach program that cares for the community in which it engages must consider how one does not simply enter, start working, and living in a new and foreign town without getting to know it first.

Research on emergent collectives that collaborate across differences of race, class, power, status, and discourse can better inform our future directions in studies of literacy, rhetoric, and composition. Utilizing a methodology of engagement, we can participate as global citizen-scholars in ways that reflect how Grabill connects the public work of rhetoric with practical, professional work in the world: "Rhetoric is…a type of discursive work that is difficult to do and which is taught, often, in conjunction with what we understand as 'professional work'—managing projects, coordinating activity, learning and using information technologies, working well with others, communicating effectively. These are the skills of assembly" (Being 205). Identifying the assemblage of a public draws attention to the process of getting to know other members of that public, spending time with them outside of work activities, and learning about their local customs and everyday lives. This engagement was important to me as a program coordinator and researcher for ethical reasons—to focus on gaining the trust of the community and facilitate working with them. The formation of this public, or emergent collective, did not just happen during our clinic hours, and the local residents helped to bring everyone together to play games, cook together, and dance together in the afternoons and evenings. These communal activities were essential to helping the group feel united and understand their time together to be something more than just work in a clinic. In this way, the people we lived with were not just "patients" in need of a diagnosis but also host families, neighbors, and friends.

For the context of this study, the "performances" in Grabill's second step for rhetorical engagement included medical consultations, dental procedures, patient intake, and developing rapport with patients. To support performances, I tried to bridge communicative barriers through interpretation. As a coordinator, I constantly walked back and forth between sections of the clinic to help interpret or check in with participants. ¡Raquel! ¡Rachel! My name was constantly called out from across the clinic for help explaining what type of pain dental patients had; how often to take certain medications; when to come back for follow-up; or whether or not we could serve any more patients that day at the clinic. My role as an interpreter, coordinator, and scholar forced me to move in between languages constantly to try facilitating understanding and promoting respect for a mixed and fluid rhetoric in our multilingual space.

As the weeks progressed, other participants became more confident in their understanding of the local Spanish dialect, and the clinic became a space of many interpreters shifting between languages to utilize translingual rhetoric for developing meaning and understanding together. They worked together to respond to problems with language "barriers," misunderstanding, and communication about health and illness. Although translingual scholarship considers language difference a resource rather than a barrier, this was a term the majority of U.S. participants used to describe communicative problems. Since I intend my analysis to be grounded in participants' experiences and terminology, I will refer to the "barriers" they encountered with an acknowledgement that many of them found ways to overcome those barriers. In his recent article, "The Work of Rhetoric in the Common Places: An Essay on Rhetorical Methodology," Grabill explains that "A good rhetorical theory, like any good methodology, can be taught, can be learned, and is useful for solving particular kinds of problems. Good rhetorical theory helps us think and engage the world in ways both strategic and

practical" (256). I will address the ways in which participants supported performances more in Chapter 3 by discussing the technical strategies used to overcome communicative problems in the clinic. The pages that follow in this chapter will cover the research methodology for data collection and analysis of this project.

Methodology

Participants

Participants for this project consisted of volunteers in the Centro para la Salud Rural (CSR) summer health program from the D.R and from the U.S. All U.S.-based interviewees were pursuing professional degrees in health care (medicine, dentistry, nursing, and pharmacy) at the time of their participation in the program. Dominican participants consisted of volunteers who helped with daily clinic activities and all three community leaders in charge of overseeing the program held in their towns during those years. Generally, the summer program team for a specific community will consist of about fifteen U.S. participants and eight to ten Dominican volunteers, including the cooperadores de salud (cooperadores). These participants represent a wide variety of proficiencies and dialects in Spanish and English, thus providing important feedback on diverse experiences of language difference and working together in this program.

Traveling from the U.S., the summer program health care team usually includes one or two professional physicians, dentists, pharmacists, and nurses. Physicians can vary in their nationality and residence. Within the two groups I worked with, we had physicians originally from Venezuela and Nepal who were working in the U.S., and a Dominican physician from Santiago. In addition, usually one or two undergraduate ayudantes[9] help with interpretation and

[9] Tr. Helpers. These included both U.S. and Dominican participants who helped with the initial triage of taking vital signs (blood pressure, pulse rate, etc.).

work mainly with the patient intake process. The leadership team includes one coordinator and one assistant coordinator for each campo, who are in charge of working with the cooperadores in planning where and how the clinic services would be set up and where the visiting participants would live and eat during the four weeks in the campo. The coordinators also assist with facilitating daily communication and developing reflections and activities for the group to participate in together. The cooperadores organized an equipo de trabajo[10] that helped with interpretation for the intake process as ayudantes, kept track of the patient list and money, and performed various other tasks to keep the clinic running.

Data collection

The data collection for this project relied on ethnographic methods of participant observation and interviews. Additionally, supporting documents and presentations from the orientation week for U.S. participants were analyzed to triangulate and compare findings with the experiences described in the interview data. All data collection and research methods were approved by the University of Kansas Human Subjects Committee (Project #20174). In what follows, I will outline the process for data collection with the methods I found most useful for answering my research questions.

Preparing for the data collection, I encountered various considerations that come with multi-institutional and –national ethnographic projects. First, I encountered resistance from the U.S. institution that I was working for in conducting the research while also working in my role as coordinator. There was concern about my priorities for the research versus my daily responsibilities as a coordinator and interpreter in the program. The U.S. director suggested that I take field notes outside of clinic hours, and that I seek approval from the director of the

[10] Tr. Work Team

organization in Santiago instead. I did gain that approval and later engaged in many productive conversations with the U.S. director concerning feedback from my participants about the program. Secondly, I was concerned that getting human subjects' approval would be a lengthy process considering I was working abroad in a health care setting. Instead of doing a comprehensive study by incorporating feedback of patients and volunteers under the age of 18, I focused solely on the adult volunteers: both the visiting practitioners from the U.S. and the local leaders and clinic helpers in the D.R. This, coupled with preparation of the IRB application in a qualitative research course, resulted in an expedited approval within three days. There were limitations to this approach, but it also helped narrow my focus for the research questions. Instead of focusing on a broad, and possibly extremely large data set, I was able to focus in on the strategies of the adult volunteers who worked together to run the clinic and incorporate their descriptions of working with the three volunteers (from both summers) who were under the age of 18.

Limitations

Limitations with this project included: a lack of feedback from volunteers under the age of eighteen, an inability to capture the perspective of patients, and insufficient time and material resources to reach all of the adult volunteers from both countries for interviews. Many patients were only in town for the day they visited the clinic, and I did not want to disrupt their time at the clinic with my research agenda. The director had asked that I not collect data during clinic hours, and follow-up outside of the clinic and program was easiest with the participants I had developed relationships with: the health team volunteers. Taking field notes outside of clinic hours was another limitation to my recall of events that occurred; however, I would argue that any form of field notes taken while being an active participant in a program would be somewhat

delayed in order to fully participate in communicative interactions as they happen naturally in any setting. I also began the project in 2012 but included interview participants that worked with me in 2011. This led to some data being more generalized from the 2011 group in comparison to the 2012 group since the interviews were conducted a year after their participation in the program. Nevertheless, I would argue that the data has produced detailed and informative results that can guide an investigation into translingual rhetoric within this transnational health program.

While some may question whether "subjective" relationships can get in the way of a rigorous, scientific study, I argue that no single project is ever truly objective, and it is through relationship building that I was able to complete this project with productive insight from the various stakeholders involved. Though personal relationships undoubtedly influenced the way that I conducted and analyzed this project, the benefits of having insight into these participants' experiences and the ability to follow up with them years after should be weighed against any negative, or unavoidable, subjective influences.

Observation and Field Notes

During June-July 2012, I participated in the summer program as a coordinator for the second time and took observational field notes. At the request of the program director, I took all of my field notes outside of clinic hours in order to allow my focus to remain on my work as a coordinator for the group. If there were ever moments of "down time," I would jot notes about experiences to remember to elaborate on later. When describing fieldwork, Thomas R. Lindlof and Bryan C. Taylor explain that it "derives from anthropological and sociological traditions that direct qualitative researchers to travel to unfamiliar research sites, to develop successful relationships with their inhabitants, to engage with them in activities yielding relevant information, and to create records of that interaction required for subsequent phases of the

research project" (134). Since my time with the participants and in the D.R. was relatively brief, around 5-6 weeks during two summers, I do not claim that this project represents a full ethnography. However, my data collection draws on elements of observation, field notes, and participant observation in ways that represent Lindlof and Taylor's concept of fieldwork. While my travel was to a somewhat unfamiliar site, the environment and program were familiar from my experience with the program the year before. The CSR health clinics serve various communities in the area, so some of the Dominican volunteers I worked with in 2012 may have been patients or visitors to the other clinic I worked with in 2011, and vice versa. These connections were crucial to developing relationships and building my credibility as a successful group leader. I also made my cooperadores aware that I was starting a research project and that I would follow up with volunteers outside of the summer program dates about interviewing them to discuss their experiences.

Lindlof and Taylor explain that "participant observation is, at its core, *a role that is negotiated and performed*" (144) where the researcher may take on roles that are already available or a new role created for him/her to occupy. I negotiated my roles as coordinator, interpreter, researcher, and friend constantly as I moved in and out of environments and interactions with local residents and the volunteers. Before embarking on this project, I understood that qualitative research, especially participant observation, are methods that must be flexible and open to change as the subjects' or researcher's needs may change. I was constantly aware of what Lindlof and Taylor explain as the embodied experience of this type of research. My own physical state influenced the ways I interacted with others, especially if I was not feeling well or was mentally exhausted from interpreting all day. There were also moments when cultural values and assumptions surfaced and collided with how others perceived me in positive

and negative ways as a Caucasian woman appearing to be from Nueva Yor(k).[11] From hearing conversations about me by people who thought I did not know Spanish to making strong bonds with patients and volunteers, my understanding of how to continuously negotiate my performance as a participant and observer grew deeper with each week we were in Rancho de la Vaca. My previous experience with the program established some rapport with the health practitioners, but it was through our interactions in and outside of the clinic that I gradually gained their trust as someone who could provide support through medical interpretation and cultural orientation.

Additionally, during June 2014, I visited CSR to attend and help out at the program's orientation. I was invited to give a presentation for the coordinators, and I attended three sessions of the beginner-level Spanish classes to learn more about the in-country preparation the program provides for participants with little to no proficiency in Spanish. Part of my analysis is informed by the notes I took while attending orientation sessions and having conversations with the program director that week.

Textual Analysis

I also analyzed three documents: the medical patient intake form, the participant guidebook, and a Spanish language packet for participants. Both attending the Spanish classes and rhetorically analyzing these documents helped inform my understanding of why the U.S. interviewees focused on certain types of conversations or words that they felt were especially important to master when interacting with host families and patients. This additional set of field notes helped inform my analysis and write-up for Chapters 3 and 4, as well as the recommendations in Chapter 5.

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[11] Tr. New York; Many local residents referred to the U.S. as New York, which is where the majority of Dominican immigrants live in the U.S.

Interviews

In the beginning of June 2012, I began conducting semi-structured interviews in person with two U.S. volunteers from my 2011 group who were also serving as coordinators with 2012 groups. After the program ended in July 2012, I continued my interviews with Dominican volunteers from both 2011 and 2012 communities in person. In August 2012, when I arrived back in the U.S., I resumed conducting interviews with U.S. participants both in person and over the phone. I completed 23 interviews with participants (n=10 Dominican and 13 U.S.) from the two groups I worked with as a coordinator.

When designing interviews, I aimed to develop open-ended questions that allowed the participant to describe experiences of language difference and collaboration. Questions included topics concerning moments of misunderstanding, working with others who were from a different nation, nonverbal communication, and instances of interpretation, among others. For additional details of my interview protocol, please see Appendix 1. Since the interviews were semi-structured, I allowed for revision and rephrasing as I gradually realized which questions were not as clear as others were, or which ones needed explicit follow-up questions. The 23 interviews conducted included participants from both summers (n=11 who worked in Buena Vista and 12 who worked in Rancho de la Vaca), with various roles in the clinic and multiple linguistic backgrounds.

Spanish was the first language of all of the Dominican interviewees, and English was the first language of all of the U.S. interviewees. However, I worked with other participants (not interviewed) that traveled to the D.R. from the U.S. but had a native language other than English, such as the physicians originally from Venezuela and Nepal. The chart below represents only

those interviewed for this study. When asked "What languages do you know how to speak and understand?" participants responded with the following:

Spanish Only	Fluent in Spanish with a little English	Fluent in English with a little Spanish	Fluent in English with Medium Proficiency in Spanish	Fluent in English with Advanced Proficiency in Spanish
4*	6	6	3	4

*I observed at least two of these participants utilizing English words or phrases during the program and in their interview, but they reported as only knowing Spanish.

Other language abilities reported:

Fluent in Cantonese	Knows a little Italian	Knows a little French	Can count in Japanese	Basic Arabic
1	2	2	1	1

Transcription and Coding

I transcribed all interviews with a sincere attempt to represent the subject's dialects and natural language use as much as possible. A common trait of rural, Dominican Spanish is the dropping of the letter "s" at the ends of sentences. So, for instance, in quotations from Spanish transcripts, there may be instances of a word written as "estamo(s)" to represent that the full word being said was "estamos," but that it was pronounced as "estamo" when the interviewee stated it. I checked the transcribed interviews against the audio files for accuracy. Once I completed the write-up, I asked a trusted colleague to review my translations of quotations for accuracy (See Translator's Note). After transcribing the interviews, I used comparative analysis (Corbin & Strauss 195) and pattern coding (Miles & Huberman 69-72) to develop thematic categories centered on moments of misunderstanding, language "barriers," translation, and other

communicative strategies in the clinic. I also incorporated memoing (Miles & Huberman 72-76) while reviewing transcripts to note any emerging themes or connections with my field notes. NVivo 10 software was used to aid my coding and categorizing processes. Once I narrowed my focus, grounded practical theory was determined to be most fitting for my analysis of the data.

Analysis

I intend this project to produce both theoretical and practical implications that can help inform future practice in transnational health care. With this in mind, I conducted the analysis of this data with a *grounded practical theory* approach as set forth by Robert T. Craig and Karen Tracy in their article "Grounded Practical Theory: The Case of Intellectual Discussion." Grounded practical theory is a fitting approach to facilitate engaged scholarship with the mission of uniting theory and practice. This method strives to describe people's experiences while treating communication as a practical discipline that can help move toward a theoretical reconstruction of practice. Craig and Tracy explain inquiry in a way that promotes a dialectical movement between theory and practice: "Inquiry moves in a hermeneutic circle of preinterpretation, action, critical reflection, reinterpretation, and further action. 'Theory' (conceptual thought) and 'practice' (situated action) can be understood as moments within this process" (252). My own categorization of the data revealed a number of conceptual thoughts and situated actions being mutually informative in my participants' practice. Thus, I needed a theoretical framework that not only interrogated communication as practice, but that also critically analyzed it on various levels to move it beyond a thematic analysis. This approach also reinforced my goal to provide practical recommendations for administrators, participants, and host community volunteers engaged in global health programs.

The grounded practical theory approach uses three levels to analyze data: technical, problem, and philosophical. The technical level identifies a practice as "a repertory of specific communicative strategies and techniques that are routinely available to be employed within the practice" (Craig & Tracy 253). The problem level identifies problems or dilemmas that affect communicative techniques. At the second level of this analysis, "a practice can be reconstructed as a problem logic or interrelated web of problems that practitioners experience and that bring forth both normative reflection (at the philosophical level) as well as strategic action (at the technical level)" (Craig & Tracy 253). The philosophical level explores what situated ideals may surface when considering options for responding to communicative problems. This abstract level considers "reasons for resolving the problem one way or another, accepting certain trade-offs among competing goals, and thus choosing to use certain communicative strategies and techniques rather than others" (Craig & Tracy 253-254). Grounded practical theory provides a useful approach to developing theoretical and practical implications for cross-cultural communication in health care. By examining the struggles and successes of lived experiences, researchers can identify the problems that occur, technical solutions used to respond to problems, and situated ideals that may influence the decisions made in those experiences.

Following my approach to this research as engaged scholarship, Craig and Tracy also describe grounded practical theory as "a rational reconstruction of situated practices for the purpose of informing further practice and reflection" (264) and intend for it to stimulate dialogue among academics and practitioners. The process of collecting data and following up with research participants has stimulated this dialogue thus far. Since working with the program, the U.S. program director asked me to meet with the coordinators for the 2013 and 2014 summer programs to give advice and share some of my experiences to help them prepare for the program.

Chapter 5 will demonstrate how I utilized this study to give recommendations to the coordinators and share the potential areas for future inquiry for the Center and program administrators.

P'alante[12]

To improve health communication in transnational programs, programmatic reflection is important for the development of the field of global health and the well-being of patients involved in it. In their chapter "Unpacking Global Health: Theory and Critique" from *Reimagining Global Health*, Bridget Hanna and Arthur Kleinman explain that

> well-intentioned global health and development projects can have unintended—and at times undesirable—consequences. Careful evaluation of the conditions that enable such consequences can help practitioners design better programs and cultivate a habit of critical self-reflection, which would surely be an asset to global health scholarship and delivery. (15)

I argue that the potential for unintended and undesirable consequences increases within contexts where participants (health providers, volunteers, patients, etc.) do not share the same language background or proficiency. This project attempts to contribute to the cultivation of critical self-reflection around what works best for translingual collaboration in global health programs. From the beginning of this project's design to its final recommendations, I have found that dialogue between academics and practitioners can cultivate and enhance our scholarship in ways that reveal our own biases and shortcomings. With the input and insight from various stakeholders involved, I can move forward with this project knowing that useful, practical applications can emerge from investigating theoretical concepts "on the ground" within transnational and

[12] Tr. Forward. ["Para Adelante"]

multilingual spaces. The fact that my investigation was based within a very specific context, a transnational health program, allowed for a concrete and tangible understanding of moments of success and challenges within the negotiation process of translingual moves in situated contexts. Chapter 3 will examine these negotiation processes as they developed among languages, dialects, and gestures of the various participants in this program. I examine these translingual moves as rhetorical strategies, and their purpose as public rhetorical acts emerges in how they forged connections through the assembly of this collective and how they supported performances in the clinics.

As I have explored the public work of rhetoric in this context, my main motivation has been my hope for making strides toward social change. In her book, *Tactics of Hope: The Public Turn in English Composition,* Paula Mathieu encourages rhetoricians and compositionists to participate in tactical projects, which have "hope for intangible changes—in students, in community members, in the university itself. The key to that hope, however, is an acknowledgment of the radical insufficiency of any single project" (114). In a similar way, I acknowledge that this project holds hope for intangible changes while also being insufficient in addressing all the aspects necessary to invoke that change. This project aims to enhance our understanding of the ways U.S. students and transnational publics engage in translingual rhetoric. It attempts to demonstrate how transnational health programs can approach communication in ways that set up mutually beneficial relations within multilingual spaces. However, a successful movement toward this will require critical thinking and constant reflexivity on the part of transnational health program participants and leaders. Having reflected on the methodological steps and theoretical background that brought us to this point, we now

move forward toward the messy, (hopefully) enlightening experience and results of this study.

Vamo(s)[13].

[13] Tr. Let's go.

Chapter 3: Engaging the Messy: Interpreting the Public Work of Translingual Rhetoric

It is with deep gratitude to the health practitioners and local volunteers with whom I have worked that I present their stories as part of this study. They taught me about translingual rhetoric before I even knew the term "translingual" existed. In a similar fashion to how I have learned from them, I hope this study can serve to demonstrate what researchers and teachers in the field of Rhetoric and Composition can learn from language users and the public work of rhetoricians outside of universities and in contexts outside of the United States. Grabill describes this public work of rhetoric as something that "should help us engage the messy. To engage the world as we find it and to work to understand it as best we can and then act" (Work 262). Furthermore, Grabill argues that what he calls "a methodology of rhetorical engagement"

> positions rhetoric as the art designed for the persistent burden of detecting shared problems, guiding inquiry, and shaping responses. It is empirical, pragmatic, and collective. The rhetor is not and perhaps never has been the individual, the good man speaking well. But there are specific, key roles for individuals with this art of rhetoric. Indeed, it requires lots of individuals pulling together to do the rhetoric imagined here. To assemble and care for that assembly, that is the proper aim of rhetoric. (Work 259)

For this study, I initially set out to explore the messy, complicated practices of translingual literacy. I wanted to demonstrate how translingual theory could better represent the messiness of cross-language processes as they develop, rather than focusing on fluent rhetors who can easily adapt across languages and contexts. In addition to the individual processes of navigating translingual moves, I was curious about the collective uses of translingual rhetoric. How do groups of people negotiate languages to navigate rhetorical moves across differences in

workplace settings? What might an investigation into the communicative practices of a specific team working with cross-cultural health care demonstrate for translingual theory and practice?

Transitioning from the focus on individual rhetors to collective action is helpful for exploring the public work of translingual rhetoric within this situated context of health communication. This perspective allows for an investigation into all of the interpreters, sponsors, and team-building efforts that enable the integration of translingual rhetoric within publics. Additionally, ethnographic methods and qualitative data can provide nuanced, rich descriptions of the communicative phenomena that occur within multilingual health settings. Thus, pairing qualitative research with a methodology of rhetorical engagement provides a framework to understand how engaged rhetoric can support the public work of global health. Research on global health programs can benefit from investigating the potential for providers, patients, and host communities to assemble as publics, forge personal connections across differences, and develop language skills. This study aims to serve as one step in contributing to the discussion of global health by investigating the assembly of multicultural health teams and the cross-language rhetoric that can enhance the clinical work these programs set out to do.

This chapter presents and analyzes the findings concerning language barriers encountered and rhetorical strategies negotiated in the temporary health clinics of this study. It applies Craig and Tracy's grounded practical theory and Grabill's methodology of rhetorical engagement to answer my first research question: *What strategies do transnational health program participants and local volunteers develop to negotiate meaning and develop mutual understanding with varied levels of proficiency in different languages?* These strategies were examined in their relation to Grabill's methods of rhetorical engagement: assembling publics and supporting performances. I examine the communicative strategies of these participants as engaged rhetorical

acts intended to support performances in the clinics. Clinical performances include medical consultations, dental procedures, patient intake, and the development of rapport with patients. Ultimately, the act of supporting performances in these clinics aims to create connections across language and culture and contribute to what Grabill refers to as “knowledge work.” He defines knowledge work as “analytical and discursive activity requiring problem-solving, abstract reasoning, and material things” (Work 249). For this specific study, that knowledge work was activity that focused on problem-solving amid linguistic difference to provide health care in these temporary clinics and the negotiation of material things such as patient intake forms. I identified themes of problem-solving by analyzing the data with grounded practical theory and searching for moments of the problem level (communicative problems) and the technical level (strategies developed to respond to those problems). The following pages will describe the assembly of this group, the linguistic and cultural differences that participants encountered in communicative problems, and the rhetorical strategies they developed to do the knowledge work required for supporting clinical performances.

Assembly of the Public

The assembly of a public, which is the first method of Grabill’s approach to rhetorical engagement, includes three steps: “research to assemble a group in order to discern patterns of activity and their possible agencies; rhetorical assembly of ideas toward the making a Thing; and the related and always material assembly that must be gathered into any thing” (Being 201). In the context of this study, the “Thing” that was “made” was a health clinic. Without the assembly of these individuals, the compilation of their resources, and their public work together, these two clinics in Buena Vista (2011) and Rancho de la Vaca (2012) would not have existed. Without the gathering of individuals and medical supplies across nations, the “clinic” building would still be

the local grade school. The material assembly of supplies and volunteers contributed to the program's public work of creating a clinic that would provide medical and dental services to the nearby communities. Thus, by assembling themselves and their various resources into a communal space where they would work together, this transnational collective created a temporary health clinic that served the local residents in the region. Since participants from multiple nations, regions, and languages ran the medical and dental clinics, this emergent collective encountered both challenges and benefits in terms of coming together as a cohesive group. One factor that aided the assembly of this group each summer was the shared goal of providing affordable and accessible medical consultations and dental procedures for the local communities. To achieve this goal, the various members of the public needed to prepare for their assembly in order to serve the patients in the area effectively.

Similar to Grabill's first step in assembling a public, the assembly of this collective began with research and preparation for the separate groups of individuals that would participate in the program. Before coming together with the local community for four weeks, the health practitioners spent one week in Santiago upon their arrival in the country for orientation. The CSR director organized this orientation week by dividing time among programming for Spanish classes, cultural and historical lessons, trips to visit museums and outreach programs in Santiago, and the packaging of medical supplies. Each morning, three different levels of Spanish classes were held for participants to familiarize themselves with conversational and medical Spanish, along with "Dominicanisms" that are present in the rural, Spanish discourse. These classes were in addition to the six-week course, which CSR's U.S. office offered to participants prior to the program. The second method of assembly was the rhetorical assembly of ideas toward making the clinic function as a medical and dental clinic. The coordinators for each group checked in

with their assigned team members to discuss preparation for immersion in the campos, but overall the students and professionals for all six communities integrated as one large group for the orientation week. CSR staff, coordinators, and visiting doctors used PowerPoints and printed documents to discuss topics concerning epidemiology in the country, cultural values, and running the clinics. The nursing students and ayudantes had meetings focused on the patient intake forms, referral forms, and other documents related to the summer health care and follow-up after the program. Once the groups embarked on their trips to work and live in the campos, the coordinators communicated daily with the U.S. program director to set up any clinical supply deliveries or to discuss medical, emotional, or behavioral issues that we would need to address within the group dynamics and with the local residents.

The preparation of the Dominican volunteers was less structured and varied by community according to however the cooperador/a decided to organize it. Before the U.S. participants arrived in Santiago, the coordinators for each campo had their own one-day orientation with the cooperadores in Santiago to discuss procedures, emergency plans, and research to complete before the U.S. participants arrived. For one weekend, the coordinators travel to their assigned campos with the respective cooperador(es) to get to know the area, visit the houses where participants would be staying, discuss clinical assembly and organization with the work team, and discuss preparation with the cooperador(es). For both Buena Vista and Rancho de la Vaca, the cooperadores had previously hosted a summer program team and clinic in their communities. During those planning meetings, I divided our time between learning about how they ran the clinic(s) in the year(s) before me, and then how we might make changes to improve the functionality of the clinic and integration of community. Although this weekend provided helpful interactions for the local volunteers and cooperadores to prepare and

demonstrate what was already prepared, for the program, the focus of the majority of this preparation was on orienting the U.S. visitors with the local culture, language, and format of the program. Otherwise, the CSR summer program director and other staff worked directly with the cooperadores in preparing for the program and discussing issues as they arose while the program was in session. As I will discuss further in Chapter 5, the pre-program preparation could have included more education for the local teams about their visitors. At least one of the cooperadoras shared with me a desire to learn more about the U.S. participants, their adjustment to living in the campos, and their preparation for the program during orientation week.

The third step of Grabill's methodology, material assembly of the clinic, occurred in the actions taken to create a daily schedule and set up the medical supplies, dental chairs, exam tables, and waiting area each day. Clinics ran from approximately 8:00am until 1:00pm, Monday through Friday, for four weeks. During the program, the local work team helped keep things running smoothly in and outside of the clinic. One of the cooperadores, José Luis, explained some of the major duties and benefits of having these local teams: "Se hicieron un grupo de trabajo y había un grupo del logística, había grupo de nosotros fue vamos aquí por el trabajo en todo las áreas: para limpiar la clínica, para trabajar en la cocina…Todo se hecho a través de este equipo de trabajo."[14] Much of this organization was completed before the U.S. group arrived to the community, and the equipo de trabajo in José Luis's community held meetings multiple times each week to discuss daily plans for bringing the visitors and local residents together for work and social activities. Checking in to discuss planning for the clinical work and social activities positively contributed to the morale for all of the volunteers. These various roles that the groups served were also important to account for the material factors of running a volunteer

[14] Tr. "They made a work group and there was a logistics group, there was a group of us that came here for work in all the areas: to clean the clinic, to work in the kitchen…Everything was done through this work team."

health clinic. To ensure that members of the team worked with tasks focused on material concerns such as cleaning, cooking, and logistics enabled other volunteers to effectively meet with patients and provide health care in a clean and positive environment.

Afternoons were set aside for relaxation and integration with the community, and all meals were eaten together at either the cooperador/a's house or the designated "cocinera's"[15] house. The coordinators and the local community leaders planned evening activities. Maria, a young woman who served as a cocinera and an ayudante with groups in Buena Vista, explains how our day was organized: "En la mañana trabajamos y en la tarde siempre no(s) podemo(s) compartir todo(s) junto(s) dominicano(s) y americano(s). …Jugamos mucho y siempre vamos a los rio(s). Que muy divertido... cocinamo(s) junto(s); comimo(s) junto(s)."[16] Although holding clinic hours for the entire day would have seemed to better "help" the community by seeing more patients, the program administrators saw value in building relationships with local residents. This also allowed the health providers to rest and recharge amid the tiring process of running a clinic while adjusting to a new climate, culture, and language. Grabill argues that "Rhetoric is always material, and it is most powerful when it makes things that enable others to perform persuasively" (Being 201). By organizing the daily schedule and community integration in this specific way, it enabled the practitioners to perform their roles in the clinic effectively and dedicate time to their patients.

Temporal aspects of the public work of rhetoric can also create limitations on a collective's potential for serving others with their work. The temporary nature of this program also added tension between the health providers' desire to serve as many patients as possible and

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[15] Tr. Cook's (female)

[16] Tr. "In the morning we worked and in the afternoon we always could all share time together Dominicans and Americans. ….We played a lot and always went to the rivers. It was very fun…we cooked together; ate together."

their concerns for the quality of each patient's visit. The Centro para la Salud Rural (CSR) participant guidebook states: "Clinic operations do not function like standard clinics in the United States. The goal is not to see how many patients can be seen in one clinic period. Spending time with and listening to each Dominican, no matter how small the problem is important" (29). Joshua, an ayudante from the U.S., reflects on the tension he felt with the balance of these goals during the program:

> [Y]ou feel like you're doing so much good and I felt like us as a clinic, especially when we heard about our numbers compared to other people's numbers, like wow, we're really seeing a lot of people. But I think it's a challenge to really…appreciate the symptoms and the problems with each patient…I kind of wondered if we saw 40 med patients in a day and some other clinics saw like fifteen, did those fifteen patients get a much better experience than the 40 patients[17] we had?

It was common for participants in different groups to compare their numbers of patients seen when they reunited in Santiago. The clinics in Buena Vista and Rancho de la Vaca served more patients from different communities than some of the other campos because of their geographical location and the ease of access for travel. Thus, both clinics I worked at saw some of the highest numbers of patients out of the entire program. However, there were also many days when I had discussions with the cooperadores and volunteers about the patients that we could not see. There were always more patients to see, and it was a temporal and emotional concern to keep the daily number at a reasonable amount of patients so that the practitioners were not exhausted and that they did not sacrifice the quality of patient visits for quantity of patients during the hours the clinic was open.

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[17] This was higher than our daily average and may have been used as an example of one of our busier days with multiple physicians seeing patients at the same time.

Overall, the assembly of a public is a key method, as indicated by Grabill, in carrying out rhetorical work and rhetorically engaged research. The assembly of this specific transnational collective occurred in various stages. First, the group assembled with designated Dominican and visiting volunteers to work as a health team in running the clinics each day. Second, each of the visiting participants lived with a host family in the community, and many of them developed a familial-type identity with the members of those households. Many host families began calling their guests "hija/o"[18] and/or "hermana/o"[19], and quite a few of the visiting participants reciprocated in calling their hosts "family," "mom/dad," and/or "sisters/brothers" depending on the composition of the household. Not all participants developed such an intimate relationship with their hosts, but the ones that did, did so regardless of their proficiency in Spanish. As a whole, the four weeks of immersion provided a constant movement of language and relationship building that enhanced the performances of the health clinic and developed connections with patients and local residents.

Inquiry into the assembly of an emergent collective is crucial to the rhetorical work of supporting performances. As Grabill explains, "this assembly work is required in order to be useful to others" (Being 201). Examining the research, rhetorical assembly of ideas, and the material assembly that go into the making of a Thing, or in this case a temporary health clinic, can identify the relationship-building and material concerns that must be addressed in order to support performances in temporary clinical settings. Without an emphasis on this assembly, the support of performances would not easily persist over time, let alone for four weeks of cross-cultural immersion. It took both the organizational and emotional work of assembling these individuals into a more cohesive collective to accomplish the interpretation, literacy

[18] Tr. Daughter/ Son
[19] Tr. Sister/Brother

development, and rapport building that would be crucial for serving patients and forging connections across differences. These connections, in turn, supported the development of translingual rhetorical strategies as the participants built their trust in each other and self-confidence in taking risks with languages to improve their communication tactics during this program. Additionally, investigating the assemblage of this collective alongside the process of supporting performances highlights the complexity and messiness of translingual moves in a way that encourages development and recognizes the process, not just the product, of these performances. The following pages serve as a discussion of this study's findings about Grabill's second method of rhetorical engagement: supporting performances. This framework investigates the communicative problems that arose in this multilingual setting, and the rhetorical strategies participants used to overcome these problems in order to support performances in the medical and dental clinics.

Supporting Performances

To further draw on Grabill's methodology of rhetorical engagement, I examine the communicative strategies of these participants as *supporting performances* in the clinics, which included both supporting the ongoing assembly of the collective and "supporting the rhetorical activity of others" (Being 204). Performances in this study include medical consultations, dental procedures, patient intake, and developing rapport with patients. By utilizing Craig and Tracy's grounded practical theory approach, I analyze the three levels of communication (problem, technical, and philosophical) influencing the movements across languages and gestures to support performances in the clinics. In this chapter, I discuss the analysis of Craig and Tracy's first two levels which identify the technical level of "communicative strategies and techniques" (253) that are used in response to the problem level dilemmas that affect communicative

techniques. In Chapter 4, I will address the philosophical level of situated ideals that influenced the participants' willingness to engage in translingual negotiation together.

Since this study is framed by rhetorical engagement, I identify these problems as distinctly "rhetorical problems" (Grabill "Being") in which participants face dilemmas concerning mutual understanding, rapport building, and performing procedures. Grabill states, "to be useful as a public rhetorician or engaged researcher is to become one who understands associations and, in understanding them, becomes a creator of associations" (Being 195). Identifying rhetorical problems is a form of making associations, and by creating these associations, I was better able to identify the rhetorical strategies used to respond to communicative dilemmas. The way to address these problems was through rhetorical strategies that incorporated interpretation, gestures, and cultural understanding to accomplish certain goals. Both the problems and the strategies developed were collective, and the translingual moves negotiated in these clinics were only possible by drawing from linguistic and cultural resources of various members of the health team.

Grabill's notion of supporting performances is a useful approach to engaged research with the facilitation of communication in transnational health programs. As a participant in this program with no medical training, my contribution to the clinic was always in a supportive role: interpreting, making administrative decisions about clinical procedures, and/or mediating understanding between individuals. Many days at the clinic, numerous people approached me asking in English or Spanish about what to do next, why something happened, and/or how to communicate a point effectively. Additionally, each team member had moments where s/he would support someone else in a performance at the clinic: holding a flashlight for the dentist, interpreting, or acting as a consult in one of the three sections (medical, pharmacy, dental). To be

useful in supporting these performances, team members needed to make associations across languages and non-verbal gestures to ensure mutual understanding between patients and health providers. Through a variety of communicative acts, participants supported each other's performances in speaking, diagnosing, and conducting procedures. Before developing the rhetorical strategies to support these performances amid linguistic difference, individuals needed to identify rhetorical problems they encountered. When a rhetorical problem surfaced because of differences in language, dialect, or terminology, the individuals would first need to identify the source of misunderstanding and then proceed in utilizing a specific translingual strategy to move forward in the conversation with a patient or fellow volunteer.

Participants encountered a variety of communicative problems influencing their movements across languages and gestures to support performances in the clinics. U.S. participants most often referred to these problems as stemming from "language barriers." Drawing from the unique experiences of various language users, I examine which language barriers arose with varied proficiencies in Spanish and English, dialectical differences in Spanish, and medical terminology. In response to my first research question, I identified three translingual rhetorical strategies as responses to these problems: English-Spanish interpretation, Spanish-Spanish interpretation, and non-verbal tactics. These strategies represent how various members of the group relied on, and learned from, the linguistic resources of other members in the emergent collective to resolve communicative problems and support the "knowledge work" of medical performances in the clinics.

Problem Level: Layers of a Language Barrier

In my analysis of the problem level, three key themes emerged. When working together, participants encountered, and worked to overcome, what they described as a "language barrier."

Upon analyzing their varied accounts of this barrier, I noticed that it was a result of three layers of linguistic difference. For the US participants, this barrier took on various forms depending on their proficiency in Spanish and ability to adapt to the vernacular discourse. Thus, the following pages describe the three predominant layers of linguistic and cultural differences connected with some form of a language barrier: basic or no Spanish or English proficiency, Spanish dialectical difference, and vernacular medical terminology.

Basic to No Proficiency in Spanish or English

The first, and I would argue most predictable, language barrier came between English speakers who did not know Spanish and Spanish speakers who did not know English. Since the dominant language of this community was a regional, Dominican dialect of Spanish, local residents did not express much concern for difficulties with language, except when trying to understand English. In order to be respectful to our hosts, my assistant coordinators and I encouraged the English speakers to try to use Spanish as much as possible when spending time with Dominicans in the program. To avoid alienating participants that did not understand Spanish, we often communicated bilingually, even while having informal conversations with the group outside of the clinic.

Working inside the clinic presented many difficult moments of misunderstanding for participants with little to no proficiency in Spanish. Jackie, a pharmacy student, explains, “It was very frustrating to not be able to understand it...or speak back...or know what anyone was saying.” These feelings of frustration and struggle were consistent across the majority of native English speakers in this study, regardless of their proficiency in Spanish. At one point or another, each of the participants expressed having the experience of feeling frustrated at their inability to understand or express themselves in a Spanish-speaking atmosphere. Other participants like

Peter, a dental student, saw the clinic as something that aided his ability to understand Spanish: "it was definitely a lot easier in the clinic 'cause at least in the clinic, I knew dental terms and things related to dentistry and the mouth, but when conversational Spanish—I mean they could be talking about anything or asking me anything and so that made it a lot harder." Depending on their location and situated language use, participants encountered various forms of language barriers in which they could not understand what someone was saying or others could not understand what they were saying.

For the local residents, having little to no proficiency in English may have affected their willingness to interact with, or say anything to U.S. participants when they were speaking in English. When I asked what her experience was like hearing others speaking in English around her, one of the cooperadoras, Rosa, explained, "La experiencia e(s) que como yo no entiendo me quedo callada. Pero, despué(s) quizá(s) si me interesa yo le pregunto a uno que sepa, especialmente a la supervisor(a), para que me diga que fue lo que ello(s) dijero(n)…para saber."[20] For the times that Rosa did not ask me or another participant to translate, she was left out of the conversation and remained quiet because of her exclusion from the conversation. Rosa was one of four respondents who stated that Spanish was the only language she knew, but even participants with basic or moderate proficiency in English had trouble following conversations that the U.S. participants had in English, and thus it could signal exclusion when they turned to English-only conversations without offering interpretation into Spanish.

Abby, a pharmacy student, explains how being someone with a lower proficiency in Spanish resulted in a complicated process of trying to implement learned language from the orientation week: "they teach you terms in that class like that first week that we're there and then

[20] Tr. The experience is that since I do not understand [English] I stay silent. But, after, perhaps if I'm interested I will ask someone who knows, especially the supervisor, to tell me what it was that they said…to understand."

you try to remember them and implement them, and they don't understand what you're saying. Like you could try to say in Spanish, ‘Please slow down,’ and they don't know what you're saying, and then you feel foolish because you're trying to speak their language.” This reveals the importance of considering the risk that comes with trying to speak a language one is not confident in, and the emotional factors that accompany trying to speak it and not accomplishing a mutual understanding with the listener. Both successful and challenging negotiations were daily occurrences, and because of rationales concerning time and efficiency, attempting to negotiate languages without a fluent interpreter was not always the most attractive option.

Demonstrating her desire for self-sufficiency in the clinic, Jackie explains, “I would've liked to have been able to tell them how to use the nasal spray on my own without having to go through someone else.” Although the participants acknowledged interpreters as helpful components of the entire clinical team, it seemed only natural for the participants with lower proficiencies in Spanish to want to be able to communicate on their own. Abby also describes the challenges of having someone translate for her in this specific clinical setting: “it was a little odd because you really can't talk normally when you have somebody translate because you have to stop every few words until it's translated and then pick up again. And a lot of the time I had forgotten the point of what I was trying to make.” Abby’s description demonstrates how “translation” is unique to this temporary clinical setting and may be different from other institutional settings. Since the interpreters in the clinic were not trained medical interpreters with the ability to do live interpretation, they often needed to stop every few words or sentences in order to ensure an accurate translation. This resulted in longer interactions when participants were not proficient in Spanish, and especially when interpreters needed additional clarification about medical terminology.

Additionally, some patients were of Haitian descent and only spoke Haitian Creole, which resulted in clinic volunteers turning to family members or friends who could help with the Spanish-Creole interpretation. This often set up a negotiation of questions concerning the consultation that included all three languages (Spanish, Haitian Creole, and English). However, since many of the Haitian and Haitian-Dominican residents in these communities spoke Spanish fluently, the number of patient visits where this occurred was fewer than ten, resulting in insufficient data about this phenomenon.

Spanish Dialectical Difference

Spanish took many forms in this program, and this study revealed a few different varieties of Spanish as the participants saw it emerge in their daily discourse. U.S. participants categorized the types of Spanish into the following five categories: *professional*, *American*, *Dominican*, *campo*, and *medical*. Dominican participants often used a binary to describe the types of Spanish for these groups: *Dominican* or *American* Spanish, or possessive pronouns such as *our* and *your* Spanish. The U.S. participants that identified the varied forms of Spanish often had intermediate to advanced proficiency and could recognize language variances more easily. They also described this experience as noticing distinct differences between what they had learned in school and what they heard and spoke during the program abroad.

To explain characteristics of Dominican Spanish, Lisa, a nursing student, notes that with "the grammar, they cut off...a lot, and they say 'ta' like ¿Cómo tú ta? instead of saying ¿Cómo estás?[21]…and then for slang terms, there's the types of food like 'con con[22],' or 'pin [pun]' which means you look the exact same." Lisa's first point about "cutting off a lot" represents similar comments of participants while in the campo on the dropping of the letter "s" at the ends of

[21] Tr. How are you?
[22] Overcooked rice at the bottom of the pail. (Definition from CSR guidebook)

words. In their article "The status of s in Dominican Spanish," Barbara Bullock, Almeida Jacqueline Toribio, and Mark Amengual examine vernacular Dominican Spanish, s-deletion, and the "intrusive s." They describe the intrusive s as something that can occur within a word, at a pause, or between words, as it appears in speech habits of Dominicans whom they refer to as "semiliterate" speakers. Although I do not classify members of this emergent collective by literacy levels, the "intrusive s" was present in local discourse and the U.S. participants did mention it as a curious phenomenon they had not encountered before this immersion. Bullock, Toribio, and Mengual explain that "[t]he Spanish spoken in the Dominican Republic is often described as innovative relative to other national varieties" (21) in sociolinguistics research, and they argue that characteristics such as s-deletion represent social norms associated with "Dominicanness" (23). In an earlier article, "Language Variation and the Linguistic Enactment of Identity among Dominicans," Toribio establishes that while the Dominican Spanish dialect may not receive overt prestige among other global varieties of Spanish, it does carry "covert prestige" as a symbol and enactment of national identity.

For the participants in this study, daily encounters with the Dominican Spanish dialect revealed a number of words and phrases that they noticed had different meanings than what they had learned in the US. Instead of calling beans "frijoles," they were "habichuelas," a public bus was a "guagua," a little bit of something was "un chin," et cetera. While the first week of orientation included a bit of discussion about unique terminology of Caribbean Spanish and "Dominicanisms" (See Appendix 2), visitors would encounter various forms of those phrases depending on the region that they visited and the context in which they had conversations with local residents. Some campos were in the northern mountainous regions, while others, like the ones in this study, were closer to urban areas and the DR-Haiti border on the Western side of the

island. It was almost impossible to educate visitors on all of the possible phrases and dialectical features of Dominican Spanish before their time in the campos. What became more useful was learning within situated contexts, such as work in the clinic or helping cook a dinner, in which the visitor could learn terminology and phrases in meaningful contexts that they would remember or encounter again.

Multiple participants with intermediate to advanced proficiency in Spanish noted differences in the “professional” Spanish they learned in textbooks in the U.S., and the local, “campo” Spanish that was spoken in the communities where they were living. Paul, a medical student, discussed his own form of Spanish:

> I use more of a Spaniard Spanish type accent, which I acquired from my time studying over there. And because of that, there were definitely times when I would say a word or a phrase that I realized from the patient's blank face that I needed to repeat in a different way or try to make sound more Dominican. And…usually when I'd try to do that, we were able to communicate well enough.

Most of the U.S. participants who had an intermediate to advanced level of proficiency reported attempting to make their Spanish sound “Dominican.” These participants also noted their recognition, and at times, integration of unique characteristics of the dialect—cutting off the letter “s” as the end of words, “slurring” words together, and “improper” grammar. The words U.S. participants used to describe these speech habits such as “slurring” and “improper” reflect the low prestige value placed on Dominican Spanish globally (Utakis & Pita). Lisa explained how even after the program, she noticed that she brought “that [accent] back to the United States…[and] every Spanish [speaking] friend I talk to is like, ‘Oh the Dominican accent is just so ugly…they have one of the worst.’” This experience reveals the global hierarchy of Spanish

for Lisa's friends who lived in the U.S. but were originally from other Latin American countries. Calling the Dominican accent one of the "worst" might influence whether Lisa decides to keep using it when engaging in Spanish discourse in contexts outside of the D.R.

Toribio examines the vernacular use of Dominican Spanish in different contexts by interviewing Dominicans that live in New York and in the region where the towns of this study are located. She explains that "the Spanish dialect of the Dominican Republic distinguishes itself in significant respects from the prescribed norm for the Spanish language. These speech forms are readily identified and recognized as being of low prestige…and yet, the vernacular enjoys a considerable measure of covert prestige" (Toribio 1139). Among the speakers interviewed in the D.R. for Toribio's research, the region where my study took place is considered a place with a regional dialect that is "discounted or disparaged for incorporating other, less agreeable characteristics, namely those of neighboring Haiti" (1140). From both a global and regional perspective, the Dominican vernacular that participants in this study encountered is stigmatized and undervalued. However, Toribio's argues, "In this predilection for the northern Iberian variety and emphatic repudiation of the influence of the Haitian Creole, Dominicans ignore a central axiom of linguistics—language variation is normal" (1142). Similarly, I argue that a translingual approach to health communication recognizes language variation as the norm in health care. Therefore, language variation and the cultural dynamics that mark variances as "good" or "bad" will influence how health providers, translators, and patients negotiate differences together.

In this specific context, the ability to acquire speech habits of the local, Dominican dialect was highly valued as a form of Spanish that could ensure understanding and develop rapport with patients and host families. Reflecting "covert prestige," the U.S. participants found

that speaking Spanish "like a Dominican" also resulted in positive interactions and deeper connections with the community. In this specific context, other "good" accents or dialects received blank looks and questions. Even if a participant qualified the vernacular language as "bad" language, many still performed it because of its usefulness in this context. Retrospectively, I would have liked to reflect with the group on these stigmas and critically interrogated whether global versus local perspectives influence value judgments placed on varieties of Spanish. Ultimately, examining translingual rhetoric within this context highlights the unique dialectical features of layered linguistic difference in a way that recognizes how situated practice affects whether a way of speaking is considered positive, negative, and/or useful.

Vernacular Medical Terminology

Aside from needing to acquire new approaches to their use of Spanish, certain participants who worked as interpreters also encountered issues with translating between their medical Spanish and local lay terminology for symptoms and disease. I identify this lay terminology as vernacular medical terminology. In my analysis, the patient intake process was one of the areas where participants encountered the most difficulty with language barriers of this kind. The intake process was set up as a dialogue between the patient and an ayudante or nurse to facilitate the filling out of a patient information form to prepare for the examination in either the dental or medical side of the clinic (See Appendix 3 for medical form).

CSR provided patient intake forms in Spanish and informed US ayudantes that they would use the forms as an aid for orally asking the questions for documenting a patient history. Andrew explains how some of the terminology did not translate when having conversations with the patients: "some of the vocab that they have written out, the questions that we had to ask, were different from what…the patients would understand…It was frustrating at times when…[you]

have a question written for you, and you read it, and it's not being understood...[or] that you didn't know how else to ask it." The tension between the written terminology on the patient intake form and the oral articulation of it surfaced in the disconnect that happened between what was said and ultimately understood in the clinic.

Certain intake questions might include the official terminology, such as asking "¿Tienes diabetes?" (Do you have diabetes?), but the ayudantes were informed by group leaders in Santiago that it was more common to ask, "¿Tienes azucar?" (Do you have sugar?). Other terms were more easily understood in a shorter form like suffering from the heart (¿Sufre del corazón?) rather than suffering from heart disease (¿Sufre de la enfermedad del corazón?). Yoel, a Dominican ayudante, lists some of the questions that were the same for every patient: "como: si sufría de diabetes; si sufría del corazón; si sufría del alguno otro enfermedad, y que se iba hacer como el odontología, si a filling si empaste."[23] These examples show how ayudantes shortened formal terminology to reflect how the local residents discussed common health issues. His short code switch at the end of his response also shows how Yoel learned intake terminology in English because many times the US ayudante would write the word "filling" in English so that the dentist knew what it was.

Another common term that created a dilemma with terminology was the word "gripe." Paul explains that it seems like "Everybody and their children, have 'the gripe' in the DR…It takes a little while to get used to this because in Medical Spanish classes, you learn that that means 'the flu'...but, I came to realize this is just kind of a catchall term that meant everything's not well." Patients most often used this term when presenting cold or allergy symptoms, and U.S. participants even heard the diagnosis when they would sneeze or cough and a local resident

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[23] Tr. "Like: If you've suffered from diabetes, if you've suffered from the heart (heart disease); if you've suffered from any other illness, and what they were going to do like dentistry, if a filling (in English) if filling."

would ask, "¿Tienes gripe?"[24] Paul adds that this created a dilemma as a medical practitioner in balancing his own understanding of illness and a seemingly cultural concept deeply engrained in the local discourse:

> [W]hen somebody's convinced that they have something that they don't, you kind of run into the age-old dilemma in medicine of saying, 'Do I spend the time telling them No, they don't have that problem, or do I just say, yeah, okay, well this vitamin will fix that?' In a sense...there was some cultural miscommunication there until I kind of understood what they were trying to say, but even as such, I still don't think I fully understand what they often meant by "the gripe."

Recognizing when he and the patient did not share the same definition for the term gripe, Paul decided that asking follow-up questions to further clarify the patient's symptoms and needs was the best approach. Other examples of cultural differences with health terminology included when patients would refer to stomach pain as "gastritis" or answer the patient intake question about kidney problems as "Yes," because of back pain. As volunteers around the clinic realized the words and questions that had different meanings between them and their patients, the health team recognized a need to approach consultations in different ways. The health team adjusted their language use and asked for additional clarification to ensure mutual understanding with hopes of reaching the most accurate and helpful diagnosis for each patient.

This section has examined three layers of the language barrier which created "rhetorical problems" (Grabill "Being") for these participants by examining the struggles they faced with basic Spanish or English proficiency, dialectical differences in Spanish, and medical terminology. As a rhetorical problem, these linguistic and cultural differences created an impetus

[24] Tr. Do you have the flu?

for the public work of rhetoric in this health care setting. Grabill explains, "The study of the rhetorical…is the study of particular kinds of associations that are actively created and re-created. The rhetorical is and creates particular kinds of connections" (Being 195). After studying the rhetorical associations in this setting, I argue that individuals utilized translingual rhetoric to make connections across differences. As I stated in Chapter 1, *translingual rhetoric* refers to cross-language rhetorical acts that move back and forth between languages by negotiating dialectical and cultural differences in order to achieve a mutual understanding. Without negotiating differences and developing mutual understanding, the clinic would not function and patients would not receive sufficient care. Thus, the next section will examine the technical level of rhetorical strategies that participants used to respond to, and cross over, these language barriers. The three major strategies presented are examples of the different layers of a specific type of hybrid interpretation: English-Spanish interpretation, Spanish-Spanish interpretation, and non-verbal tactics.[25] The descriptions of these strategies, as a whole, represent the messiness of negotiating translingual rhetoric, and the ways in which the participants' willingness to take risks with language use supported performances in the clinics.

Technical Level: Translingual Rhetorical Strategies

English-Spanish Interpretation

The first strategy that individuals utilized to respond to the language barrier was a form of English-Spanish interpretation. The most basic and common use of interpretation could be found with individuals who were able to move back and forth between English and Spanish. Katy explained that whenever she could not understand what someone said, she would go

[25] Bloom (2014) explores this concept and represents an initial analysis into the results of this study.

"buscar la coordinadora y decirle 'Ohh, no entiendo que me dice. ¿Podría explicarme sobre de lo que me hablan?' O, por ejemplo, cuando iban personas para consultar y le decíamos 'Ay, tengo un dolor de cabeza,' y ellos quizá(s) no entendían, pues la coordinadora le explicaba y también le explicaba a nosotros en español lo que ellos decían."[26] Katy describes how she would approach my assistant coordinator or me to ask for an explanation any time that she did not understand what someone was saying. She also demonstrates how the coordinator might work between U.S. participants, Dominican volunteers, and patients to facilitate conversation and support performances across the clinic. Since I did not serve a role as a health provider, during clinic hours, my role was predominantly to interpret in any areas of the clinic wherever patients or volunteers needed language support.

Serving as an interpreter in these clinics required the "ability of multilingual speakers to shuttle between languages, treating the diverse languages that form their repertoire as an integrated system," which is also known as "translanguaging" (Canagarajah, "Codemeshing" 401). When describing his experience as a member of the team that could shuttle between English and Spanish, Andrew explains that "it's exhausting…when you switch and you're always constantly having to think in Spanish and figuring out what it means in English, and then formulate your response in Spanish...it's tiring going back and forth like that." For many of these participants, this was one of the first times that they needed to constantly shuttle between languages in a work and home setting. The additional need to help other members of the group understand Spanish conversations increased the pressure for individuals who could more easily translanguage to constantly be prepared to interpret for someone else. Joshua adds that for the

[26] Tr. to look for the coordinator and to say to her, "Ohh, I don't understand what he's saying to me. Could you explain to me what they're talking about?" Or, for example, when people went for their consultation and we said "Ay, I have a headache," and they perhaps didn't understand, but the coordinator explained to them and also explained to us in Spanish what they said.

U.S. participants “who spoke Spanish so well…[they] had no trouble speaking Spanish and then turning it off and then speaking English with us. I think the people who don't speak as good Spanish really appreciate that because we know you're doing twice the amount of speaking that we are, (laughs)…at least.” Referring to the bilingual conversations that the group would have and the constant interpretation he observed, Joshua acknowledges that the language work for these individuals was at least twice as intense as for those who needed the interpretation. Recognizing the mental and physical fatigue that participants encountered when needing to constantly cross languages and interpret for others, we can better understand the complexity of developing proficiency in translingual rhetorical moves.

Many U.S. participants took on roles as interpreters in addition to their designated role as a nurse, doctor, pharmacist, et cetera. Lisa describes the complex process that happened as she moved back and forth across languages while translating for a physician and patient:

> I was helping translate for our doctor, who was from Nepal, and then the patient who spoke Spanish...we struggled through it. I think a guy came in with a rash and he kept saying ‘Comí, Comí’ which means like ‘I ate.’ And I was like, ‘But it's on your skin!’ And I don't know...I just had an ‘aha’ moment where ‘comí’ is like rash is eating your skin...and then I had to look up the word for powder and then was trying to translate all of this between English to Spanish. It was kind of chaotic.

Understanding the ways patients use metaphors to explain health issues is important when translating in a multilingual health setting. Lisa was able to move from a literal translation and misunderstanding toward making connections and helping support the physician in her diagnosis. She also mentions that this process was chaotic. Understanding “translingual negotiation” as something that is not always clean-cut and fluent is important to recognize practical implications

for its potential in health communication. It is a complex, chaotic process; a negotiation that moves back and forth in a plethora of ways: between patients and providers, interpreters and providers, and in the liminal spaces between symptoms and diagnoses. Only through patience and the determination to work through this complexity could participants attempt to find that "aha" moment which Lisa describes.

When discussing difficulties with adjusting to the Dominican Spanish, U.S. participants often mentioned that it was very fast. One of my assistant coordinators, Jacob, explains, "I'm fluent in Spanish, but you have to really stop people, 'cause Dominican Spanish is very fast, very, very...[but] if you have the willingness to really slow people down and if the other person is really willing to listen to what you have to say, and meet you there, then from there, you can have a lot better communication." At the technical level, both Spanish- and English-speaking participants mentioned the need to ask someone to slow down in order to understand them better, and the need for patience in frustrating situations of misunderstanding. Regardless of dialectical differences, the simple nature of speaking fast made Dominican Spanish that much harder for the visiting practitioners to catch up and translate sentences in their heads.

The differences in professional versus vernacular medical terminology in Spanish and English also required strategies that would disrupt the normal flow of interpretation. Since we did not staff the clinics with trained medical interpreters, differences in terminology required tactics of slowing down, defining terms, and alternating eye contact between the patient and the interpreter. Thus, when utilizing English-Spanish interpretation, it was important that all parties involved understood technical terminology in the conversation. Nicole, a dental student, explains,

> [I]n the dental school we're taught [that]…it is best to make eye contact directly with the patient and not the translator. So the translator is a third person and you need to directly communicate with the patient. But, in [this setting in] the Dominican Republic it's hard because the translators don't know the words or know the entire phrase that we're trying to say in their language…it was a lot more one-on-one communication with the translator and then the translator with the patient, versus me talking to the patient and having it translated.

Describing the back and forth which health providers need to have with their translators before even transferring the information to the patient demonstrates the complicated negotiation that took place in the clinic. Though my own health literacy grew through participation with these programs, there were still moments when I would have to ask for clarification of diseases, medications, or follow-up procedures to ensure that I was translating them properly for the patients. This happened with other interpreters, as well, since the team represented a wide variety of specialties and disciplinary backgrounds. However, since many of the U.S. participants served in some capacity as interpreters at one point or another, unique dynamics emerged with the varied ways that each of them spoke Spanish. This required interpretive assistance from the Dominican ayudantes who were the most familiar with the local dialect of Spanish and lay terminology. Ultimately, one of the most detailed themes that emerged in my analysis of these interactions was the strategy of utilizing Spanish-to-Spanish interpretation to respond to dialectical differences in the clinic.

Spanish–Spanish Interpretation

All of the U.S. participants tried to speak Spanish in the clinic, whether it was with a few words and pointing or attempting to hold entire conversations. Thus, there were multiple layers

of Spanish translation, re-articulation, and pronunciation happening at any given time. Through these occurrences, a type of Spanish-to-Spanish interpretation emerged in the daily clinic activities. This interpretation entailed the volunteers negotiating different dialects of Spanish, and Dominican volunteers most often executed it. Yoel, one of the Dominican volunteers, explains, "Yo le ayudaba a traducirle a todo los pacientes…A veces de inglés a español y de español a español…Porque no estaban impuestos a escuchar a esa lengua—escuchar la manera de hablar de los americanos."[27] For U.S. participants, the Dominican volunteers and their Spanish–Spanish interpretation were crucial to the success of supporting performances in our clinic. Elizabeth explains, "The first week in clinic was really difficult doing intake, because I just kept getting super tongue-tied every time I tried to ask something and…they would just look at me...then like my Dominican ayudante helper would translate and they'd eventually get it." Seeing the success of pairing up Dominican ayudantes with nursing students and U.S. ayudantes for the patient intake process during my first year with the program, I began the second summer with the plan to set up the clinic similarly. I had asked the Dominican ayudantes to be available to help with interpretation, but first to allow the U.S. participants try to speak Spanish and encourage them to learn to do it on their own. In this way, I encouraged a specific approach to assembling the public that was similar to the year before, but with new participants.

Daniel, a Dominican ayudante, explained how the differences in Spanish affected patient understanding in the clinic: "Mi experiencia fue que habían muchas personas en la clínica que no entendían lo que decían ustedes."[28] When I asked for clarification about whether the U.S.

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[27] Tr. "I helped translate for all the patients…Sometimes from English to Spanish and sometimes from Spanish to Spanish…Because they (the patients) were not used to hearing this language--hearing the way the Americans speak."

[28] Tr. My experience was that there were many people in the clinic that did not understand what it was that you all said.

participants were speaking in English or Spanish, he explained: "[H]ablaban en español, pero los dominicanos no entendían bien."[29] Daniel and the other Dominican ayudantes quickly proved to be able to understand the U.S. participants' Spanish usage. While patients struggled to understand the practitioners' language use, it was immensely helpful to have younger volunteers in the clinic who were able to adapt between the Spanish of the patients and the Spanish of the U.S. participants. By working with each other and spending time together, Dominican ayudantes were able to familiarize themselves with the visiting participants' language use and common medical terminology used in the clinics. This led to a useful approach in the clinic in which the Dominican ayudantes served as interpreters when patients and U.S. practitioners were unable to achieve mutual understanding between their different dialects of Spanish.

Miguel also explains how sometimes the Spanish needed to be simplified for patients: "Algunos entendían pero siempre había alguien que le podía...interpretaba má(s) fácil lo que ello(s) decían y le explicaba…como [en] un español más...más simple para ellos."[30] Miguel interpreted for patients, especially older patients, and used a "simpler" Spanish so they could understand the questions. Simplifying the complicated or mispronounced Spanish of the U.S. participants was one of the many tactics these Spanish-Spanish interpreters took to support patient care in the clinics. Daniel describes one experience where he stepped in to help with interpreting in the pharmacy: "Yo recuerdo que hubo una señora que le estaban explicando cómo debía tomarse lo(s) medicamento(s), y ella no entendía. Entonce(s) yo…les dije que me explicaron a mí para yo explicárselo a ella…Me lo decía(n) en español, pero decía(n) palabras en

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[29] Tr. They spoke in Spanish, but the Dominicans did not understand it well.

[30] Tr. Some understood but there was always someone who could…interpret more simply what they said and I explained…like [in] a Spanish that's more…that's simpler for them.

inglés que yo le entendía."[31] With so many sections of the clinic needing language support, it was helpful to have ayudantes like Daniel who could understand both English and Spanish.

Although a few of the Dominican ayudantes understood English, they mainly utilized it for helping with interpretation in the clinic. The Dominican participants rarely held conversations with the visiting participants in any language other than Spanish. This provided an impetus for promoting and developing Spanish conversational skills. Thus, the integration of local volunteers in the clinics influenced conversations and language choices. When discussing the Dominican ayudantes who helped in one of the medical clinics, Paul explains that

> [T]hey made it very interesting to interact in the clinical setting because we couldn't always just revert to English…Over the course of the four weeks that we worked with them, I did notice that we obviously grew more comfortable with them and...I think they, without doubt, grew more comfortable with us, and that was a very fruitful relationship and one that ended up being very beneficial for us in the clinical setting.

Both the need to challenge themselves to speak in Spanish while running the clinic and the ways participants grew comfortable with each other throughout the program were important to the collaboration that could happen in the clinic. Lisa states that the Dominican ayudantes "were the biggest asset to us. Like, they helped us out more than *anyone* with the language barrier...they allowed us to try to speak Spanish to the patient, and then once the patient was like, 'I have no clue.' They would repeat it in Spanish and it would sound the exact same thing like I said, but the patient would get it." Many U.S. participants mentioned that it felt like the Dominican ayudantes would say "the same thing" but just in a different accent or a few different endings on

[31] Tr. I remember that there was a woman to whom they were explaining how to take the medications, and she did not understand. So I told them to explain to me so I could explain it to her. They told me in Spanish, but [also] said words in English that I understood.

words. Whether they were just re-stating phrases, or re-formulating a set of words into a full sentence, their help with translation in the clinic was clearly a crucial component to supporting performances during the intake process.

Certain participants were not even sure whether they should call this process "interpretation" or "translation" since it was all within the same "language" of Spanish. Additionally, some English speakers were not always aware of times when they tried speaking Spanish but still inserted English prepositions or words for when they did not know the Spanish terms to use. Paul reflects on instances when he encountered this language problem: "I'm not sure if it was a language thing or if it was an accent thing, but there were definitely a couple of times that I had patients who would voluntarily yell outside of the room for…one of our Dominican helpers to come and interpret, which was really just kind of [to] repeat what I said in Spanish, but in a different accent, which was the first that I've ever had that as a quote-unquote 'interpreter.'" When this occurred within the medical examination room, it became a bit more complicated. Paul and other interpreters already available would try to encourage the patient to work through the language difference with them so that they could try to resolve the issue and not involve too many people from outside of their exam room. However, if trying to negotiate the language difference did not work after a few attempts, they turned to either an ayudante or one of the coordinators to help facilitate the conversation.

For other participants with lower proficiencies in Spanish, they did not see the Spanish-Spanish translation as just a restatement of a question with a different accent. Nicole describes her own attempts at Spanish in the clinic:

> [T]he first verb should be conjugated; I would not conjugate it…I don't know if nouns can be in the wrong tense, but it probably was…This one time Pedro kind of was just

> standing there next to me, and he turned to the patient and he changed all the words, but I could tell that they were the same words; they just had different endings. The patient nodded their head...It was translating my Spanish to better Spanish.

Noticing that Pedro was adjusting the grammatical structure of her sentences by changing the endings of words was a unique observation among the participants in this study. Nicole worked to learn more Spanish each week that she was in the campo and was very attuned to grammatical structure while speaking, as many beginning-level Spanish learners are in the U.S. Drawing from coursework that emphasized how to conjugate verbs, but also not always catching everything that was said in Spanish, Nicole saw this translation as a move to improve her Spanish. While some participants saw Dominican Spanish as a low prestige form of the language with slang and improper grammar, others saw it as the correct way of speaking Spanish. In this context, the vernacular dialect and pronunciation was the most useful form of the language, and thus the participants considered the ability to speak it as being skilled at communicating.

Although the unique interpretation of this clinical setting may have extended each patient visit, individuals considered having an interpreter present to help someone who was struggling with the language barrier as the key to efficient information transfer. When describing the Spanish-Spanish translation help he received, Joshua explains that having Pedro re-articulated questions was “way faster, especially when we were asking for what they were allergic to, it was like Penicilina, Novocaína, Aspirina, and I'd say it like that and then Pedro would just rattle it off in a second and they'd be like, ‘Oh, oh, no no no.’” Not only did this use of Spanish-Spanish interpretation help improve efficiency with the patient intake process, it also promoted the ethos of the clinic as a whole. When the first interaction a patient has with the clinic is a long, drawn-out process where the U.S. volunteer is struggling to communicate, the credibility and quality of

the rest of the visit may be in question. By collaborating as a team to prepare patients for their visit to the medical or dental clinic, the team of ayudantes boosted the entire clinical team's credibility as one that could communicate effectively in a multilingual environment.

Ultimately, the strategic approach of Spanish-Spanish translation provided many benefits within this specific clinical setting. Participants utilized this strategy enough on a daily basis that they considered it a major tool to overcome language barriers that emerged from dialectical differences in the Spanishes that various participants spoke. In addition to this approach, and sometimes in place of it, individuals employed a third rhetorical strategy: non-verbal tactics. In what follows, I demonstrate how the participants understood this as a unique communicative strategy, which aided, and at times replaced, verbal communication.

Non-verbal Tactics

Although scholars in communication studies and linguistics have studied nonverbal communication in numerous ways, my purpose for this study was to see how participants used it rhetorically in translingual moves. Participants from all backgrounds utilized non-verbal tactics during this program, but they also noted that the vernacular discourse included a variety of significant non-verbal gestures. Local residents utilized three major gestures that were notable in the context of the group's time together. The first was the quick scrunch of one's nose, which signified "I don't understand," or "What?" This occurred daily in the clinics, and oftentimes seemed like such a natural movement that the patient might not have been consciously aware of doing. Whether it happened mid-sentence or after a question, understanding its meaning helped the providers know that they needed to repeat or re-articulate what they were trying to say. The second gesture was the pursing of one's lips and simultaneous movement of one's head in a certain direction. Whichever way the lips pointed to was a signal to look or place something

"over there." Last, the impact of utilizing an index finger was apparent in various contexts. Shaking one's index finger signified a definitive and forceful "No," or "Stop," and simply pointing it at the ground in front of you was enough to stop a speeding guagua for a pickup. With these gestures engrained in the local discourse, understanding and being careful with our use of them was crucial to successfully communicating in and outside of the clinics.

The dental clinic provided an interesting site for studying non-verbal tactics since most of the participants that worked as dentists had little to no proficiency in Spanish. Additionally, in contrast to medical consultations where the majority of their interactions consisted of verbal exchanges, dentists identified oral issues by looking at the mouth, and that visual was supplemented with a description of the pain and purpose of the visit. Within these clinics, dental visits could only have one of three procedures: cleaning, filling, or extraction. The majority of the dialogue between dentists and patients was at the beginning of the appointment to determine what type of pain patients had and for how long. Then throughout the procedure, there was a set of commands that the dentists had learned from orientation such as "Bite down, "Spit," "Open," and "Show me where it hurts." Peter described his encounters with Spanish as being easier inside the clinic than outside it. He says, "inside the dental clinic was a little bit easier 'cause…you're dealing with one part, so if you ask, 'Are you in pain?' and they say 'Sí,' I mean you can have them open up their mouth and have a pretty good idea of where they're at." I spent most of my time interpreting within the dental clinic and also noticed that the dentists often accompanied words with actions such as pointing to different areas of the mouth, physically demonstrating how to bite down or spit, and showing children how the instruments would not hurt them by tapping the tool on their finger and saying "No duele."[32]

[32] Tr. It does not hurt.

Participants with little to no proficiency in Spanish provided some of the most detailed descriptions of how to utilize non-verbal tactics in communicating. Peter explains, "I would only know a few words so then I would try to almost act out…the rest of it, so even if it didn't make sense, so to speak, they had a good idea of what I was trying to ask or tell them." Since Peter worked as a dentist, he was often able to pull from a small set of vocabulary with almost every patient alongside the physical work he did with patients' teeth. Nicole also explains, "I think across nations, we communicate very much through facial expressions, body motions, and non-verbal cues. And in the Dominican Republic, I think I saw a lot more non-verbal communication through action...through just eye contact and motioning to try to get a point across." Nicole's emphasis on the bodily cues demonstrates how they function as rhetorical tactics in crossing linguistic and cultural differences. Translingual literacy in practice inherently includes aspects of embodied, non-verbal communication, and investigating it in this health communication context further emphasizes the importance of understanding and learning its role and function in translingual rhetoric.

Within the medical clinic, the consultations were almost entirely verbal exchanges and thus required creative rhetorical tactics to overcome not knowing a word or phrase. Alexis, one of my assistant coordinators, explains,

> I would be helping translate for a physician and a patient wouldn't understand like a symptom I was trying to describe or I wouldn't be able to understand some sort of illness that they were describing to me, and it…really challenges the creative side of you because you have to come up with different ways to say things or use body language to help describe, so I think that language barrier really forces you to think outside the box.

Identifying body language as a useful tool for describing symptoms was a common theme for participants in this health setting. Christina, a medical student, specifically noted hand gestures as something that helped in her consultations with patients: "If I asked, 'Well, do you have any headaches? Abdominal pain?' I'd point to my head; point to my belly, and it kind of facilitated the whole communication process." Accounting for these gestures in the process of translingual health communication is important to ensure that patients understand what the provider said. With the power dynamics of patient-provider relations in a transnational health setting between "first world" and "developing" countries, the potential for not wanting to disrespect a provider by challenging his or her language use is even higher. Using non-verbal tactics and asking follow-up questions to ensure accuracy in the verbal exchange are crucial to consider when providing health care in a multilingual and transnational setting.

When explaining how he saw others communicating without words, Yoel explains that "se hacen mimica. Mimica, por ese medio."[33] Similar to Peter's description of "acting out" phrases, Dominican participants explained how one could mimic the action of a point they wanted to get across in a dialogue. One of the cooperadoras, Miladis, also explained this process as mimicry, and explained how she would act out certain things when having morning conversation with participants when they would visit her house for breakfast. She accompanied questions like, "How did you sleep?" (¿Cómo dormiste?), with the action of lying her head to the side on her hands to make the association with "dormiste." This performance of acting out, or mimicking, what the person wanted to say was clearly a limited approach that would take a bit longer to get a point across. However, this tactic often accompanied verbal communication when faced with a loss of words or misunderstanding.

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[33] Tr. They mimic. Mimicry, through this way"

Playing and communicating with children in the town proved to be easier for participants with lower proficiencies in Spanish. Whether they decided to draw together or play with figurines, individuals found that mimicry and nonverbal communication had a lot of potential for making connections with children in the community. Abby shares that one of "the kids at my host family's house--we would draw pictures in the dirt, and then she would use Spanish to explain it, but then she would also take her stick and point out things and draw things for me." Abby added that the girls would be frustrated at times when she did not understand what they were saying, but that this use of drawing and pointing was one approach to remedying a language barrier in order to spend time together. Similarly, Nicole had an experience when she took shelter from the rain at a nearby house, and began playing with a boy, Marco, who lived there. She explains that he had a toy alligator and they

> kinda just got this little bond going and playing...The sounds that I was making of "Chomp, chomp, chomp, chomp, chomp!"…repeating the sound and doing the actions, he would start to repeat them to me. So I knew we were somewhat communicating of this is the action…I would take one of my fingers and roll it over and he would understand that I thought that meant he just ate my finger and so when I did it to him, he would do the same. …I don't think during that entire playing time a single actual word was said.

Nicole's experience illuminates the importance of play, repetition, and figurines for communicating nonverbally. Although at least one word was said in their interaction, it represented a sound Nicole was trying to make to signify the biting action of the alligator. In their time together, Marco listened and received the message Nicole was making, and in turn, reciprocated with the same message to signal that he enjoyed that way of playing with his figurine. Whether the children were trying to teach their visitors new words by drawing or they

just wanted to enjoy time playing together, they showed the U.S. participants that it was possible to make connections with limited shared vocabularies.

Non-verbal communication also included common gestures used when listening during the CSR summer program. During the U.S. participants' orientation in Santiago, there is usually a discussion of "the cultural nod." This refers to the gesture of nodding one's head, even though s/he does not understand what the other person said. Participants noted that they both saw Dominican patients doing this, and that they also did it in their own interactions with host families. Often from fear of seeming unintelligent or inconsiderate, the person enacts a cultural nod to be courteous, but may not express a need for further clarification. This is especially important to understand in a health care setting, since the doctors, dentists, and pharmacists often give instructions for the patient to follow after leaving the clinic. Jacob explains that in the clinic, interpreters needed to "make sure that every little piece of information that was really crucial was fully understood," and that "you'll have Dominicans who will say yes to you all the time in the clinic because they just don't want to be mean, or standoffish or whatever…but you have to make sure that they actually do understand, as opposed to just continuing with the translation." Encountering a cultural nod presents a key moment during interactions that required translation. If any possibility of misunderstanding was apparent, the interpreter needed to decide whether to continue translating or to stop and ask whether the patient understood or if s/he could repeat back what the interpreter said.

This cultural nod makes it difficult to verify whether the listener actually understands, so health providers and interpreters must follow up with questions about understanding and whether further clarification is needed. Elizabeth, like other visiting participants, admitted that misunderstanding was also common "when I was home with my [host] mom…because she

wouldn't ever try to like rephrase things when she said them, she would just say them louder and louder and she would use the same words that I didn't know and I would just end up like saying 'Sí.' I never really knew what I was saying yes to." Acknowledging the interactions she had where meaningful conversation was lost through the façade of understanding, Elizabeth demonstrates how the U.S. participants enacted non-verbal gestures that their patients might also use in the clinics. Additionally, her description of her host mother's language use demonstrates how the U.S. participants experienced what many second language learners experience: people speaking louder, but not slower or in different words. These experiences helped participants recognize when someone was unable to adjust his/her speech to help them, as Spanish language learners, better understand. The data from this study included several instances of U.S. participants mentioning both when they saw Dominican patients and when they, themselves, used the cultural nod. These instances of the cultural nod reveal a non-verbal gesture that requires attention, especially when considering the stakes of what the person might be saying yes to without knowing it.

Participants did find that non-verbal communication could provide space for making connections across differences when faced with a loss of words or wanting to accompany words with meaningful gestures. Jacob describes how people can connect in various non-verbal ways: "the smiles that people have, the kind of quirky humors or whatever, just like playing pranks on people, or walking up and giving someone a good handshake or a kiss on the cheek." However, he adds, "I think that verbal communication is more meaningful in terms of forming deeper relationships…I mean you can only do so much on a non-verbal level." This was a common perception for participants with more advanced proficiency in Spanish, including myself. I was intrigued with the connections participants could make without much Spanish proficiency, but I

began this study with a bias that having more advanced proficiency did result in deeper connections. It was not until these interviews and following up with community members years later that I realized the ways participants and local residents connected were simply different depending on a variety of factors. Not only did local residents ask about their guests from previous programs years after, the host families that would spend my entire follow-up visit talking about their American hija/o were most often those who hosted U.S. participants who spoke the least amount of Spanish.

The non-verbal tactics of translingual rhetoric in this study demonstrated how many participants had success in utilizing language resources of the team and providing their own embodied support in the health performances of the clinic. Abby explains,

> [W]hen I applied for this program, I was told that being able to speak in Spanish was necessary, and granted it is helpful, but it's not necessary. You can still help out the community without being able to speak their language. Whether it's helping out somebody else who can speak the language and you're just any extra pair of hands or just being there physically. You don't need the language.

Abby's explanation further demonstrates how looking at these rhetorical strategies as "supporting performances" can be fruitful for translingual rhetorical studies. Non-verbal tactics and embodied strategies can be just as, if not more, helpful to support medical performances in cross-cultural clinical settings. The place where participants with lower proficiencies in Spanish found non-verbal tactics to communicate seemed to often happen outside of the work settings and at home with host families or children who lived nearby.

Conclusion

This chapter has examined the layers of linguistic difference that created various forms of a language barrier in this program. It also demonstrated how hybrid interpretive strategies were used across languages, dialects, and non-verbal gestures to support performances in the clinic and make connections across cultural differences. Ayudantes like Yoel and Miguel demonstrated how "translation" works across varieties of Spanish in the ways they helped facilitate communication in the patient intake process. The dentists developed common gestures to clarify what they needed to ask the patients to do (bite, spit, etc.) during their procedures. Additionally, having a lower proficiency did not directly correlate with the inability to support performances or develop rapport with local residents. Nicole learned that playing with children could forge connections without the use of many words, and Abby argued that having proficiency in Spanish was not required for supporting the work done in the clinics. My examination of these communicative interactions and strategies demonstrates a need for discussing multiple dialects and collective resources for interpreting in predominantly Spanish-speaking health contexts. It also provides evidence that cross-language rhetorical moves and non-verbal tactics can support medical performances in cross-cultural clinical settings.

This data has outlined a variety of ways in which translingual rhetoric, though messy, can be engaged in transnational health care. Its usefulness in these specific clinics should serve as a motivating factor for health providers to consider the varying levels of language learning and the potential for forging connections across difference amid language and variance in health literacies. In Chapter 4, I will address my second research question: *How can the study of communication within these specific transnational health clinics inform understanding of collaboration across cultural and linguistic differences?* I will highlight language learning and assemblage that helped forge connections across cultural and linguistic differences. Through a

look at the challenges and potential for collaborating across differences, I will examine the philosophical rationale and situated ideals that influenced decision-making about whether or not participants engaged in this type of translingual negotiation.

Chapter 4: Considerations for Collaboration in Cross-Cultural Health Care

Thus far, this study has examined the problem level of grounded practical theory in the layers of a language barrier and the cultural differences that participants encountered in this summer health program. It has explored the technical level of analysis by examining the rhetorical strategies that participants used to respond to, and overcome differences and dilemmas of daily communication together. Through English-Spanish and Spanish-Spanish interpretation, along with non-verbal tactics, participants worked together to support medical and dental performances in the temporary clinics of Buena Vista and Rancho de la Vaca. In this chapter, I explore the theme of forging connections across difference to answer my second research question: *How can the study of communication within these specific transnational health clinics inform understanding of collaboration across cultural and linguistic differences?* Using Craig and Tracy's third and final level of grounded practical theory, philosophical, I examine the findings related to communication across difference to describe situated ideals that influenced decision-making in whether or not to engage in translingual negotiation. Analyzing these ideals illuminates factors that may have promoted and prevented collaborative relationships in this multicultural health care setting. The personal connections that members of this collective made shaped and informed the negotiations of language that took place in the clinics. These connections also served as favorable outcomes of negotiating languages together. However, when certain factors influenced participants to decide against translingual negotiation, moments of disconnect and alienation arose which further emphasized their various differences related to language, culture, and class.

By examining what motivated participants to engage in translingual negotiation, this chapter demonstrates a value, or ideal, within the collective for transforming moments of

translation into opportunities for language learning. Additionally, both Dominican and U.S. participants utilized colloquial sayings and discursive tactics to mirror one another's vernacular use of language. Individuals took risks with translingual negotiation through vernacular performances because of an ideal for forming emotional connections with others. Alternatively, considering the risks that came with translingual negotiation illuminated concerns of feeling like an outsider. For fear of saying something wrong, not knowing whether someone was talking about them, or simply not being able to articulate ideas in a clear way, both Dominican and U.S. participants made choices to not to engage in translingual negotiation. These concerns represented disconnect between individuals, and challenged their willingness to work across differences in the short time the participants were together. In the following pages, I will examine these two situated ideals, language learning and emotional connections, and draw together negative and positive factors determining the potential for cross-cultural collaboration in this temporary health setting.

Situated Ideal: Language Learning

The purpose of this program was not predominantly for language development. Language acquisition was much more as a side "perk" or possible benefit of assembling as a collective for four weeks. However, conversational skills in Spanish or English were important for working together and bonding as a community. By building their proficiencies in various forms of English and/or Spanish, certain individuals were able to move back and forth between languages easily. This, in turn, built their translingual literacy in a way that helped individuals communicate more effectively and connect with each other inside and outside of the clinical environment. However, in order to see all of the patients who had been promised an appointment by the time the clinic was supposed to close each day, we could not allow everyone to just sit and

struggle through language for long periods of time with each patient. Not only would this be inefficient, it could also harm the ethos of the provider as being unable to truly help patients, medically. Instead, moments of translingual negotiation were relatively short and most often enacted over time and during “in between” moments when practitioners could take risks or decided to spend their down time developing a phrase or literate skill that might help them begin the next interaction with a patient more effectively.

As I noted in Chapter 3, utilizing other members of the team who could easily shuttle between languages was a crucial part of the assembly of this public and supporting performances in the clinics. There was an appreciation for the individuals who were proficient bilinguals in Spanish and English, but there was also a recognition of their potential as language teachers. Nicole noted that there were various team members who could help with this language learning process while working in the clinic. She explains that what helped her with translating was “asking whoever's helping, whoever was translating for us; the coordinator, the assistant coordinator, just random people in the back, having them repeat it three or four times for me, and saying it myself.” The way that Nicole transformed moments of translation into opportunities for learning was a self-empowering move. By taking the initiative to ask for repetition and then to re-articulate words, herself, Nicole utilized translingual moves to develop the ability to speak Spanish on her own. Since full fluency was not really a possibility to acquire in just four weeks, participants focused on short phrases and words that they could learn and then utilize in connecting with each other.

Six out of ten of the Dominican participants, all who served as ayudantes, described their interest in learning English in relation to the benefits of immersion with the U.S. participants. Katy was preparing to begin classes at the local university for teaching English and French at the

time of our interview, and she explains: “me interesa mucha aprender inglés e involucrándome con demás personas que estén hablando ese idioma como que me ayudaba desarrollarme aprender más, entender más en inglés, o sea, escuchar otro hablándolo. Me ayudó muchísimo en lo que es y va a ser mi vida profesional de hoy y adelante.” [34] For Katy, learning and practicing English with native speakers was not only beneficial for her work in this program but also for her future studies and career in teaching. Additionally, Miguel explains how these intercultural interactions motivated local residents to want to learn conversational English and that the time together was “una experiencia inolvidable que, a veces quería saber lo que estaban diciendo y no podía…no(s) motivo mucha(s) persona(s) saber inglés para otro grupo un día saber lo que estaban diciendo.”[35] Since Buena Vista hosted the summer program the year before I worked there, Miguel knew that there was a possibility that another group would return in the future. Even though the organization, El Centro para la Salud Rural (CSR), switches communities every two to three years with this program, the local residents expressed hope for hosting another group in the near future. This provided an incentive for learning English outside of the program to prepare for future interactions with native English speakers who might visit and live with the community. Although many of the young residents had taken English classes in school, they explained that it was not the same as having conversations with native English speakers like their visitors in this program.

The desire for language learning also shaped relationships within the clinics while helping support performances of the ayudantes and nurses during the patient intake process. By

[34] Tr. “I’m very interested in learning English and getting involved with other people who speak this language in the ways that it helps me learn more, understand more in English, that is, to listen to another person speaking it. It helped me so much with what my professional life is today and what it will be in the future.”
[35] Tr. An unforgettable experience that, at times, I wanted to know what they were saying and I was not able to…it motivates a lot of us to learn English for another group one day to understand what they were saying.”

examining these interactions as performances, we can understand them as instances of ever-evolving acts of "languaging." In their chapter "Translingual Literacy and Matters of Agency," Lu and Horner explain that "a translingual approach defines languages not as something we have or have access to but as something we do. It centers attention on languaging: how we do language and why" (27). This definition resonates with the ways in which participants performed language in trying out new words and phrases that they learned from each other. Elizabeth explains how she and the other ayudantes would support each other's performances of language in their down time between patients: "[E]ach of them spoke just like a little bit of English where we would try and teach them words, and they knew how to like talk slower [in Spanish], but we also would pull out our dictionaries sometimes…[and] I think they were just…a lot more understanding of the fact that we didn't speak fluent Spanish." With the aid of dictionaries, the ayudantes set up a mutually beneficial relationship by teaching each other English and Spanish as they worked together throughout the program. Joshua adds, "in a clinical setting, when I was just trying to learn words and phrases, I would work with the other ayudantes and just be like, 'How do I say, Stand here so I can measure you?' Or…just something very basic...and then they would ask me how you say that in English." The moments of "down time" that they would have together provided space and time for developing new rhetorical strategies to perform language in new ways. The U.S. ayudantes were able to develop their proficiencies in Spanish by having co-workers who understood their struggles with the language. Supporting each other's language development allowed them to serve the patients better in the clinics, and by utilizing that time in between work with patients to learn from each other, the ayudantes also deepened their relationships with each other.

Katy explains that the Dominicans who wanted to connect with their visitors across language difference should "preguntarle, 'Yo quiero aprender inglés…¿Qué significa esto? ¿Qué significa aquello?'"[36] Taking that step to ask for help learning the meaning of words and their pronunciations was one that both Dominican and US participants saw as beneficial in this program. Again, it represented a move away from relying on others for translation and toward a type of self-sufficiency in connecting with others across linguistic difference. Daniel adds that when he heard others speak English, "Mi experiencia era que cada palabra que decían, yo lo entendía un poco. Entonce(s), cuando no entendía algunas, le preguntaba y así aprendía más."[37] Just as Daniel emphasizes that he would ask questions about the meaning of words when he did not understand them, other participants mentioned the need to slow people down or ask for clarification in order to learn and acquire new words and phrases.

I often told the youth of the towns, and the U.S. participants, that the local residents were some of my best Spanish teachers. Whenever a local resident would help me better understand a new phrase, I would thank him/her by saying "Gracias, profe."[38] The deeply engrained relationship of acting as language teachers in any setting was also apparent during my interviews with Dominican participants as I tried to ensure that my notes matched up with what the interviewee was saying. When describing a phrase in English that he had learned, Miguel said, "Never give up [pronounced "oop"]...como nunca te rinda en inglés."[39] To which I asked, "¿Cuál es?"[40] "Never...give up," he restated. Trying to make sure I was writing my notes properly, I asked, "¿Nunca...te rinda?" And Miguel said, "Rinda, rinda, rendirse." By repeating the word

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[36] Tr. ask them, 'I want to learn English…What does this mean? What does that mean?'
[37] Tr. My experience was that each word that they said, I understood a little. Then, when I did not understand some [words], I asked and in this way I learned more.
[38] Tr. Thank you, prof(essor).
[39] Tr. like never give up in English.
[40] Tr. Which is?

and conjugating it for me, I was able to catch what he said and learn a new term that I was not familiar with before the interview. As he told me about a phrase he had learned in English, Miguel actually taught me a new phrase in Spanish.

In addition to learning about language during their experiences of misunderstanding and attempts at speaking, participants acquired language skills by listening to other individuals in the group having conversations. Nicole explains, “[W]hen an American and a Dominican were talking, the Dominicans tend to slow their speech a little bit and the Americans definitely have slower Spanish, and to see the facial interactions and everything like that, I was able to somewhat understand a word or two.” This example of observing conversations of others in the group demonstrates how this situated context set up certain conditions that made it easier for participants with basic proficiency in the language to learn new words and phrases. By spending time with both U.S. and Dominican participants and hearing how both of them had slower speech habits together, Nicole was able to recognize situations in which she could try to follow along and learn. The process of acquiring new words and phrases in her second language allowed Nicole to develop new connections with individuals that she could not originally communicate with at the beginning of the program. As various participants in this collective helped each other develop new language skills, they collaborated in a way that encouraged translingual literacy development, developed new relationships, and supported their performances in the clinics.

Although success for language development varied by participant, those who did not believe that they improved their Spanish speaking skills still recognized some type of communicative development through their observations of others. This observation might include listening to interpreters and patients having dialogues or watching bilingual participants utilize translingual negotiation. Abby states, “I don't think that I picked up more that I was able

to speak, but I got to the point where I could understand more…which was very helpful 'cause even though I couldn't communicate back to them, at least I was able to listen." Noting this ability to gain understanding before the ability to re-articulate and speak fluently was a common observation from U.S. participants that had basic to intermediate proficiency in Spanish. However, in my observations, I did notice that this process was a bit more complicated, and fluid, than these participants felt it was. Although they may not have been able to hold fluent conversations or they might have felt that they did not know how to conjugate words correctly, participants like Abby did "language" in ways that demonstrated their ability to speak some Spanish. What did prevent the "ability" to speak Spanish was most likely more a question of confidence, practice, and confirmation rather than the comprehension of the meaning of words and how they are pronounced. Regardless of my observations, five of the U.S. participants mentioned that they felt they could understand Spanish more than they could speak in Spanish. This may have been influenced by the way I phrased the question as "What languages do you know how to speak and understand?" However, the participants did specifically describe these differences in their language development during their time in the campo as well. What would have been helpful to further investigate this point would be to consider what factors influenced an individual's confidence in pronouncing words, articulating points, and connecting sentences rather than a general question about what they "understood" or "could speak." What can be drawn from these data is that translingual negotiation can account for different stages of language development and translingual research should interrogate those stages as an important part of the process of developing rhetorical adaptability in multilingual settings.

The various stages of language development and the process of shuttling across languages represent a constant negotiation of translingual moves within this emergent collective.

By integrating a translingual rhetorical approach to global health projects, health providers can investigate strategies for communicating with patients who they traditionally would see as presenting a "language barrier." Global health programs may provide spaces for investigating the nuances of translingual rhetoric and its possibilities to break apart monolingual ideologies that may perceive language barriers as unsurpassable boundaries. As Horner, NeCamp, and Donahue state,

> Rather than striving for 'fluency in' a particular language or set of languages, we believe it more appropriate, and more broadly accessible, to develop ways to grow fluent in working across and among languages. […]While the ambition of achieving a high degree of fluency in another language is certainly admirable, its pursuit can prevent the flexible, fluid relationship with languages we believe might be more effective for this work. (287-288)

I also argue that in cross-language relations for health care, an approach that utilizes a flexible, fluid relationship with languages can be more effective in the ways that it promotes language learning within these programs. In addition, the development of language learning within informal contexts and "authentic" conversations as they happen in practice can better prepare individuals for the challenges and messiness of work across and among languages. The participants who were able to take a more flexible approach to language learning within this study were more easily able to develop their fluency in working across languages, and in turn, developing connections with patients and local volunteers.

Situated Ideal: Emotional Connections

The second situated ideal that surfaced in my analysis was the desire for making emotional connections with other individuals in this emergent collective. As I argued in Chapter

1, a translingual approach to public rhetoric requires a recognition that acquiring vernacular language is crucial to participating in conversations and belonging to a community (Hauser). This process was most notable in the ways that participants in this study performed vernacular phrases and gestures of their non-native language and culture in order to connect with other individuals in the group.

Katy explains that she saw a change in the local community as they began to try out new phrases in English during the four weeks when the participants lived together. She observes how the children began utilizing idiomatic phrases in English and the communal interest in language learning helped set up the conditions for a good "mezcla," or mixture, between the cultures: "[L]os niños...decían palabras en inglés que ya yo aprendía un poco y le escuchaban, 'Ah, hello! Good morning!' Se ha saludaban a los americanos...Entonce(s) allí no(s) mezclábamos y podíamos trabajar todo satisfactoriamente."[41] Simple phrases such as greeting each other every day were small steps that the children, and any participants with lower proficiencies in either English or Spanish, could utilize to develop their vocabulary and make positive connections with each other. Similarly, many of the U.S. participants began greeting their host families and neighbors each morning with "¡Hola! ¡Buenos días!" These moments of morning greetings and utilizing each other's native language contributed to the assembly of this emergent collective outside of the clinic. The local residents saw these translingual moves as ways to make their visitors feel welcome, and the visiting participants saw them as opportunities to engage in the community in personally meaningful ways.

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[41] Tr. "The children…they said words in English that I had already learned a little and they heard, 'Ah, hello! Good morning!' They greeted the Americans…So there we mixed together and were able to work with everything successfully.

Additionally, for the U.S. participants, incorporating regional terminology of vernacular language demonstrated that one “knows” the language and can connect with local residents. Paul recounts,

> I found that when I was able to incorporate the phrases, or colloquialisms, of that region or of the D.R., the people often lit up or were excited about somebody knowing about their idiosyncrasy of that language. So, even if I were to say it in a joking manner…I'm confiding in you that I'm speaking in your language, I'm saying "Hey look, pin pun, they look the same," or..."it's just 'un chin' of this," or a little of that, then they often responded very kindly to that and seemed to appreciate that I was making an extra effort.

Paul’s description articulates the rhetorical strategies that participants described as speaking Spanish like a Dominican. By making the extra effort to incorporate colloquialisms of the region, the visiting participants were able to develop personally meaningful connections by recognizing phrases and terms that were valued in the vernacular discourse. It also developed their ethos as knowing how to speak Spanish well in this specific context which valued Dominican Spanish as a symbol of national pride and “Dominicanness.”

In their interviews, both Dominican and U.S. participants shared stories about how they supported each other’s learning and linguistic performances with idiomatic phrases and songs. These stories speak to the assemblage of the public and the building of associations beyond just their work relationships. One example of bonding over playful language was in Buena Vista when local residents were singing a song that they thought the US participants would immediately recognize. Miguel said that he and his friends realized they had it all wrong “con una canción de una vez que aquí decíamos (laughs) Sha-ke-ton y decía Jacob no que era ‘Who

let the dogs out?'…estuvimos todo el día riendo. No conocimos."[42] What Miguel was referring to were the lyrics that he and others were singing, "Who let the dogs out?" as "un sha ke ton ton!" from the popular song by Baha Men released in 2000. After Jacob explained the lyrics in English, the local residents found it extremely comical that they had been singing what sounded like the words without knowing their actual meaning in the song. Although it may appear to be an insignificant interaction when looking at relations amid participants in a temporary health program, a moment like this represented some of the most memorable interactions for participants. Not only were they memorable in how they enjoyed time together, they were also significant in how individuals made new connections across languages because of their transnational immersion together.

In addition to the verbal phrases that the participants learned from each other, they also taught each other non-verbal ways to make connections. In a follow-up meeting two years after we worked together, I asked Miladis whether it was possible to have a connection with patients even without the language or with an interpreter and she said yes, "porque el amor de ustedes…"[43] to which I asked, "¿Se mostraron en otras maneras?"[44] And she replied, "Exactamente."[45] Following this, she began to recount the story about a day when Nicole had an exceptionally difficult dental procedure. What was expected to be a twenty minute appointment turned into a four hour-long process filled with vomiting, nausea, tears, prayers, and a communal effort to support our young dentist working to extract a wisdom tooth without any x-rays or equipment she would have had back in the U.S. In what Miladis described as a day she will

[42] Tr. "with a song one time that here we said "Sha-ke-ton" and Jacob said that no it was "Who let the dogs out?"…we were laughing all day. We didn't know [that we were singing the wrong words]."
[43] Tr. Because the love of you all…
[44] Tr. They showed in other ways?
[45] Tr. Exactly.

never forget with "tanto amor,"[46] Nicole made it through a physically and emotionally tiring process in which she did not speak much Spanish and the patient only spoke a few words amid the pain and nausea he felt during the procedure.

Nicole describes this procedure as "an emotional experience" and states that even though she felt an overwhelming amount of relief and joy once she finally extracted the tooth completely, she also worried for how the patient would heal and hoped she could follow up with him after the procedure: "I hope I just know you're okay tomorrow and I hope everything goes okay tonight and you're able to sleep…It's now a bond him and I have that is something that I probably will never have with another person because we together—I'm sure he was going through those same emotions—went together through them, and this…this sense of connection between him and I." Because she felt (and demonstrated in her actions), empathy for his pain and wanted to be sure that he recovered well, Nicole clearly was able to make connections with this patient despite her limited proficiency in Spanish. Years later, Miladis, the patient, and the patients' father still mention that as an incredibly moving experience in which they saw how much the visiting team cared about the patients of the local community.

Other group members described the dental students in Rancho de la Vaca as having an exceptional ability to connect with patients without having advanced Spanish proficiency. Elizabeth explains that with

> Peter, our dental student, who spoke like zero Spanish, I felt sometimes that people understood him better than they understood me. Even with his poorly pronounced, one—two word Spanish, just like his facial expressions and his pointing, I don't know, people...they understood him, which was amazing to me because, even though I could put

[46] Tr. So much love

> a sentence together, I still felt like people just looked at me like they had no clue what I was saying.

Multiple participants mentioned Peter's ability to connect with patients and local residents without being proficient in Spanish. His humor and ability to use gestures creatively with simple Spanish words was something that put patients at ease in the dental area, made all team members laugh during tense situations, and impressed the volunteers at the clinic. Peter's engagement of translingual negotiation enabled him to forge connections even with limited Spanish proficiency. Alexis explains that "some of the coolest connections that are made are [with] the people who come down and they don't really know much Spanish, and they really stretch themselves to practice their Spanish, especially with their host family. I thought Peter did a great job…jumping into the culture and trying to get everything he could out of the experience." She added that he would try to talk with his host family every night despite multiple moments of misunderstanding whenever he and Joshua attempted to communicate with them. This willingness to engage in translingual negotiation, even at a basic level with a large portion of non-verbal gestures, was a result of the desire to make develop emotional connections with people in and outside of the clinic.

The non-verbal connections individuals made were also types of vernacular performances. They reflected local gestures and values, and ultimately contributed to the assembly of this collective to connect across differences. A primary non-verbal approach to connecting with others that the U.S. participants learned from local residents was the value of "sitting" together. Paul explains,

> [O]ne of the major lessons I learned in the Dominican Republic…was the value of sitting. I came to appreciation of how much, especially in their culture, but now that I've

> contemplated it further, in our own, we value when people sit with us. In the Dominican Republic, if you don't sit down when you visit somebody it really wasn't a visit…The first thing that the majority of the people would say when we'd either walk through their threshold or near their home was, "Sit down, sit down, have a seat."

Paul and other participants also mentioned how surprised they were by how quickly local residents could round up a large number of plastic chairs to have everyone in the visiting group sit together on someone's front porch. They often proceeded to offer coffee or food, demonstrating a constant reminder of the hospitality of the local residents. The U.S. participants' recognition of this value of spending time with others, accompanying each other in daily activities, and even just sitting in silence together noted a cultural factor that they felt seemed to be lost or uncommon in their own cultures. This form of body language was an important tactic for developing connections and respecting the hospitality of our host communities.

By sitting with people, and compartiendo juntos[47] outside of the clinic, the U.S. participants opened themselves to new relationships. When they were sitting on the porch of a neighbor, sipping a freshly brewed taza de café[48], and listening to or joining conversations about the weather, they left their role as health provider and took on the role of a companion and guest. The relationships developed in these liminal times, between patient visits, clinic hours, and planned activities, those were the connections that made the assembly of this collective possible. Taking the time to nurture these relationships and learn from small instances of vernacular discourse—whether it be terminology only used when playing games of Dominoes or non-verbal gestures to demonstrate care and hospitality—allowed the visitors to gain new insights into language and culture. These relationships further demonstrated the care that the visiting team had

[47] Tr. Sharing (time) together
[48] Tr. Cup of coffee

for their patients by better understanding their daily lives and language use. This, in turn, solidified their commitment to learning from, and working with, the local community in assembling and running these temporary clinics.

(Dis) connections

Although the majority of interviewees felt that connections across differences and collaboration was possible, this was not the case for everyone. It is important to note that there were participants of this collective not represented in these interviews, and many participants from other campos that may have had very different experiences than my groups. While I will address those limitations further in Chapter 5, I want to first note that attempts to cross differences sometimes resulted in unpredictable negative results. Additionally, certain factors may have influenced the participants negatively in a way that dissuaded them from wanting to try out translingual negotiation.

In my analysis, the persistent mention of moments when U.S. participants felt like an "outsider," "othered" in some way, or foreign made it a theme worth noting as part of the negative aspects which may have influenced an aversion to translingual negotiation or making connections across differences. The most common instance of this philosophical rationale for distancing individuals came in their description of worrying about, or not knowing whether someone was talking about them. Elizabeth explains,

> "I'm going to a Spanish-speaking country...it wasn't like I thought people would magically speak English there. I mean it's hard because it's like well, I have no idea, they could be talking about me, and I have no idea what they're saying. Like they could be saying I'm a complete idiot because I don't speak Spanish, which you know, they might have been, because sometimes I'm sure I sounded like an idiot when I tried to say things."

Saying she sounded like an idiot was similar to other participants with lower proficiencies using negative language to describe how they must appear to others. Nicole has a similar sentiment when explaining one time when her host mother was trying to ask her a question: “I found out later she was asking where our towels were…but all I could catch was ‘towel was hanging there’ and I was like, ‘Yeah, that's my towel,’ and didn't really get that she was asking me…But I did say ‘That's my towel!’ and she just looked at me like I was insane.” More than likely, these interactions were probably not as extreme as the U.S. participants imagined them to be, but it is important to note when they felt foreign, and like an “other” that was unable to communicate.

Even when U.S. participants would try to incorporate tactics for communicating, like using dictionaries, some of them still ran into moments when they could not make a connection. Joshua explains, “It's kind of a double-edged sword because it felt like sometimes like when we were trying to talk to our mom and dad...I mean we had gotten our Spanish dictionary out and we were workin' hard just to say something to her and we couldn't get it across. I felt like it was kind of like they're not talking behind your back…it's like talking about you to your face, but you can't understand.” Invoking similar language to Elizabeth about others talking about him but not knowing what they said clearly was a frustrating experience. These experiences, especially when at their houses, represented moments of being isolated from their collective resources at the clinics. Participants who could help ease the translingual negotiation and interpretation were not always readily available, and therefore, individuals might have lost motivation to keep struggling through language difference when they could not comprehend words in the process.

Jackie had similar experiences of disconnect with her host family and did not really feel that a deep relationship was ever developed. However, she did note that this experience of “seeing a new culture, being immersed in it, it gave me a lot of empathy towards immigrants

who are coming here [to the U.S.], 'cause I didn't understand that, you know, not being able to speak the language is...just very frustrating." Although these feelings of frustration may not have subsided during the program for Jackie, she did see a way in which understanding that experience of not being able to communicate in a new language and culture could be transferred to experiences back home.

A couple of the participants also encountered issues that reflected the class differences and potential struggles that come with integrating participants from privileged and marginalized communities. In the CSR guidebook, a specific section on ways to give back to the community is included under the heading "Donations," which states:

> Do NOT give gifts or donations to your host family or friends in the campo. It is extremely important to not set a precedent of gift-giving. Th[is] will cause an uncomfortable situation for future CSR participants who could serve in the same community. If you want to donate money or clothing for your campo, please bring it to the CSR Center's front office before you leave (38).

For some participants, this is a difficult rule to abide by since they have developed strong emotional connections with their host families.

Others in this study encountered difficult situations arose when host families asked the participant to leave a belonging with the family when s/he returned to the U.S. Joshua explains that the situation felt worse because he did not understand what was being said, and had to prolong the interaction by getting someone to come and interpret for him. He explains that his and Peter's host dad

> kept pointing to our watch and I thought that he was saying that, like "at this time tomorrow, I'll be gone" or something. And we're like oh, you know we'll miss you, and

> we'll have Charlie come over later and translate tonight so we can have our proper goodbye. And it turns out he actually wanted our watch when he left…which is I'm sure why we don't give gifts or whatever. …I wasn't really offended too much either way. But it was like, this sucks that I can't understand.

Although he was not offended by the question, and he did not give his watch as a present, this interaction brings up various issues that can arise when 1) individuals spend time together from very different class backgrounds in the setting of a "service" program and 2) when a participant is placed in a difficult ethical situation but does not know how to articulate, or understand completely, what is going on or needs to happen. A similar instance happened with another U.S. participant (not interviewed) when his host father in Buena Vista asked for his tennis shoes. While these scenarios are often remedied by having respectful conversations with the coordinators and cooperadores, homestays may add another dimension to the complicated relations that can arise in emergent collectives for temporary health programs. While the overall data of having these complicated interactions is insufficient to draw major conclusions related to this project, noting the occurrence of situations that emphasized differences and made visitors feel foreign are important to consider when planning to assemble and support performances for collectives like the ones in this study.

Collaboration

The majority of the data analyzed for this study demonstrated that collaboration was possible, and individuals made connections while participating in this program. This study's findings demonstrate how building relationships through translingual rhetorical negotiations are crucial to collaboration in transnational health programs. Developing comfort with other members of the temporary collective, camaraderie when stressful situations happened, and a

sense of unity as a "team" running the clinic on a daily basis resulted in an overall positive experience and effective health clinics. First, language learning and struggling with layers of the language barrier led to a team effort of negotiating languages. Alexis explains that during the program she saw "a really cool kind of collaboration between the Dominicans and the Americans" especially in the ways "that the Dominicans are so excited that we're trying to learn Spanish and you know if we screw up…they're very patient with us, so I think that's one neat connection that's made is bonding over the language barrier." Similarly, when discussing the relations between participants from different backgrounds, Katy said they were excellent, explaining that [P]or ejemplo, la cultura de nosotros, Dominicano y Americano, trabajar con ellos fue muy satisfactorio porque mucho(s) hablaban español; sabían bien español. Algunos aquí interpretábamos algo de inglés y no(s) mezclamos juntos y cada cual aprendió de la cultura diferente. Aprendimos de lo(s) americano(s) y ello(s) de lo(s) dominicano(s).[49] Learning from each other's culture and vernacular language use aided the development of relationships within the program and supported the work carried out in the clinics. By "mezclando"[50] across differences, these participants found motivation to negotiate languages and take risks with communication in order to more effectively work and enjoy their time together.

Secondly, collaboration across differences was possible by a unifying purpose: to serve the health needs of the local community and create these clinics for four weeks. Joshua explains,

> I think it's maybe easier to kind of communicate from different cultures when you have a purpose that unifies you…we were there for the same reason, for the same purpose every

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[49] Tr. For example, our culture, Dominican and American, to work with them was very rewarding because many of them spoke Spanish; they knew Spanish well. Some people here, we interpreted something from English and we mixed together and each one learned from the different culture. We learned from the Americans and they [learned] from the Dominicans"

[50] Tr. Mixing

> day… [and] I think when you're there for other people, I think you're going to be more open to communicating with someone that's not from your culture because it's not about you; it's about the person you're helping.

Joshua's description of what unified the U.S. and Dominican volunteers in the clinics highlights the higher purpose that required collaboration and communication across differences. Peter echoes the description of "a common goal, so to speak," and explains that in the dental clinic they would "communicate through a common goal of tryin' to address some kind of oral health need that [the patients] have." Having a common purpose shaped how individuals utilized translingual rhetoric; in turn, the translingual rhetoric that individuals developed helped accomplish this shared purpose: to care for the patients and keep the clinic running each day. Situated studies of translingual practice that highlight a common purpose for crossing differences can inform our understanding of how translingual rhetoric can shape and respond to the world.

Among the U.S. participants, individuals also noted that there was collaboration across differences based on their regional "homes" in the U.S. and their various disciplinary backgrounds. Joshua described that program as a positive program in the way that it allowed "all the professions to come together, because you don't see that. Well, just not as much--you'll rarely see a dentist and a physician interact, you know?" This was a similar response across most of the U.S. interviewees when I asked about "people from different backgrounds coming together." I originally wrote that interview question with an assumption that the responses would focus on working with someone from a different nation or language, but many U.S. participants discussed working with other U.S. participants since most of them did not know each other prior to the trip and they came from different health care specialties. The program provided a unique clinical setting that featured much cross-cultural communication, but it also required a daily

collaboration across health professional roles (doctors, dentists, pharmacists, nurses, and undergraduate helpers).

The U.S. participants' collaboration across differences increased with their bonds over the immersion experience of this program. Matthew explains,

> I think it was easy for us to come together in the group because we all are facing these new challenges together, so everybody kind of understands what everyone's going through, and you can have a laugh about a giant spider in your bathroom, or you can have someone understand your frustration when you're trying to communicate with the patients and they look at you like you have three heads.

These new challenges came in many different forms, and Matthew's summary from the spider to miscommunication demonstrates the variety of new experiences participants encountered in the four weeks they were in the campo. Matthew's brief description of having a shared experience of having patients "look at you like you have three heads" is also important to note. His descriptive metaphor refers to moments of the language barrier and non-verbal cues of misunderstanding by patients in the clinics. It resonates with Elizabeth and Nicole's descriptions of worrying that people thought they "sounded like an idiot" or were "insane." The U.S. participants bonded over having similar dilemmas with the language barrier and felt less alone when they made mistakes in pronouncing words or could not get patients to understand what they were asking.

When used productively, the connections they developed through a shared struggle with translingual negotiation led to the collective language learning and rhetorical adaptability of the health team. Individuals would not have pursued translingual rhetoric if they felt that they were the only ones experiencing problems of feeling foreign or like an outsider. Also, without recognizing the translingual negotiation as a communal activity, there may not have been as

many instances of participants utilizing moments of translation as opportunities for learning. With each attempt at negotiating languages, dialects, and non-verbal gestures, participants discovered new ways to communicate and new avenues for connecting with other members of this collective: other volunteers, community leaders, patients, and host families.

The U.S. participants were adjusting to many challenges, including (but not limited to): extreme heat with no air conditioning, using latrines rather than toilets with running water, eating different food on a pre-set schedule, sleeping in close quarters with people they just met, and being constantly surrounded by sounds of farm animals and a fast, different form of Spanish. The material differences from their daily lives required the ability to adapt constantly as they navigated life in the campo for four weeks. Recognizing these material aspects of their time together recalls Grabill's methods for assembly and how rhetoric is always material. The physical experience of living in these towns during June and July, when most participants would have had air-conditioned offices or homes in the U.S., must be accounted for in the ways that it influenced, and at times prevented, the motivation to engage in translingual negotiation and collaboration across differences. Theoretically, the goals to cross differences and make connections are noble and important goals. In practice, trying to balance achieving these goals while also possibly dealing with extreme heat, mosquito bites, indigestion or diarrhea, anxiety about unknown insects, and a constant battle with dehydration proves to be a bit more difficult. With those material aspects of assembly publics in mind, the successful negotiations of language and culture across differences should be recognized as challenging and remarkable, to say the least.

Conclusion

This chapter examined two situated ideals to demonstrate the philosophical level of grounded practical theory and to answer my second research question about how this study can contribute to understanding about collaboration across differences. The desire for language learning and developing emotional connections influenced the decisions to engage in translingual negotiation. Verbal and nonverbal vernacular performances were driven by, and resulted in, connecting across differences. Moments of "disconnect" surfaced when differences in language, culture, and class further alienated individuals from making connections or wanting to engage in translingual negotiation. Ultimately, this chapter demonstrated how the majority of participants felt that collaboration and positive connections across differences were possible through their negotiation together of barriers, differences, and the ultimate driving force of a common purpose for serving the community together.

In their down time between patients, ayudantes supported each other's language development. Walking along the dirt path toward the clinic, Dominican children shouted greetings in English to their visitors. Within the dental clinics, Peter made U.S. and Dominican participants laugh as he pointed to his mustache asking if the patient liked his "bigote" that he had grown out over the time in the campo. Relationships formed and collaboration was possible because of the various ways in which these participants utilized translingual negotiation. When they saw moments of translation as opportunities for learning, individuals were empowering themselves to make new connections with future performances of certain words or phrases. Without taking risks and making mistakes, they would not have turned to each other as much or "bonded over the language barrier."

In Chapter 5, I will describe the theoretical and practical implications that have resulted from this study. As the goal of grounded practical theory is to draw practical applications from

the analysis to improve practice through reflexivity, I will explain how I have shared the results of this study with other program coordinators in CSR. Finally, I will describe the limitations and areas for future inquiry this study illuminates for CSR, the field of Rhetoric and Composition, and health practitioners and researchers in global health.

Chapter 5: Taking a Translingual Approach to Health Communication

Each year, hundreds of "first world" health care students and practitioners take medical volunteer trips to "developing" countries. The growing desire for health education to incorporate global health in its curricula (Khan et al.) indicates that transnational public engagement in health care will only continue to grow in the upcoming decades. If this is the case, researchers and participants must consider ways reflexively approach communication when publicly engaging in discourse communities around the world. Examining transnational public engagement is an especially important arena to investigate how vernacular voices emerge in publics to ensure that participants respect and integrate local customs and discursive strategies into any collaborative project.

This study has examined one such collaborative project between visiting health practitioners from the U.S. and local residents from two rural towns in the Dominican Republic (D.R.). The previous chapters have examined their work together as a type of transnational public engagement that formed an emergent collective to serve health needs, temporarily, in the Dominican towns. Using Grabill's methodology of rhetorical engagement, I highlighted how a focus on the work of assembling this collective and supporting performances could demonstrate the ways in which individuals came together across differences in language, culture, class, status, and disciplinary specialty to create temporary health clinics. Drawing from my field notes and semi-structured interviews, I examined how participants encountered, and responded to, problems with language and cultural differences as they worked to communicate together during the four-week immersion together. As a collective, participants developed strategies of translingual negotiation across hybrid forms of interpretation that included moves across English-Spanish, varieties of Spanish, and nonverbal tactics.

By exploring the “messy” process of translingual negotiation in this context, I discussed how the situated ideals of language learning and developing emotional connections with others influenced participants. Individuals made decisions about engaging in translingual negotiation based on these ideals and the concerns about feeling foreign when attempting to speak a second language. The findings of this study illuminate a few of the social factors that influence judgment of different dialects of languages, and specifically those that came into play with how the U.S. participants perceived the vernacular dialect of Dominican Spanish. Overall, this research demonstrated how, even with a global stigma attached to the vernacular dialect, locally, it received preference for patient-provider interactions because it resulted in mutual understanding and fewer blank looks from the patients. Within this situated context, the participants saw the vernacular dialect of Spanish as the most useful form of Spanish because of how it allowed the communicator to connect with the most people in this collective and community. Individuals utilized verbal and nonverbal vernacular performances to develop emotional connections with others, and through those connections, they were empowered to try out new approaches to translingual negotiation.

Various experiences of challenges with crossing languages and failure to understand did result in disconnects between individuals, and in some cases, the class differences caused issues with having conversations about gifts and personal possessions. Although the moments of disconnect were often driven by U.S. participants feeling like “outsiders” or foreign to the local community, these moments were also opportunities for the U.S. group to bond together over the challenges of this transnational immersion. A key moment surfaced in interactions which “othered” the U.S. participants. Based on whether they decided to struggle through translingual negotiation or turn to others in the collective for help, these interactions influenced the potential

for collaboration across difference. Ultimately, drawing on the resources of other members in the collective led to the most successful translingual rhetorical moves. Assembling as a collective through work, play, and daily activities also promoted the development of emotional connections and solidarity in common struggles of language learning, culture shock, and embodied experiences of living in a new environment.

This final chapter will examine the theoretical and practical implications that have resulted from this study. Highlighting practical applications is crucial to completing a study with grounded practical theory, and in turn, approaching theory reflexively through practice. As a tactical project of hope (Mathieu) that studies the public work of rhetoric, I recognize that this project is only partial and just one step in a longer struggle for positive change in cross-cultural relations and translingual communication in global health programs. Thus, I will conclude this chapter with an acknowledgement of the limitations of this study and set forth areas for future inquiry that I hope this research may inspire.

Theoretical Implications

I see this project as contributing to three major areas of theory within Rhetoric and Composition. First, it serves as a case study that represents the "internationalization" of the field and integrating transnational public sphere research with literacy studies. Second, it contributes to translingual theory within the field by arguing for a definition of translingual *rhetoric* that highlights the role of oral varieties of languages, embodied acts, and gestures in the negotiation of literacies. This examination of translingual rhetoric also emphasizes its potential for using translingual negotiation as a public rhetorical act to support the performances of others within cross-cultural health contexts. Lastly, this study challenges the dominant "colonizing" narrative

of global health by incorporating experiences of local residents in the host community and integrating data in Spanish and English.

From Hesford's 2006 examination of the global turn in Rhetoric and Composition to the increasing investigation of international composition practices, the field is moving in a distinctly global direction for theory and pedagogy. This movement is driven by an acknowledgment, and desire to learn from, the increasingly transnational nature of publics today. In her article, "'Internationalization' and Composition Studies: Reorienting the Discourse," Christiane Donahue explains that

> The attention to internationalization and its relatives, globalization and cross-cultural comparison, has tended so far to focus on the increasingly global nature of U.S. classrooms and U.S. students or students attending U.S. universities—the internationalizing of *our* world, whether through theorized ESL explorations, contrastive rhetorical analysis to explicate difference, or discussions of cultural, ideological, or political encounters in U.S. composition classrooms and in anecdotal encounters overseas. (213)

Donahue argues that these efforts, while important, have been highly partial, "export-based," and "might create obstacles for U.S. scholars' thinking and thus impede effective collaboration or 'hearing' of work across borders" (214). I began this project by asking how an investigation into this specific transnational health program could inform our understanding of collaboration across difference. I investigated "collaboration" by examining the strategies of cross-language, cross-dialect, and non-verbal tactics used for interpretation that were developed among the members of this collective to support clinical performances. Collaboration across difference occurred because of an intentional effort to assemble as a unified group and focus on the connections that could be

forged outside of, and during moments of down time between, the “work” that was done in running these clinics.

I came to understand translingual rhetoric from these participants, rather than entering the program with an agenda of how to implement it. With its research design and findings, I hope my project contributes to Donahue’s vision for a “focus on internationalizing by opening up our understanding about what is happening elsewhere to adapt, resituate, perhaps decenter our context” (215). Although this study may have implications for U.S. students, composition, medical Spanish classes, and other pedagogical perspectives, I present it without specifically naming these implications. That is my attempt to “decenter our context” and encourage the “hearing” of my participants’ experiences in a way that focuses on what happened within this specific context of communicating across differences.

The theoretical contributions may be broad in the ways that this project simply “opens understanding,” but I argue that there is considerable value in hearing the voices of these participants and examining their practices in a framework that highlights the collective work they did “on the ground” of a transnational collective. This study reinforces Hauser’s view that vernacular voices constitute publics. By investigating how vernacular discourses informed their communicative strategies, this study promotes inquiry into translingual rhetoric within situated practice of an emergent collective. Public discourse within emergent collectives requires a translingual approach to listen to all of the vernacular voices that constitute it. This study also demonstrates how individuals assemble as emergent collectives (Asen) to collaborate across differences. Overall, it presents a case study on a specific instance of transnational public engagement to investigate the increasingly transnational nature of the public sphere today. Drawing together public sphere theory and translingual negotiation sets up a mutually beneficial

relationship in theory and practice. While translingual rhetoric examines discursive practices within emergent collectives, understanding translingual rhetors as members of emergent collectives focuses on the relationship building, assembly, and material concerns that influence translingual rhetoric. Ultimately, using translingual negotiation as a public rhetorical act within cross-cultural health contexts can promote useful strategies for individuals to develop as rhetorically adept health providers in their communication with patients and fellow health team members.

The second key implication of this research is setting forth a definition of translingual rhetoric for translingual literacy studies. This definition includes hybrid interpretive strategies that move across varieties of languages and vernacular performances as ways to connect across differences. In this project, I defined *translingual rhetoric* as cross-language rhetorical acts that move back and forth between languages by negotiating dialectical and cultural differences in order to achieve a mutual understanding. By examining these rhetorical acts in a predominantly Dominican Spanish-speaking context, this study gives a situated example of how translingual rhetors negotiate language variation and ideology, especially within transnational health settings. By examining an environment where individuals define "Spanish" by a few different varieties, stigmas, and vocalizations, this language is clearly not a static code. This collective negotiated varied concepts of Spanish, which form to use, and how to utilize it in a medical setting in the daily interactions of these multicultural clinics. The notion of "translation" was also complicated in the ways that local volunteers re-stated, re-articulated, corrected, and translated information during the patient intake process. The negotiation of language and culture was not always neat and fluent, but when participants worked together, they found beneficial approaches to developing mutual understanding with their patients. If more of the U.S. participants had

proficiency in Spanish, they may have avoided many of the messy negotiations that occurred in English-Spanish relations. However, even if this were the case, the negotiations of Spanish-to-Spanish and vernacular medical terminology would remain.

In Toribio's research that I cited in Chapter 3, she quotes participants who explicitly mention one of the towns in this study and another nearby town that we served in our clinics. When her Dominican interviewees mention those towns, it is in a negative way that describes their speech as "bad" and having an influence from Haitian Creole. Not only were my U.S. participants learning to navigate Spanish in a context where "globally" the vernacular dialect would be considered low prestige, but the region we were in added another dimension that individuals from middle and upper classes or other regions of the D.R., would consider it a "bad" form of Spanish. Yet, to acquire characteristics of this dialect, whether it was dropping the letter "s" off the end of words or utilizing vernacular terminology, was seen as speaking "Dominican." To speak Spanish like a Dominican signified rhetorical adaptability and successful communication with patients. The global frame of the low prestige of this dialect did influence some of the participants' judgments about the language and their inability to understand it at first. However, participants with lower proficiencies saw it as "the way to speak Spanish," and those who may have placed judgment on the dialect still "performed" it at times in order to ease understanding and negotiate differences better. If I had conducted this study in any other context, any one of these variables could have changed. Therefore, I do not aim to make generalized comments about the widespread application of this study's findings in other contexts. However, I do argue that there is value in this approach to translingual rhetoric that accounts for the stigma in varieties of non-English languages and how second language learners negotiate those differences across different situated cultural and national contexts.

Overall, this project further contributes to a shift away from a monolingual norm toward a translingual approach (Canagarajah) to health communication research and writing. In addition to incorporating data in both Spanish and English, the chapters of this project have integrated certain terms in a way that if you, mi querido/a lector/a[51], did not already know, hopefully you do now. I only translated roles within the program, such as “cooperadores de salud” and “ayudantes,” the first time they appeared. Similarly, I integrated the word “campo,” and other terms into my writing because I did not feel that the English translation would suffice for describing their use in this program. Maybe campo means a rural area, generally, but within the context of this program, it also meant a specific town or community. We were in the campo, generally, but specifically serving el campo de Rancho de la Vaca or Buena Vista. These inclusions of Spanish, and written representations of the Dominican Spanish of my participants, give a sense of the ways that the participants’ took up various speech habits and negotiated languages in a variety of ways during the program.

The third theoretical implication concerns global health narratives and the need to challenge the dominant narrative of the missionary role of physicians. By incorporating data from local volunteers who helped run the clinics, and keeping their data in Spanish, I attempted to add to the discussion of this specific narrative of a particular transnational health program. Multiple perspectives informed my analysis of cross-cultural communication within this specific program. Recognizing the assembly work that is done and the individuals that helped “run” the clinics without medical specialties was integral to drawing a broader picture of the work of health care in this setting. While recent literature in global health studies has included more qualitative data concerning patient experiences and local resident input in decision-making for

[51] Tr. My dear reader

these programs, additional inquiry into the perspectives of patients, health leaders, and practitioners in these “non-Western” countries is important for challenging the dominant “colonizing” narratives of global health programs.

Craig and Tracy’s grounded practical theory approach, when applied to an ethnographic project, encourages a mutually beneficial approach to theory and practice that draws from rhetorical history. Conducting a study that developed from practice in a constantly evolving context such as a transnational health program leaves room for “the messy” which Grabill describes. It also helps uncover the creative processes of cultivating technical skills and practical knowledge in multilingual contexts. Translingual moves in this study were not always successful and success often only came from the risks, failures, and half-understanding that often accompanies language learning, in general. However, to inform translingual theory, we must explore this messiness, and taking a three-layered approach to identifying problems, technical strategies, and situated ideals was useful for making sense of the practical implications that could emerge from this study.

Practical Implications

Global health programs and cross-cultural health research can benefit from a translingual approach to health communication. As this study demonstrated, language varieties influence the implementation of learned languages within specific contexts. If health providers are engaging in transnational programs without knowledge of the local language, or with an assumed knowledge of the language but no understanding of the local variety, this research can illuminate practical strategies to develop during the programs in collaboration with local residents. Drawing from the expertise of local health leaders and volunteers willing to spend time with a visiting health team, transnational health programs can encourage collaborative approaches to engaging in

communities and advocate for language preparation in local varieties of language and local understandings of health and illness. Overall, there were three practical implications for this study: strategies for learning vernacular languages of host communities, the recognition of the importance of assembly in the global health work of emergent collectives, and the practical advice about the structure of the clinic and collaboration that I shared with coordinators in the subsequent years since this study began.

One of the basic takeaways from this study was that participants should try to learn the vernacular language of their fellow participants in the collective, when possible. When asked about what future participants in these programs could do to prepare for working and living with people from another nation in this program, Katy explains that they as

> dominicanos…puede[n] preocuparlo más para aprender inglés...Y también los americanos tratar de aprender español y dominarlo para que cuando vienen a la Dominicana también comunicarnos en esto idioma y relacionar a la cultura y por ejemplo cuando estemos hablando que digan los americanos, '¡O saben ingles! ¡Puede hablarlo! ¡Qué bien!'...O también nosotros como dominicano(s) a decir 'O mire, ese americano sabe español. ¡Ay, qué bien! Yo lo entiendo. Me gusta como habla.' Entonce(s), allí podemos…aprender los dos idiomas y culturas diferentes.[52]

Katy articulates the importance for participants wanting to work and live with these types of programs to learn the language and culture of other participants in the program. Her explanation highlights how excited one might get when they find out that someone else can speak his or her

[52] Tr. "Dominicans…can be more concerned with learning English…And also the Americans can try to learn Spanish and master it for when they come to the Dominican Republic so we can communicate in this language and relate to the culture and for example when we are talking, the Americans would say, "Oh they know English! They can speak it! How nice!"…Or also we as Dominicans would say "Oh, look, this American knows Spanish. Oh, how nice! I understand it. I like how s/he talks. Then, there we could…learn the two different languages and cultures."

language, and how the relationship can be one that supports language learning as a way of forging connections across cultures.

The focus on preparation in learning the host country or region's language before travel and arriving with an openness to learning while in country will be beneficial to participants of all language proficiencies in the local language of the community. Although learning the local language of a host community or the vernacular language of a visitor is ideal, it is not always feasible for students. Aside from the unpredictability of language varieties in different global health programs, the time between when students choose to apply for these trips and leave for them is often not enough for them to learn a new language. Nicole explains that the six week "Spanish courses that we took really got me through the first hour of my entire…life in the campo. …I feel the best preparation that they can do is a desire to want to actually learn while they're down there. …by going to those Spanish classes before…by looking up words, by bringing a dictionary, you are mentally preparing yourself to learn as much as you can." Preparing oneself to learn as much as possible during the time of the program was a common piece of advice the U.S. participants shared in their interviews.

Matthew adds that while CSR helped provide Spanish classes and Dominican phrases, once they were in the campo, individuals just needed to try their best to pick out words from conversations and that "the more and more you can sit and talk with someone, the easier it is to understand them. So I think just being down there with the Dominicans and having people who were fluent and then also having Dominicans who could kind of understand us just taking the time with people like that helped us interact better with the community." Spending time together highlights the importance of assembly with this collective and a focus on the time they spent together. Through conversations and strategies in their daily interactions, members of this

collective supported each other's language development, and in turn, their translingual rhetorical adaptability.

The second practical implication of this study is the focus on assembling a collective. The importance of the work of assembly and all of its administrative, material concerns must accompany discussions of health communication in temporary health contexts. From the perspective of a coordinator who did not serve a role as a health provider, I was able to examine the various ways in which supporting the making of the Thing—temporary health clinics—was crucial to successfully assembling as a collective and serving patients. Not all groups had a positive experience with the summer program, and some of those negative experiences stemmed from needs with the infrastructure of the clinics and their assembly as a collective. Additionally, my data may not represent the negative experiences participants had in my groups because they may not have wanted to talk to me, their coordinator, about that. Nicole explains some of the negative experiences she heard about from dental students who were in other campos: "the dental students were saying…it was so unorganized, we were fighting with our coordinator every day. They wanted to do this, and we didn't break until 3:00 in the afternoon and we were so frustrated. We had to see all the patients and we had to organize it; we never had a translator…it sounded like such a draining experience and no fun." Noting how difficult it was when they would not end clinic until 3:00 in the afternoon resonates with my adherence to the program's recommendations to end clinic at 1:00 and allow for rest, time with host families, and other activities of assembly outside of the clinics.

Nicole adds that she felt there was a breakdown in communication between students and their coordinator, whereas our relationship entailed "the coordinator making sure that they were the drawing line and that patients weren't then coming straight to the dentist. The patients were

going to cooperador and going to the coordinator to be able to figure things out. And letting the dental students do their job which is dental work, and not organizing patients and figuring things out." This was a major emphasis of my job in Rancho de la Vaca since Alexis was able to look after the medical side of the clinic for most days. I had an experience in Buena Vista where one day the dental clinic was bombarded with patients: they were walking straight into the exam room and asking to be seen, different people were promising things that could not be met, and I was not allowing the dentists the time and space to decide how many they would see and when they would stop. What made the situation worse was that many of them had lower Spanish proficiencies and so they could not partake in conversations that were happening (in Spanish) about the procedural aspects of the clinic. After seeing how exhausted they were and listening to where they felt the communication broke down that day, I talked with Jacob (assistant coordinator) and the José Luis (cooperador) about changing our system and promised that we would try not to let that happen again. Recognizing the purpose of my role as an organizer, liaison, and administrator allowed me to think ahead to possible issues the next year in Rancho de la Vaca, and do as Nicole said, support the dentists in a way that let them focus on their dental work.

The third practical implication from this study comes in the form of follow-up and feedback I have given to other coordinators with the program. In the two years following my work with the CSR summer program, the U.S. program director invited me to do presentations for the coordinators on my experience and advice for them in preparing for the program. In those presentations, I shared some of the initial findings from my study to develop suggestions for facilitating communication and working with these diverse groups of people from the U.S. and the DR. Primarily, I explained how I set up the clinics to pair up local residents with visiting

volunteers to encourage relationship-development and utilize local volunteers for facilitating communication. I shared a bit about how the hybrid interpretive strategies worked, and those who had previously participated with the program recognized how helpful it was to talk about adjusting Spanish to the vernacular use of Spanish. I also shared some of the major approaches I took to helping with the assembly of these groups and supporting their performances. For the two presentations I gave, the following is a synthesized version of my presentation notes:

1. Since all coordinators have had some type of cross-cultural immersion experience before, it is important to allow your group members the space for struggling through culture shock, language difference, and change. Remember that the process is not easy or graceful, and sometimes having empathy for their struggle can help them transform personally through the program.
2. Try an empathetic approach to the immersion. It can help participants better understand and respond to their experiences by considering the perspectives of their host family, the cooks, patients, and cooperadores. I usually share a story about trying to go to the bathroom in a latrine with bugs crawling around it or taking a bucket shower with bees buzzing nearby and how I constantly tell myself, “They do this every day so I can do it for a few weeks. They do this every day, so my worst nightmare of bugs jumping up on me probably won’t happen.”
3. Welcome humor, it can often be used in ways for the participants to bond with each other over uncomfortable experiences.
4. Take time for yourself. Interpreting, facilitating communication, looking after everyone and everything else you will do is exhausting. Be sure to take breaks when you need it, and ask for help interpreting so you do not overwork yourself.

5. Encourage time with families and the community, but also recognize that you set an example with how you interact with others and handle stressful situations. Be sure to encourage interpretation if individuals are sitting together speaking in English and a local resident does not understand what someone said.

Each of these presentations then turned into an open question and answer session when we discussed their concerns and questions for me.

In 2014, one of the summer program coordinators had been a medical student in my group in Rancho de la Vaca, and he specifically asked if I could share how the clinic was set up and how I encouraged collaboration between the local volunteers and visiting practitioners since he felt that we had a successful clinic because of that. I explained that the clinic setup and established expectations at the beginning of the program can have a dramatic impact on how everyone interacts throughout the program. I shared some of the details of this research, and encouraged the coordinators to be aware of ways that the participants could help support each other's language development and how they could recognize the talents of other participants who had lower proficiencies in Spanish but were able to connect with patients in other ways. Although I did not refer to "translingual rhetoric" or "languaging" in either of these presentations, the concepts and practices of my participants proved to be illuminating and relatable for the coordinators to consider how they might encourage collaboration in the clinics.

Limitations

Chapter 2 addressed a few of the limitations of this study, and now I will expand on some of the primary limitations of this study as a way of setting up areas for future inquiry. Limitations for this project included a lack of interviews with participants under the age of 18 and patients.

At least three of the Dominican ayudantes were under 18 years old at the time of this study, and the data concerning their involvement is mostly from the U.S. participants who talked about their help in the clinics. This study also is limited in its description of varieties of Spanish from Dominican participants, and with additional research, it would include more in depth discussion on unique linguistic characteristics of the different Spanishes spoken in the clinics. Additionally, a broader survey of all the groups in this CSR program might demonstrate whether the set-up of having ayudantes together for Spanish-Spanish interpretation was a common phenomenon in other campos.

The lack of data from patients does limit the findings of this study. Additional input on these moments of translingual negotiation from the patients would have illuminated the findings and added another perspective on the perception of the visiting practitioners. I do think that the data, as it currently focuses on the health team's work together, serves an important purpose of laying out the messiness of the process of collective strategies for translingual rhetoric. In her preface to *The Struggle and the Tools*, Ellen Cushman notes a similar limitation to her research and a rationale for why her data is still relevant:

> Because I did not immerse myself in the institutions residents dealt with daily, I cannot be sure how community members' linguistic endeavors actually impacted their receivers. But a focus on the outcomes diverts our attention away from the process of the struggle and the sophistication of the tools; in our push to see significant structural change, we trample over the texture of everyday political life. (x)

Similarly, I assert that this study stands to demonstrate the process and sophistication of my participants' rhetorical strategies. The rich descriptions of their strategies for overcoming language barriers and responding to cultural differences represented complex translingual

rhetorical moves. Additionally, their situated ideals for language learning and emotional connections demonstrates the considerations that went into decision-making for developing these strategies, and the benefits that sometimes came from engaging in them.

A broader survey of other groups that worked with CSR would provide more insight into a variety of experiences, common themes in the structure of the program, and regional differences in dialect and health care. It would have also incorporated negative experiences of assembly, since I began this project knowing that other groups had encountered more challenges with bonding as a group than my groups had. This knowledge came from anecdotes of other coordinators and hearing from my team members about stories they heard from other campos. A variety of factors could have influenced negative or positive experiences, and my groups were by no means perfect. We had to work through miscommunication, differences of opinion in how to care for certain patients, and even cultural differences between medical providers. I learned a lot in my first year that influenced my approach with the second group. Even if participants had a negative experience with me as a coordinator, their experience may not appear in this study because they did not interview or feel comfortable sharing those experiences with me.

Since many participants were entering their final year of medical, dental, pharmacy, and nursing school or were about to graduate with their undergraduate degree, the timing of my meeting them was exactly when they would be looking to move and begin new jobs or professional programs. Additionally, since many of the Dominican youth who helped in the clinics were in their early twenties, many of them encountered life changes in the subsequent years such as having children, moving to live with their partner, or starting new jobs in other towns. These factors, along with my own constraints of attending graduate school in a state

where none of my participants lived, influenced my ability to contact and interview more participants.

During the summer of 2014, I returned to Buena Vista and Rancho de la Vaca with hopes of conducting member checks with participants and discussing my results. However, I found that it being 2-3 years since we worked together, many life circumstances had changed. It was difficult to get in touch with all of the interviewees, and I found my conversations were the most relevant with the cooperadores and Katy, who happened to be training to become a cooperadora for Buena Vista. Since they worked with CSR on a monthly basis, the results and reflections of the participants seemed most relevant to them and their future preparation for working with other groups. My challenges with following up with participants relates to what Hanna and Kleinman describe as the process of global health research: “Evaluation of global health work usually focuses on measuring program effectiveness. Social theory has often been relegated to the domain of post-hoc analysis by scholars writing in academic journals, sometimes years or decades after their insights might have been used to improve the delivery of care” (15). This delay between when the strategies were used during the program and my time of completion for this project further support why I felt it necessary to keep in contact with the CSR director and provide feedback for the coordinators in the subsequent years. Since the program runs fairly similarly year-to-year, I believe that the practical contributions of this study have helped in small ways for the conversations I had with group leaders who have worked with facilitating communication and the assembly of other temporary clinics.

Future Inquiry

For CSR and similar programs, this study reveals a few areas of future inquiry that would be beneficial to explore. First, I recommend that CSR considers conducting a longitudinal study

with U.S. and Dominican participants to see whom later returns to work with the program and any different perspectives they can bring to successful assembly work and translingual approaches for supporting performances. Follow-up with U.S. participants on how it has influenced their practice as health providers in the U.S. would also be informative for developing transferable skills. One of my participants, Christina, was a first year medical resident when we conducted her interview and she talked about connections she made in the hospital concerning her frustration with using phone interpreters. She stated that the experience in Buena Vista was beneficial in how it made her realize how important seeing a patient's facial expressions and nonverbal gestures are to having an accurate translation, and reception, of what the patient said. Although this project did not produce other data on any students who later practiced and transferred those skills, I believe it would be an excellent area for future inquiry to follow up with global health program participants to see how their transnational engagement later influenced their practice.

For researchers in Rhetoric and Composition, this study encourages future inquiry into the intersections of translingual rhetoric and transnational public engagement. I also encourage exploration of embodied forms of translingual rhetoric, and changes across different national and cultural contexts. What rhetorical forms of listening and vernacular performances could enhance the existing research on nonverbal communication? Health care contexts enhance discussions about and use of "body language" because of the nature of conversations explicitly discussing the physical body. Additionally, compositionists can benefit from exploring translingual literacy in its fluid movement between oral and written forms. Since much of translingual writing is an attempt to capture oral forms of code switching, code meshing, or translanguaging, translingual composition could interrogate that transfer between modes of languaging in new ways.

For health practitioners and global health researchers, this study encourages a translingual approach to engaging in emergent collectives. This study also emphasizes cross-cultural dentistry as an area for potential future inquiry concerning the ways in which nonverbal tactics can impact a rhetorical approach to patient-care. Examining nonverbal communication across cultures and languages can inform the ways that dental students learn to signal or make gestures concerning various aspects of patient care. Finally, I encourage further examination of situated health communication practices that demonstrate a preference for the vernacular voices of patients as legitimate ways to talk about health and illness. Rather than referring to vernacular discourse as "lay" terminology and something less technical or correct than professional medical discourse, health providers can recognize it as vernacular medical terminology. Conversations about health literacies and foreign language medical courses can be more inclusive to linguistic and cultural differences as resources, rather than barriers. Through this exploration, traditional "lay" terminology can be seen as an expanded vocabulary and a resource for the rhetorical adaptability of health practitioners in an increasingly transnational and translingual world.

Conclusion

As health providers travel to publicly engage in communities outside of their own nations, cultures, and languages, they encounter complex environments where they must navigate communicative differences. If these health providers engage in global health initiatives because of their concern for equity (Farmer), they need to seek out collaborative approaches to the public health work they do. In those collaborative projects, utilizing strategies like translingual rhetoric can encourage them to recognize new ways of communicating, listening, and providing care for others. Many participants in temporary global health programs talk about receiving more from the local residents than they felt they gave. By de-centering their contexts

for daily life, clinical work, and communication for four weeks, they became vulnerable to new experiences that challenged their minds, bodies, and spirits. Various participants in my groups experienced dehydration, allergic reactions, homesickness, diarrhea, anxiety, and other symptoms that develop during an immersion in a new environment. For many of them, that required that they rely on each other or their host families for help and their own health care. By suffering in small ways because of the environment, the food, and their emotions, they understood the complexities of "global health" a bit more concretely.

To conclude, I would like to return to Charon and DasGupta's point about the importance of promoting an ethical and just approach to healthcare. From the inception of this project, I was interested in how a translingual rhetorical approach might promote ethical communication practices in healthcare. While, at times, translingual negotiation is messy as individuals navigate differences of culture, race, class, power, and language, it can also promote the agency of local residents and patients in global health programs. This project examined how the vernacular language of the Dominican residents in this study, although stigmatized globally, was the most useful form of language in the situated practice of our health clinics. It influenced the discourse that circulated, and the visiting health providers' integrated it into their use of medical Spanish. Through hybrid interpretive strategies from English to Spanish, Spanish to Spanish, and non-verbal tactics, participants were able to negotiate differences and work toward mutual understanding. Individuals navigated the difficulties of translingual negotiation because of their regard for a common goal, or purpose, as a collective: to serve the health needs of local communities. As Dominican and U.S. ayudantes worked together, they also discovered ways to forge relationships across their differences, and support each other's language development in that process.

By examining the assembly of this collective and how they supported performances in the clinics, I hope to have demonstrated how public sphere theory and translingual rhetoric can be mutually beneficial in theory and practice. In my analysis and methodological design, I also promoted an interdisciplinary approach to studying translingual rhetoric by drawing from fields such as Communication Studies, Rhetoric and Composition, and Linguistics. Ultimately, I hope this study demonstrated how the public work of rhetoric can be "useful." By following emergent collectives across national borders, we might learn from complex rhetorical strategies that complement, and simultaneously de-center, our field's predominantly English-speaking, U.S. context.

As a participant-turned-researcher, I also experienced some of these complexities in ways that motivated me to produce "engaged scholarship" (Barge and Shockley-Zalabak) that worked toward tangible outcomes. Though limited, as any single study is, this project is full of hope: for deep connections with patients, friendships, language learning, improved health, and much more. Even though translingual rhetoric was messy and complicated and did not always work, it supported performances that produced all of these tangible outcomes at one point or another. If global health teams and health communication researchers take the time to sit with a variety of stakeholders in these transnational programs, they may discover that the camino[53] toward more just and equitable health care begins with restructuring the narrative. This requires the integration of voices, stories, and languages that have been previously silenced by huddled circles of "propertied and educated" deliberators discussing the best course of action about their health.

[53] Tr. Path

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Translator's Note

While analyzing the data for this project, I kept all of the transcripts with Dominican interviewees in Spanish. I translated the quotations after they had been excerpted and integrated into drafts of this write-up. Once the write-up was near completion, I asked a trusted colleague and Spanish professor, Dr. José McClanahan, to help look over the longer quotations to ensure that I was translating them properly. I am extremely grateful to him for helping me identify areas for improvement in the readability of my translations and for ensuring that I did not erroneously translate quotations. For some translations, I have added words or made minor adjustments to phrases to improve clarity for reading them in English for this piece. As I noted in Chapter 2, I tried to make the transcripts reflect the speech habits of my participants as much as possible, and that is why many of them contain words that have the letter "s" in parentheses to indicate when it was not pronounced by the individual but I wanted to clarify for my readers what the complete word was. Overall, I tried to maintain the integrity of the subject's original meaning and context with all translations.

Appendix 1: Interview Protocol

U.S. Volunteer Questions
Personal Background

1. Could you tell me your name, your age, and where your permanent residence is?
2. What is your nationality?
3. What languages do you know how to speak and understand?
4. When and how have you been involved with CSR programs? Other similar programs to it?
5. Why did you decide to get involved with the CSR summer program?

Communication

1. Can you tell me about any experiences with these programs in which you could not understand what others were saying or when someone else could not understand what you were saying?
2. Can you think of any ways you communicated or connected with people without words? How did that work?
3. What was it like to hear other people speaking in Spanish or English around you?
4. Have you had any experience of someone interpreting for you or you interpreting for them? What was that like?

Cross-cultural Communication

1. How would you describe the kinds of communication that happen between different people in these programs?
2. Can you describe a time when you learned about someone else’s culture in this program?
3. Can you describe a time when you felt you taught someone else about your own culture in this program? How did you do that?

Collective Identity

1. Tell me about a time when you noticed people from different backgrounds coming together during this program? What did this look like by the end of the program?
2. How would you describe the connections people develop through this type of experience?
3. Can you describe a time when you worked with someone from a different nation or language to accomplish something in the clinic?
4. Tell me about any benefits or challenges you think come with this type of experience?

Future programs

1. In what ways can future participants in this program prepare for communicating and working together in the clinic?
2. What do participants in the future need to know about living and working together with this program?

Additional Information

1. Is there anything else you would like to add? Is there anything you wish I would have asked?
2. Can you think of anyone I should contact who would be interested in doing an interview?

Dominican Resident Questions

Antecedentes Personales

1. ¿Podría decirme su nombre, su edad, y donde usted vive?
2. ¿Cuál es su nacionalidad?
3. ¿Qué idiomas usted sabe hablar y entender?
4. ¿Cuánto tiempo ha estado involucrado en los programas de CSR y de qué manera ha participado en el programa de verano?
5. ¿Ha tenido americanos de CSR quedando en su casa? ¿Puede describir como se ha ido esta experiencia?

Comunicación

1. ¿Puede contarme sobre cualquieras experiencias con estos programas cuando no podía entender que otras estaban diciendo o cuando alguien no pudiera entender que usted estaba diciendo?
2. ¿Puede pensar de tiempos en que comunicó con personas sin palabras? ¿Cómo funcionó esta comunicación?
3. ¿Cómo fue su experiencia a escuchar otra gente hablando en ingles alrededor de usted?
4. ¿Ha tenido una experiencia de alguien interpretando para usted o usted interpretando para él o ella? ¿Cómo fue?

Comunicación Transculturales

1. ¿Cómo descubría los tipos de comunicación que ocurren entre personas diferentes en estos programas?
2. ¿Puede describir un tiempo cuando usted aprendió algo sobre la cultura de alguien otro en este programa?
3. Puede describir un tiempo cuando se sintió como usted ensenó a alguien sobre su propia cultura en este programa? ¿Cómo lo hizo?

Identidad Colectiva

1. Cuéntame sobre un tiempo cuando podía ver gente de contextos diferentes viniendo juntos a dentro o afuera de la clínica.
    a. ¿Puede contarme sobre maneras en que usted vio la gente trabajando y compartiendo tiempo juntos en el fin del programa?
2. ¿Cómo descubriera las conexiones la gente desarrolla a dentro de este tipo de experiencia?
3. ¿Puede describir un tiempo cuando usted trabajó con alguien de una nación o idioma diferente para lograr algo en la clínica?

4. Cuéntame sobre algunos beneficios o dificultades piensa que vienen con este tipo de experiencia.

Programas Futuros

1. ¿En cuales maneras pueden preparar los participantes del futuro en este programa para comunicando y trabajando juntos en la clínica?
2. ¿Qué necesitan saber los participantes en el futuro sobre viviendo y trabajando con este programa?

Información Adicional

1. ¿Hay algo más usted quiere decir? ¿Hay algo usted esperó que yo hubiera preguntado?
2. ¿Puede pensar en alguien yo debo contactar que estará interesado en hacer una entrevista?

Appendix 2: Dominicanisms from 2011 CSR Summer Program Guidebook

DOMINICAN LINGO

1- APAGÓN: Power blackout
2- APLATANAO: A foreigner who has lived in the D.R. long enough to know what it's all about.
3- BANDERA DOMINICANA (Dominican Flag): Rice, beans and meat.
4- BUQUÍ: Someone who eats a lot.
5- CANILLAS: Skinny legs.
6- CHELE: Penny.
7- CHICHÍ: Baby.
8- COLMADO: Food shop.
9- CONCHO: Public transportation car.
10- CON-CON: Overcooked rice at the bottom of the pail.
11- DÍMELO!: What's up?
12- GUAGUA: Public bus.
13- GUAPO: Angry, mad.
14- JABLADOR: Liar.
15- JEVITO: Yuppie.
16- JUMO: When you've drunk too much.
17- MAMASOTA: Pretty woman.
18- MANGÚ: Plantain puree
19- MOTOCONCHO: Motorcycle taxi
20- PANA: Pal
21- PAPAÚPA: Important person
22- PARIGUAYO: "Partywatcher", a nerd.
23- PICA-POLLO: Fried chicken.
24- PIN-PUN: The same, alike.
25- PRIETO: Black.
26- QUEDAO: Out of fashion, square.
27- TÍGUERE: A street-wise person.
28- TUMBA POLVO: Cheap flatterer.
29- UN MONTÓN: A large amount.

Appendix 3: CSR Medical Intake Form*

MEDICO

Today's Date__________

Nombres______________________ Apellidos____________________ Apodo____________

Edad____ Sexo____ Fecha de Nacimiento (*day/month/year*)______________

Número de teléfono______-______-__________

Nacionalidad________________ Cédula______________________

Comunidad______________________ Cooperador ___________________________

Tiene Usted una historia de:

Asma	**Sí**	**No`**
Problemas con respiración	**Sí**	**No**
Diabetes	**Sí**	**No**
Enfermedad del riñón	**Sí**	**No**
Fiebre reumática	**Sí**	**No**
Enfermedad del corazón	**Sí**	**No**
Anemia	**Sí**	**No**
Enfermedad del hígado (Hepatitis)	**Sí**	**No**
Presión Alta/Hipertensión	**Sí**	**No**

Tiene Usted un problema con:

Muchos Sangrados	**Sí**	**No**
Ataque o epilepsia	**Sí**	**No**

Tiene Usted Alérgicos de:

Penicilina	**Sí**	**No**
Novocaína	**Sí**	**No**
Aspirina	**Sí**	**No**
Otra medicina o comida	**Sí**	**No**

¿If sí, que?__________________

*This is the first half of the medical intake form that includes the questions mentioned in Chapter 3.