Access
the NCIHC Journal

A publication of the National Council on Interpreting in Health Care June 2024 | Vol. 3 Issue 1

Healthcare Access Long Denied: Speakers of Indigenous and Other Small Minority Languages in the U.S.

NCIHC

National Council on Interpreting in Health Care

4 Great Reasons to Join NCIHC!

01

Be part of an important National movement

02

Participate in historic events that advance the Profession

03

Connect with and learn from experts in the field.

04

Volunteer, vote, get involved to help further the mission.

Join Today!

Scan the QR code to learn about membership with NCIHC.

CONTENTS

NCIHC

**National Council
on Interpreting in
Health Care (NCIHC)**
5614 Connecticut Ave. NW,
Suite 119,
Washington, DC
20015-2604
www.ncihc.org
(202) 505-1537
PERC@ncihc.org

Editorial Group
Linda Golley
Tatiana Cestari
Jaime Fatás-Cabeza
Alejandra Loyola
Gabriela E. Siebach
Eva P. Stitt
Tracy Young

Design & Production
Amy Niven,
Auxiliary Box Designs,
auxbox7@gmail.com

Republication
Requests for permission to republish any of the content pieces in this issue should be sent to the editors of ACCESS at PERC@ncihc.org.

Statements of fact or opinions are the responsibility of the authors alone and do not imply an opinion on the part of the NCIHC, its Board, or its members.

© 2024 National
Council on Interpreting
in Health Care

From the President

Carla Fogaren
President NCIHC

Dear Reader,

On behalf of the National Council on Interpreting in Health Care (NCIHC), I am pleased to welcome you to the third edition of ACCESS: The NCIHC Journal! NCIHC's mission is to continuously promote and enhance healthcare-specific language access at a national level for all individuals.

In today's globalized world, it is crucial that everyone be able to communicate in their own language. Not only does this allow for the sharing of knowledge and information, but it also grants access to information and resources while enabling individuals to voice their concerns and participate in decision-making processes. For ethnocultural minorities and Indigenous Peoples, linguistic rights are essential and are as important as those of individuals who use more common languages in the U.S. However, fewer interpreters are available for languages of rare diffusion. Speakers of these languages may not have the opportunity to fully exercise their human rights and maintain their distinct cultural identity. This is especially important in healthcare settings, where effective communication can mean the difference between life and death.

This third edition of ACCESS will bring to your attention the crucial topic of human rights—specifically, the rights of Indigenous Peoples and those who use minority languages. In addition, this issue will bring you specific approaches, taken by various stakeholders, on how to provide language access to individuals who use less common languages in the U.S. I hope this issue of ACCESS ignites your creativity and helps you think of innovative ways to better serve our population.

In addition to upholding fundamental human rights and principles, opposing and prohibiting discrimination is vital if we are to promote equality for all individuals. We can do this by recognizing and advocating for the equal rights of minorities and Indigenous Peoples to fully participate in society, be included in decision-making processes, and freely enjoy their own culture. Furthermore, they have the right to use their own language without fear of discrimination or persecution.

As president of NCIHC, I urge you to join us in promoting and protecting the rights of Indigenous Peoples and to work toward creating a more inclusive and equitable society for all.

I hope you find the content here useful and helpful to you in your professional work. We invite you to share it widely. I also invite you to volunteer on the various NCIHC committees and on the Board to continue to work toward advocating for and ensuring language access for all.

A sincere thank you to all the members of the Journal Work Group who have dedicated hundreds of hours to producing this wonderful third edition of ACCESS.

With gratitude,
Carla Fogaren, RN
President, NCIHC

From the Editors

Dear Reader,

Welcome to the third issue of ACCESS: The NCIHC Journal.

The editors of this issue honor and respect the diverse Indigenous Peoples in whose ancestral lands we reside. Those peoples include the Lumbe, Washoe (Wa She Shu), Seminole, Duwamish, and Chesapeake.

Language is a bundle of code that everyone in a community understands and uses to communicate. The language may be coded in spoken or sung sounds, in squiggles drawn on a flat surface, in movements, in what is worn, what is eaten, what is celebrated and grieved.

Each language codes meaning differently. Even between related languages such as Arabic and Hebrew, there are countless elements of meaning that do not translate straight across from one language to another. The more different the value sets of two communities are, the less possible it is to easily find an equivalent meaning from one language to the other. How do an English-speaking nurse and an Oromo-speaking patient who has just experienced a miscarriage communicate effectively about the patient's feelings upon losing this pregnancy?

Inspired by the United Nations resolution proclaiming 2022–2032 as the Decade of Indigenous Languages, which seeks to "promote and protect Indigenous languages and improve the lives of those who speak and sign them" (UNESCO, 2023, para. 5), this issue focuses on the Indigenous, tribal, and other small minority spoken or signed languages used in healthcare settings across the United States.

It is no secret that, although federal legislation, policy, and guidance support language access in U.S. healthcare settings, vague language such as "qualified" and "reasonable" gives healthcare systems a lot of flexibility in determining how to provide equitable access to care for those who prefer to communicate in a language other than English about their health. Although there has been great progress in the provision of language access in healthcare settings, gaps still exist, and they are more pronounced for users of small minority languages. For instance, care team members who use one of the dominant world languages may never have considered that by providing health care in the dominant language with an interpreter providing a language bridge, the care team is ignoring the underlying value set of the patient. To meet the patient where she is, the care team should ideally become familiar with the value set of the patient.

In this issue, we define small minority languages, shed light on the disparities their users face, and provide ideas to improve the current state of access for these populations. We also explore the overlap between culture and language, and dive into the professionalization gaps for interpreters of small minority languages. Finally, we share anecdotal evidence of the experiences of those responsible for providing language support in healthcare settings, as well as the patients and members of these communities themselves.

We hope you find this third issue enlightening and enjoy reading each piece as much as we have.

The ACCESS Editorial Group
Linda Golley, MA
Tatiana Cestari, PhD, CHI-Spanish
Jaime Fatás-Cabeza, MMA, USCCI
Alejandra Loyola, BA, CHI-Spanish
Gabriela Siebach, MATI, CHI-Spanish
Eva Stitt, PhD, M.Ed. (deceased 2023)
Tracy Young, CHI-Spanish, RN, BSN, MA

References:

Golley, L., & Young, T. (2023). Stakeholder group: Care team. ACCESS: The NCIHC Journal, 2(1), 20–26. https://ncihc.memberclicks.net/vol-2-issue-1-march-2023

Siebach, G. (2023). Why language access? ACCESS: The NCIHC Journal, 2(1), 6–7. https://ncihc.memberclicks.net/vol-2-issue-1-march-2023

UNESCO. (2023, April 24). About the IDIL2022-2032: 2022-2032 international decade of Indigenous languages. IDIL2022-2032. Retrieved February 16, 2024, from https://idil2022-2032.org/about-2022-2032/

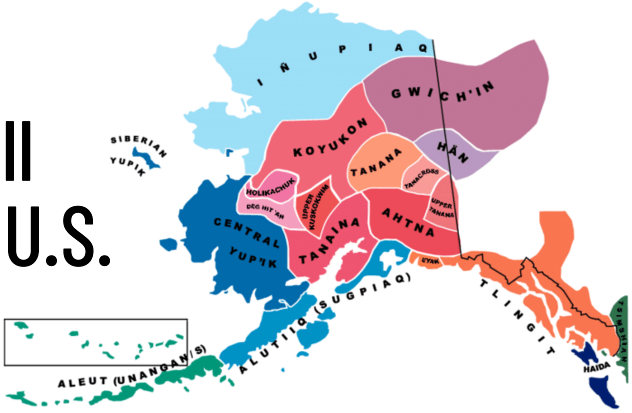
In Memoriam

We celebrate the memory of our dear friend and colleague, Eva Stitt.

Eva was a founding member of our ACCESS editorial collective. She brought deep experience in the mental health needs of immigrants, and she was a passionate promoter of language support for patients who do not speak English.

When she turned her attention to one of our projects, she would do so meticulously and with insight. We trusted her for good judgment and for honest feedback.

Even more than that, however, we appreciated Eva for her personal self. She was funny, charming, gracious, generous, thoughtful, and caring. Thank you, Eva!



Indigenous and Other Small Minority Languages in the U.S.

By David Brackett, CHI, Eliana Lobo, CoreCHI-P, Mark Rockford, and Oana Spanti Gattuso, CMI

We think you would all agree when we say that language is important! The language we use and the way we use it define a large piece of our lives, including our culture and history. It is a well-known fact that the U.S. has a number of minority languages, or languages that are used by a minority in the U.S.

Small Minority Languages in the U.S.

In the farthest corners of our world, amidst the tapestry of cultures, lie a group of vibrant and resilient languages that are often minority languages even in their countries of origin— languages known as Indigenous, tribal, and rare languages. These languages are often relegated to minority status and are generally spoken by small communities; the number of users is limited. These languages are often at risk of endangerment or extinction because the number of remaining users is small.

These small minority languages can be found within larger linguistic families (such as the Nordic language Saami) or smaller regional language families (such as Mixe, which belongs to the Mixe-Zoquean language family).

In the U.S., we have two categories of small minority languages: those that originated within these lands—the tribal and Indigenous languages of what is now the U.S., including both spoken and signed languages—and the languages of immigrants or refugees whose languages may also be minority languages in their home countries.

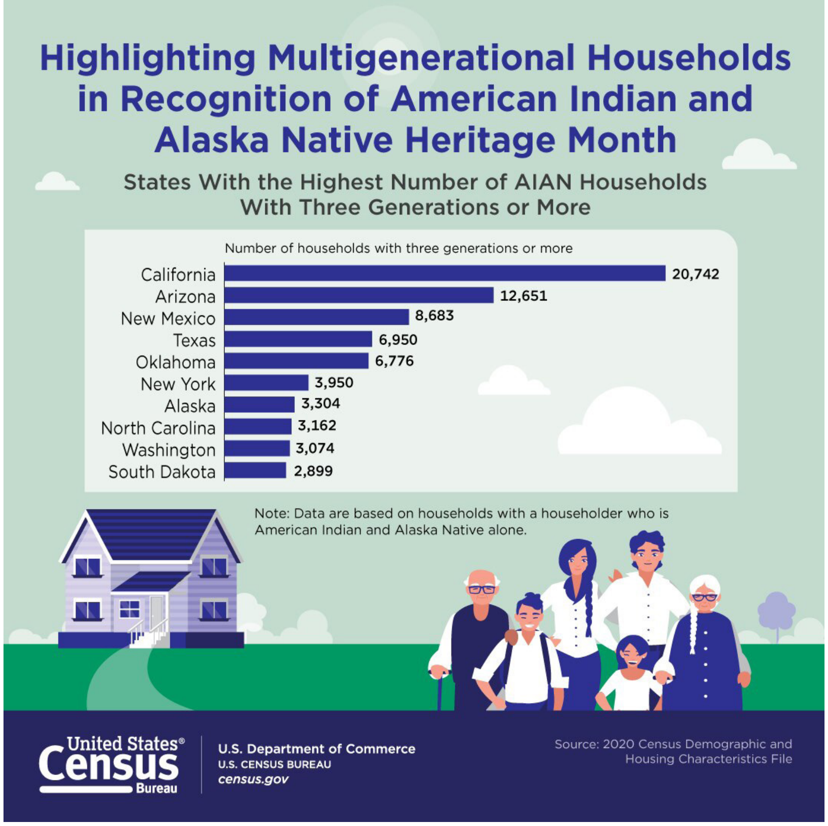
The National Congress of American Indians website (NCAI.org) states that "there are 574 federally recognized Indian Nations (variously called tribes, nations, bands, pueblos, communities and Native villages) in the United States. Approximately 229 of these ethnically, culturally and linguistically diverse nations are located in Alaska; the other federally recognized tribes are located in 35 other states" ("Overview," para. 1). About 22% of the Indigenous population lives on tribal lands, where living conditions have been compared to those in third-world countries. A startling 28.2% of the population lives below the federal poverty line. Additionally, American Sign Language is considered by Ethnologue as a stable and emerging Indigenous language of the United States.

Definitions:

Indigenous groups refer to communities that are native to a particular region or territory and have historical and ancestral connections to that land. They often have distinct cultural, linguistic, and social characteristics that set them apart from the dominant society in which they reside.

Tribal groups typically refer to communities or societies that share a common ancestry, heritage, or cultural practices and are organized based on kinship or lineage ties. These groups often have distinct political, social, and cultural structures that differentiate them from mainstream society.

Throughout the U.S., we also find users of diverse Maya languages, such as K'iche', Mam, and Q'eqchi', that have a profound presence in Latin America—especially in countries like Guatemala, Belize, and Mexico—who have been displaced and emigrated to the U.S. However,



Highlighting Multigenerational Households in Recognition of American Indian and Alaska Native Heritage Month

States With the Highest Number of AIAN Households With Three Generations or More

Note: Data are based on households with a householder who is American Indian and Alaska Native alone.

Source: 2020 Census Demographic and Housing Characteristics File

Latin American languages are not the only small minority languages in the U.S. War and other situations in Asia and Africa have also resulted in increased linguistic diversity in the U.S., bringing languages like Kamara and Daai Chin. Even some languages that may be widely used in their countries of origin (like Swahili, which traverses boundaries from Kenya and Tanzania to neighboring countries) are used only by a very small minority in the U.S. Additionally, members of Deaf and Hard-of-Hearing communities from other countries may come to the U.S. and either use the signed language of their country (like Mexican Sign Language or Armenian Sign Language) or communicate using their own set of gestures and signs. These communities contribute to the multicultural fabric of the towns and cities in which they are located.

Health Disparities and Small Minority Languages

The Native American Aid program website (https://nativepartnership.org/) states that "the pressures to shift from a traditional way of life toward a Western lifestyle has dramatically impacted the health and welfare of the Native peoples and created a terrible epidemic of chronic diseases" ("Health," para. 3). The website also cites a number of alarming statistics, including those illustrating how Native peoples are more likely to die from diabetes and tuberculosis and the higher incidence of cancer, suicide, and infant deaths among Native peoples.

In U.S. healthcare facilities, interpreters play a crucial role in facilitating effective communication and understanding for patients who prefer to communicate about their health in a language other than English, promoting equitable access to healthcare services. A systematic review of studies has shown that the quality of care received by a patient is reduced when the patient does not receive interpreting services or when interpreting services are provided by untrained interpreters (Flores, 2005).

For small minority languages, limited training and testing options are available for interpreters because of how rare the languages are. Additionally, Indigenous or tribal communities are often relegated to minority status even in their country of origin, and in many cases, their languages may be in danger of disappearing. That means that not only are there few users of the language, but there are also limited options for training and qualifying interpreters to interpret in these languages, who often have to rely on a gateway language (or relay language) to provide language support.

Cultures Fading Away...

According to a 2014 article by the World Bank, Indigenous Peoples are often discriminated against simply for not using the mainstream language of their region. Their life expectancy is often up to 30 years less than that of their non-Indigenous counterparts, and infant mortality rates are up to 3.5 times higher than for the general population. Often there is less access to employment, health care, and social services (Casma, 2014).

Let's put ourselves in their shoes: Can you imagine if your family's and your community's stories and anecdotes, sayings, jokes, metaphors were to simply fade away? Even the words and the way they are put together—their grammar, syntax and vocabulary—simply are no more? Horrifying, isn't it? This is what is happening to many Indigenous languages around the world, as their populations are educated in languages that weren't originally theirs, as they are being forced to assimilate into a culture other than that of their ancestors.

For many Indigenous Peoples, the change in culture (and in language) has caused a huge change in their living conditions and quality of life. Although it may not be possible to fully reverse this but with effort, it may be possible for these people to preserve a part of their history, language, and culture. To do so, qualified and trained interpreters could play a critical role in allowing these Indigenous Peoples to interact with the general population while retaining their independent cultural and linguistic identities. Everyone has the right to a seat at the table to fully participate in their health care and daily decision-making. Ensuring that all languages and cultures have qualified and trained interpreters will be a huge step toward bringing this goal to fruition.

What is the LLD Work Group?

The mission of the NCIHC's Languages of Lesser Diffusion (LLD) Work Group is to support trainers working with interpreters of languages of limited diffusion. Their focus includes, but is not limited to, the identification of resources, provision of information and guidance on language proficiency testing, helping to develop technical terminology, and supporting interpreting students who speak LLDs, including those for which there is no written form or only minimal diffusion of a written form. If you

Terminology for population groups including "Native American/Alaska Native" and "Native American" are used interchangeably to reflect use of these terms specific to published research and among people. American Indian/Alaska Native is defined by the Office of Management and Budget as "a person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment." There are approximately 6.9 million American Indian/Alaska Native people in the United States.

have resources to contribute to the database, if you want to comment on a listed resource, or if you have other questions or comments, please contact us at LLD@ncihc.org.

References:

Casma, J. C. (2014, April 16). Discriminated against for speaking their own language. World Bank. https://www.worldbank.org/en/news/feature/2014/04/16/discriminados-por-hablar-su-idioma-natal-peru-quechua

Ethnologue. (n.d.). American Sign Language. https://www.ethnologue.com/language/ase/

Flores, G. (2005). The impact of medical interpreter services on the quality of health care: A systematic review. Medical Care Research and Review, 62(3), 255–299. https://doi.org/10.1177/1077558705275416

Native American Aid. (n.d.). Living conditions. Retrieved February 16, 2024, from https://nativenewsonline.net/opinion/learning-a-new-language-can-help-preserve-indigenous-cultures.

Additional Related Resources:

https://news.arizona.edu/news/researcher-will-showcase-native-american-sign-language-super-bowl-performance

https://americanindian.si.edu/nk360/code-talkers/native-languages/#:~:text=The%20Importance%20of%20American%20Indian%20Languages,-Play%20Narration%20Your&text=Although%20most%20American%20Indian%20people,now%2C%20many%20are%20still%20spoken.

https://www.cancertodaymag.org/cancer-talk/cancer-care-on-a-native-american-reservation/

https://nativenewsonline.net/opinion/learning-a-new-language-can-help-preserve-indigenous-cultures

Native Languages and Language Families of North America

The Intersection of Language and Culture in the Context of Healthcare

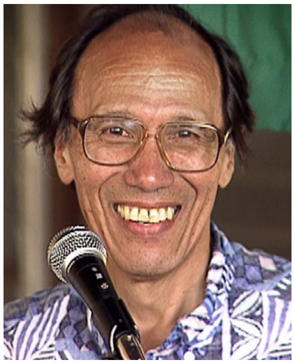
By Brent Ryan Pav, PhD

When was the last time someone at work asked you what you thought? How about how you felt? How did you answer? Now imagine the same situation, but in this case, no one knows how to speak or understand your language. They do not know your code for communication.

In this article we will examine the intersection of culture and language. We will explore the common misperception that it is simple or even possible to substitute words in one language for similar words in another language and attain full communication. We make a plea to approach communication in health care by understanding the patient's mindset and values first, before making plans to intervene in his or her situation.

"We're *kanaka maoli*.
Kanaka means human being.
Maoli means true, real, genuine.
What the colonizers call us
— Hawaiians, Native Hawaiians,
Americans — we're not.
We're *kanaka maoli*."

Kekuni Blaisdell, MD
Sovereinty advocate
Medical doctor



Fostering diversity and inclusion in the healthcare system can improve outcomes by alleviating patient anxiety and increasing compliance. Doing this requires clear communication between the patient and the care team. Communication in general requires a method, be it spoken, written, signed, touch, music, sound, dance, or visual drawings and symbols. These methods are all coded content that usually combine linguistic and paralinguistic elements. They convey meaning if all parties share the same understanding of the meaning. When the parties have little shared experience or values, there will be greater difficulty in finding language terms that convey the intended meaning. In the healthcare network, healthcare workers who take time to explore and discover the language used by their patients gain the critical benefits of clear understanding, compliance, and most importantly, trust. This is particularly valuable when patients are speakers of languages of lesser diffusion (LLD).

In the healthcare sector, we drive ourselves to perform tasks, deliver results, cater to our clients' needs, attain a quick and accurate flow using lightning-speed decision-making skills. We pride ourselves on making use of the seemingly boundless communication resources available to us via the technological worlds of Apple, Microsoft, and Dell. Many times, we hit the internet before even asking another person.

Searching the internet can be a simple and convenient method of finding information, but is it accurate? When interpreters and frontline workers have questions about a topic expressed by a client and need answers quickly, is it safe to look for insight through sources derived from speakers of the major global languages? Consider our patients who speak LLD or Indigenous languages like Hmong, Lisu, Karen, or Padaung. Speakers of these languages live in northern Thailand and eastern Myanmar. How accurately would an online encyclopedia describe, or explain, cultural concepts from these lesser-known languages? People living in Thailand and Myanmar will articulate that these Indigenous languages are quite different from the national languages of Central Thai or Burmese people.

We need to stop and realize the power differential between people from powerful countries who speak the global languages and people from smaller communities, many of which are both economically and culturally suppressed. The term and concept of Indigenous People gained legitimacy only very recently in law, through the advocacy of the 1982 UN Working Group on Indigenous populations.

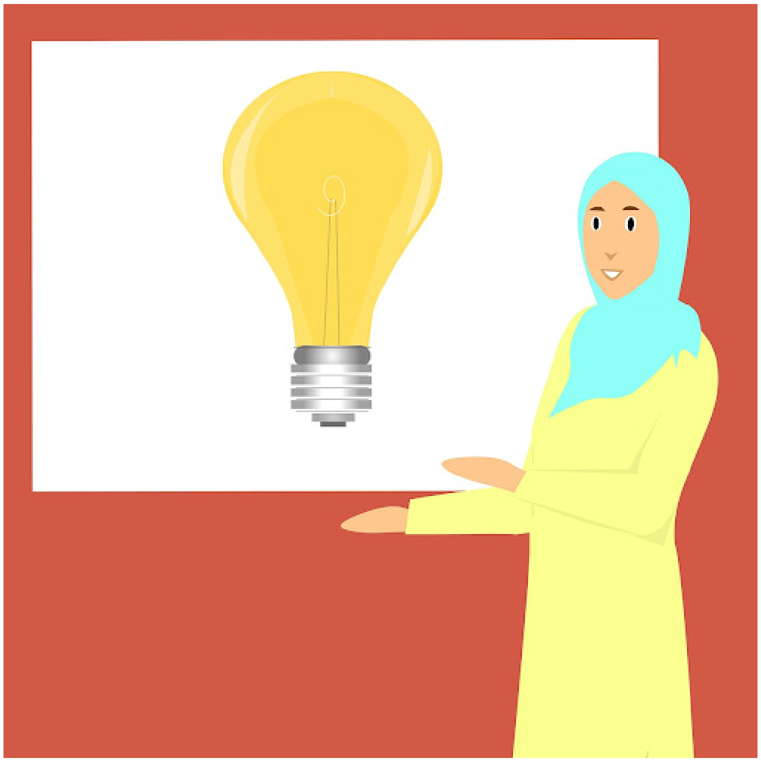
The Declaration of Indigenous Rights was accepted by the UN General Assembly in 2007. This law impacted critical rights for Indigenous cultures around the world. For example, in Latin America, the word " indigena" replaced "indio" and, subsequently, emphasized cultural distinctiveness. Political reforms restructured territorial rights, access to natural resources, and military and police powers over Indigenous Peoples.

However, the Indigenous rights movement also provoked reactive pushback in the context of globalization. Resistance to Indigenous mobilization included assassinations of leaders and their supporters. The concept of autochthony, which means having an identity of being native to, or formed in, the place where one lives, was co-opted by efforts to exclude "strangers" or immigrants in many parts of Africa, Europe, and the U.S., relative to the debate about illegal immigration. The pushback continues to this day.

To a great degree, however, the new appreciation of cultural and sociolinguistic diversity has proven beneficial in pluralistic societies such as the United States. Favorable outcomes include broader understanding of different perspectives, increasing acceptance and tolerance of diversity of values, and learning of new problem-solving skills to tackle challenges across politics, economies, and religions. These broadened perspectives have promoted a more people-centered vision of promoting social change, respecting the value of human biological and cultural diversity, and increasing the understanding of similarities and differences among humans throughout the world.

How does the dominance of the more common languages in the United States manifest itself in social interactions? Ethnocentrism is a tendency to view one's own culture as superior and to apply one's own cultural values in judging the behavior and beliefs of people raised in other cultures. In contrast, cultural relativism promotes the ethic that behavior in one culture should not be judged by standards of another culture. As a key element of human rights, we can advocate that cultural rights—the right of a group

What is she trying to say?



A platter of herbal medicines at Goa, India

to preserve its culture, language, and economic base—should be maintained. Doing so will protect Indigenous intellectual property rights and will help to conserve each society's core beliefs, knowledge, and practices.

Personal and community cultures are sets of values, beliefs, and practices that relate to health, life, and death. Language is a way to encapsulate and convey meaning, both to self and to others. Edward Burnett Tylor (1871), considered a founder of cultural anthropology, stated that "culture . . . is that complex whole which includes knowledge, belief, arts, morals, law, custom, and any other capabilities and habits acquired by man as a member of society" (p. 1).

Culture is shared by individuals as members of groups. Enculturation unifies people by providing common experiences. Culture is all-encompassing and integrated. It is integrated by economic activities and social patterns and by sets of values, ideas, symbols, and judgments centered on core values that are key, basic, and central. It is instrumental, adaptive, and maladaptive to fulfill basic biological, psychological, and emotional needs. Cultural features can be universal across all cultures, generalized across several cultures, or particularized to one culture. For example, ways of referring to death may vary significantly from one group to another living close by.

But cultural values are not set in stone. Cultural patterns are not perpetuated forever. Culture and language are learned, both consciously and unconsciously. The discipline of sociolinguistics investigates the relationships between social and linguistic variation, focusing on features that vary systematically with social position and situation. Variation within language is a historical change in progress. For example, references to homosexual attraction may include older cultural concepts as well as newer cultural attitudes.

Humans are unique in their capacity to use symbols and signs that have no necessary or natural connection to the things they represent. Cultural expression is symbolic, and symbols are often linguistic.

Acculturation is the exchange of cultural features that results when groups come into continuous firsthand contact. Healthcare focus groups and patient questionnaires about health topics would benefit from being phrased in terms that resonate with the patient groups being engaged.

Ethnic diversity and other forms of diversity are mirrored by linguistic diversity. Key concepts in a culture will be represented by language. Less important concepts may not have words. Concepts related to health, life transitions, gender, power roles, and agency may be represented precisely or in less precise terms, some in abstract terms and others in concrete terms. How does American Sign Language refer to music? How does a lesbian person refer to loss of libido? How does a patient who has been seeing a shaman refer to evoking spirits by taking certain medicines?

Nonverbal communication plays an important role as well. Kinesics is the study of communication through body movements, stances, gestures, and facial expressions. These are all shaped by culture and vary cross-culturally. Language acquisition theory depends on the variables of thought and culture. There are opposing theories about the universality of human culture formation:

> Noam Chomsky claimed that the human brain contains a limited set of rules for organizing language called a universal grammar:
> All languages have a common structural basis. All humans have similar linguistic abilities and thought processes. People can learn foreign languages, and words and ideas translate from one language to another.
>
> The Sapir-Whorf hypothesis suggests that grammatical categories of particular languages lead their speakers to think in different ways. However, language does not tightly restrict what thoughts can be thought because changing cultural experience can produce changes in both thought and language. Some medical interpreters must return to their homeland on a regular basis in order to keep up with changes in the language being used by the community, particularly if there is a continuous stream of immigration from that homeland to the United States. (Chan, n.d.).

Language, culture, and thought are interrelated through vocabulary. Vocabulary, or lexicon, also influences perception. Focal vocabulary is specialized sets of terms and distinctions that are particularly important to certain groups.

Indigenous Love Words Project

**The Editorial Group invites you to listen to how people say "I love you" in many different Indigenous languages.
YouTube link: https://www.youtube.com/watch?v=Zvt4Eba_EJM**

Vocabulary is the area of language that changes most readily and impacts semantics, a language's meaning system. For example, people knowledgeable about the sport called "hockey" might use hockey words to signify different meanings. In less common languages, what words are there for pain? What kind of pain is this? Physical, spiritual, existential? What words are there for aging, dying, healing? What phrases give clues of health agency or causation of illness or cure? What healthcare concepts are discussed in a language group? Does the care team member always know these words used by her clients/patients? For example, some languages may refer to "depression" as "being tired all the time," or to "never getting out of bed" as meaning "bad brain."

As our care teams now provide services to a great number of patients from smaller language communities, we should remember that language, thought, and culture intertwine. Healthcare workers, through interpreters, need to ask people what they think, want, or do not want in efforts to build an effective therapeutic relationship. People from Indigenous and small language groups deserve careful attention to discovering what *they* mean, as opposed to all attention being on whether the patient can understand what the *care team* expresses. Healthcare focus groups and patient questionnaires about health topics would benefit from being phrased in terms that resonate with the patient groups being engaged. Clear bi-directional communication promotes open, honest, "real talk" between people. Relationships matter.

Inclusive cultural respect guidelines can provide clarity about the steps needed to initiate effective, bi-directional communication strategies in the healthcare setting; identify useful tools to engage staff; and prioritize participation at all levels to achieve successful patient health outcomes. To achieve this goal, the healthcare system needs to develop a stronger foundation built on trust and buy-in between patient and care team, creating a more unified healthcare culture in which the dominant culture integrates with the culture of the patient. It should continuously collect employee and patient feedback to analyze the root causes of resistance to cultural relativism. Careful attention to language and cultural traits, in all of its coded complexity, is the mechanism for this integration, so that everyone receives the level of care that they deserve.

References

Chan, B. (n.d.). Linguistic anthropology [Flashcards]. Quizlet. Retrieved February 16, 2024, from https://quizlet.com/72134740/language-and-communication-flash-cards/

Tylor, E. B. (1971). Primitive culture: Researches into the development of mythology, philosophy, religion, art, and custom. J. Murray. https://archive.org/details/primitiveculture0171tylo/page/n11/mode/2up

Section 1557: Protecting Individuals With Limited English Proficiency From Discrimination

By Mara Youdelman, managing director for Federal Advocacy, National Health Law Program; Commissioner, Certification Commission for Healthcare Interpreters

United State Department of Health and Human Services

In the next few months, we are expecting the Department of Health and Human Service (HHS) Office for Civil Rights to finalize regulations implementing Section 1557, also known as the Health Care Rights Law (it is called Section 1557 because that is where it is included in the Affordable Care Act).

Language-related barriers may severely limit an individual's opportunity to access health care, assess options, express choices, and ask questions or seek assistance. As a recent example, individuals with Limited English Proficiency (LEP)—in particular Spanish speakers and speakers of Asian and Pacific Island languages—were among the least likely to be vaccinated and have suffered disproportionate rates of COVID-19 infections and deaths.

Section 1557 itself has been in effect since it was signed into law as part of the Affordable Care Act (ACA) by President Obama in 2010, and it has not changed. But we have had three sets of regulations implementing Section 1557 from the Office for Civil Rights. First, President Obama's administration issued regulations in 2016. Then President Trump's administration significantly scaled back those regulations in 2020 and withdrew many of the specific requirements related to language access. The Biden-Harris administration proposed new regulations in 2022. These proposed changes, discussed in this article, could be amended before being finalized, and we cannot predict what the actual final rule will include until it is released.

Who is protected by Section 1557? Section 1557's protections extend to discrimination related not just to language but also to race, color, sex (including pregnancy status or related conditions; sexual orientation; gender identity; sex stereotypes; and sex characteristics, including intersex traits), age, and disability. It is actually the first federal law to ban sex discrimination in health care.

Who is subject to Section 1557? Section 1557 prohibits discrimination in health programs and activities receiving federal financial assistance; in health programs and activities administered by the executive branch; and in entities created under the ACA, including the Marketplaces and health plans sold through the Marketplaces. Entities subject to §1557 ("covered entities") include virtually all


US Supreme
Court Building

healthcare providers—hospitals, clinics, and health care providers' offices—and issuers selling health insurance plans in and outside of the ACA Marketplaces. If an entity is principally engaged in providing or administering health services or health insurance coverage, the proposed regulations state that all of its activities are covered by §1557 if any part receives federal financial assistance. Also, the proposed rule would directly apply §1557 to Medicare Part B (outpatient services).

What do the proposed regulations say? The 2022 proposed regulations would require covered entities to take reasonable steps to provide meaningful access to each individual with limited English proficiency who is eligible or likely to be served by the entities.

Definitions. The proposed rule includes definitions for language assistance services, limited English proficient individual, qualified interpreter, qualified translator, and qualified bilingual/multilingual staff, and adds a definition of "machine translation." For example, an interpreter or translator is defined as an individual who:

- has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language;
- is able to interpret/translate effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary while preserving the tone, sentiment, and emotional level of the original oral statement;
- demonstrates proficiency in, and has above average familiarity with speaking or understanding, both spoken English and at least one other spoken (written) language; and
- adheres to generally accepted interpreter ethics principles, including client confidentiality.

It also restores a number of the provisions, including a requirement to take reasonable steps to provide meaningful access to each LEP individual; standards for video remote interpreting; and notices to inform individuals of their rights. And it reiterates that language access must be free of charge, accurate, and timely; must protect the privacy and independent decision-making authority of the LEP individual; and cannot be provided by minors or accompanying adults unless in an emergency (or for an adult, if a patient consents).

Machine Translation. The proposed rule adds a requirement noting that a qualified human translator must review machine translation:

- if an entity uses machine translation for text that is critical to the rights, benefits, or meaningful access of a limited English proficient individual;
- when accuracy is essential; or
- when the source documents or materials contain complex, nonliteral, or technical language.

Hmong Americans at a community meeting

Notices. The proposed rule also reinstates requirements to notify LEP individuals of the availability of language services. The proposed rule does not mandate translation of documents or the inclusion of specific taglines. Rather, it would require a "notice of availability of language assistance services and auxiliary aids and services" to provide information to both LEP individuals and people with disabilities about accessing assistance. The notice would be provided in English and the top 15 languages in the state. This notice would be provided annually, upon request, at a conspicuous location on the entity's website, and in a clear and prominent physical location. Additionally, the notice would appear in certain electronic and written communications, including:

- notice of nondiscrimination;
- notice of privacy practices;
- application and intake forms;
- notices of denial or termination of eligibility, benefits or services (including Explanation of Benefits) and notices of appeal and grievances rights;
- communications related to a person's rights, eligibility, benefits, or services that require or request a response;

- communication related to a public health emergency;
- consent forms and certain instructions;
- discharge papers;
- complaint forms; and
- patient and member handbooks.

Training. A new proposed provision would explicitly require entities to train relevant employees on the civil rights policies and procedures outlined in the "policies and procedures" provision of the proposed rule. This provision includes general requirements, nondiscrimination policies, grievance procedures, language access procedures, effective communication procedures, and reasonable modification procedures. This training must be provided within 1 year of the effective date of a final regulation, and for each new employee within a reasonable time after a new employee joins an entity's workforce.

Enforcement. Individuals who believe they have been subject to discrimination can file a complaint with the HHS Office for Civil Rights. And others can also file complaints—interpreters, advocates, providers, anyone who has knowledge about discrimination that occurred. To file a complaint, go to the Office for Civil Rights at HHS. Individuals may also be able to file complaints with a state Insurance Commissioner, Medicaid agency, state or federal marketplace, or Health Ombuds or other state entity (depending on state law and policies). Individuals may also go to court to stop ongoing acts of discrimination. They are advised to contact an attorney through a local legal services provider or a state bar association for help.

Once the Biden-Harris Administration's rule is finalized, we will share additional information about its contents, scope, and application.

Here are some additional resources on Section 1557 that might be useful:

- NHeLP's Section 1557 webpage
- Questions and Answers on the 2022 Proposed Rule Addressing Nondiscrimination Protections under the ACA's Section 1557, our overview of the ways Section 1557 affects various individuals, especially those who live at the intersection of multiple identities
- Blog: What is Section 1557? An Introduction

Late-breaking news on Section 1557, see page 25.

Let’s Seize the Opportunities for Language Access Long Denied

By Jaime Fatás-Cabeza, MMA, USCCI

U.S. language access obligations toward people with limited English proficiency are grounded in the Constitution, federal and state legislation, jurisprudence, and executive orders. This body of law sets forth original regulations mandating that health service providers offer language support such that non-English speakers can access care equally to English speakers. Of particular relevance to healthcare services is Section 1557 of the Affordable Care Act (see Mara Youdelman’s article, page 16), the Civil Rights Act of 1965, and the Americans with Disabilities Act (see Gabriela Siebach in issue 2).

Further, guidance to the laws recommends that care services be concordant with the cultural requirements of the patient. Culturally and Linguistically Appropriate Services (CLAS) implementation of these language access mandates is carried out by federal and state agencies such as the Department of Justice (DOJ) and the Department of Health and Human Services (HHS). Patients can file civil rights and disability rights complaints with the DOJ.

On the ground, in the hospitals and clinics, adherence to the mandates is reviewed by private regulatory watchdogs such as the Joint Commission. When Joint Commission reviewers comb through the policies and practice in a particular hospital, they review contracts with language companies, complaints from patients about not having interpreters, and charts of surgical patients that do not have consent documents for surgery in the patient’s language. In the outpatient setting, regulatory reviewers look for translations of key documents into major languages in the waiting room and check to see whether there is a sign notifying patients that they have a right to language support. Hospital and clinic systems have language access plans that require staff and providers to use professional interpreter services and to provide translated documents.

But despite all of these laws, regulations, and policies, equal access to healthcare services for patients who do not speak English continues to have serious gaps. The system most often fails patients from smaller language communities. Next I will expose key reasons for this failure and issue a call to action to move the U.S. healthcare system toward language access justice.

Factors Contributing to Gaps in Language Support for Small Language Communities

Political Economics

The health sector has the resources needed to improve the current state of language access in general, including for small minorities; but improving these services is not a priority.

This failure is in part due to the political economics of our health system: Healthcare in the United States is a business, not an essential, universal human right. As a result, financial management in the healthcare sector is driven in great measure by such factors as maximizing profit and return for investors, administrators, suppliers, and providers. This point is proven by the fact that community clinics, which are not for-profit organizations with the lowest budget for staff and provider pay, assure their patients of language access far more consistently than do wealthier healthcare organizations.

Language support is an essential requirement for effective healthcare and good health outcomes, just like clean sheets on the beds, properly calibrated MRI machines, and qualified nursing staff; and language support costs money. There is huge pressure on interpreter services managers to cut costs on interpretation and translation when they put out a request for bids. Often, they are required to contract with the lowest bidder and allowed only one contract with a language company for spoken languages, and one contract for signed language. No language company can recruit and support interpreters for all the languages spoken in their clients' catchment areas. They concentrate their efforts on finding, assessing, equipping, and onboarding linguists who will be in immediate and constant demand.

Healthcare organizations with fewer language contracts, and with the cheapest contracts, have much less access to linguists to serve small language communities. They have little recourse to find interpreters or translators for their patients who speak or sign languages of lesser frequency. Patients experience pressure to accept an interpreter in a major language, often the colonial language predominant in their homeland. And those language companies which won contracts with the lowest per-minute bids pay their linguists very low amounts indeed. Because small language interpreters have less demand for their services than big language interpreters, they make little money interpreting and cannot make a living at it. Therefore, they become a very scarce resource. There is no financial incentive for a person in the community to train to become a professional interpreter.

Supply of Linguists

Let's further consider the supply side. Today, most healthcare interpreters are native speakers of their non-English language pair. They were born into and went to school in a community with a primary language other than English. Some are heritage speakers who were born into a non-English-speaking household here in the U.S. but never went to school or worked in a country or community where that non-English language was primary. Some interpreters are native English speakers.

To recruit interpreters and translators, healthcare organizations and language companies have to find people who have excellent language proficiency in both languages, and who have training in interpreting or translation.

We have high school and college language programs in English and major foreign languages. We have medical Spanish classes for doctors and nurses at community colleges. We have a small number of interpreting skills classes with language-specific coaching, usually for Spanish interpreters. But there are no classes of any kind, at any level, for healthcare content in smaller languages such as Tongan, or Gujarati, or Navajo. What can we do to train interpreters and translators in these languages?

Loopholes and Discriminatory Failure to Implement Language Access Mandates

Lack of clarity and specificity in key terms weaken Title VI and Executive Order 13166. Although they appear to lay out requirements that oblige the government and recipients of federal aid to take reasonable steps to provide speakers with limited English proficiency with access, existing legislation contemplates language access in theoretical terms that get us only part of the way to where we need to be. The vagueness of key terms such as "meaningful", "reasonable", and "unduly burdening the fundamental mission" allows government agencies and service providers to cut corners in quality and to excuse lack of language support by saying it was too hard to find or too costly.

Many healthcare organizations make huge efforts to find interpreters and translators for all of their patients, but many organizations draw the line at the expense. They may simply avoid registering patients' language needs, so it is on the patient to request and push for an interpreter every visit. Few patients do so. Some organizations document that no interpreter was available even though they did not try to find one. Some organizations instruct patients to bring their own interpreter. Some deny services to patients who will need an interpreter, such as Deaf patients. The patients are told that the doctors' panels are full.

Enforcement is lacking. For instance, the Office of Minority Health has no authority to ensure that language access measures are implemented. Patients from smaller language communities often have little power or leverage to force a healthcare organization to start providing proper language support. Regulatory reviewers and some government lawyers can be persuaded by hospital administrators that there simply was no source for the rare languages requested (which is sometimes true).

Bias in favor of colonial languages is deadly to ensuring language access. This is a systemic problem that disproportionally affects small minority languages in healthcare settings (see Odilia Romero's article, page 58). Speakers of noncolonial and Indigenous languages frequently experience language violence. Their situation is particularly difficult given the challenges posed by the provision of services in a wide variety of languages for a small number of speakers. Cultural aspects of health must be integrated into language services so that they result in effective, dignified care. Care teams are not well-versed in the importance of truly understanding the patient's goals and preferences (see Brent Pav's article, page 11). Rather, they try to force conversations with patients into the straitjacket mold of Western medicine. Care teams are not for the most part aware of the profound historical discrimination that led to traumatic experiences for their patients from smaller language groups. Many of these smaller language communities suffer unfavorable socioeconomic circumstances, poverty, and poor health outcomes, both in their native land if they are immigrants, and here in the U.S. When we provide language support, we must take extra care to protect their dignity and right to autonomous health decision-making.

The availability of language services in the U.S. varies from state to state, and even from facility to facility or entity to entity. We have no centralized system to recruit, train, assess, and support interpreters and translators. Healthcare organizations are not centrally organized. Language companies are autonomous, as well as in competition with each other. They do not share resources. Even linguistic associations in different parts of the country operate in their geographical silos. We as healthcare language access stakeholders have failed to leverage our experience to develop talent and resources that can be used collectively throughout the U.S.

Call to Action

So, what are we to do?
These are a few ideas:

- Renew our efforts and professional commitment to eradicate systemic linguistic violence against speakers of small minority and Indigenous languages.

- Reassess all stakeholders' approaches and priorities to make sure that every effort is made to provide linguistic and cultural access to all.

- Prioritize supporting linguists here in the U.S. rather than opting for less expensive interpreting and translation performed offshore.

- Avoid defeatist "can't be done" attitudes and give small minority languages the same attention mainstream languages receive.

- Include small minority language communities in the planning and implementation of services to get their input and suggestions so that services can be aligned with their needs and priorities.

- Renew our efforts to strengthen regulation, monitoring, and enforcement that avoid vague, fuzzy standards and provide explicit, measurable operational terms.

- Lobby for federal and state support and funding for the creation of national and state plans to develop resources and networks for leveraging and coordinating existing resources for at-risk communities/languages, including outreach; education; provision of services; reimbursement; and enforcement of the existing laws and standards, which is often lacking.

- Monitor key areas of effective implementation of services such as clear objectives and goals, measurable standards, stakeholder involvement and engagement, and resource allocation.

- Support Medicaid, an important and economic source of health coverage for communities experiencing health inequities, including Indigenous people, people of color, and people living in rural communities, and for individuals with low income living with certain chronic health conditions, as well as for children, pregnant women, older adults, and persons with disabilities.

Mountain climbers working together

- Increase educational and outreach efforts about language access rights, both to individuals and their communities (with special emphasis on the biomedical community and powerful stakeholders, such as doctors' and nurses' associations and academic institutions) and service providers. Educate to support language access, challenge stereotypes, and reduce explicit and implicit biases.

- Provide detailed information to covered entities—whether a large hospital or a small provider's office—about what they need to know, and practical guides (the "CLAS approach") beyond "don't discriminate" and "you should provide language services."

- Increase support for existing groups that have created their own programs against all odds—with little or no institutional or government support—and encourage the development of programs and apprenticeships for small minority and Indigenous interpreters who understand the challenges (illiteracy, innumeracy, nonexistent medical terms, inadequate cultural coping skills, lack of patient support services, being forcefully misclassified as a speaker of a colonial language or ethnic group) and have developed strategies to bridge the gap or denounce abusive treatment. Then these interpreters can become developers and testers and train future generations of professionals.

- Create opportunities for advancement and wage increases to attract talent and increase retention. Additionally, we need to continue with efforts to provide educational and accreditation/certification opportunities to interpreters of small minority languages (see Sarah Stockler's article, page 26) and develop protocols for official support and recognition.

- Develop networks, and repositories of easy-to-access information and documents for speakers and interpreters of small minority languages that fulfill their needs as stated by themselves, in cooperation with the medical establishment.

- Leverage the power of technology to develop resources, databases, and repositories of multimedia assets for the training and education of interpreters and the creation of national networks.

Dedication to Achieving Language Access for Small Language Communities

Promoting and protecting language access for all is a complex and ongoing task that requires a comprehensive and sustained effort on the part of the government, civil society, professional organizations, and individuals. Substantial progress has been made in recent years, thanks to countless efforts made by many dedicated people; but we are only part of the way to where we need to be—we still have a long way to go.

Let us not lose sight of our objectives, and let us not be disheartened by the challenges we face. Though difficulties in achieving it may be many, effective communication with all individuals and groups is indispensable for health equity, quality of care, public health and disease prevention, and human dignity. As a society, we have made important gains toward securing many other challenging goals, such as universal civil rights; voting rights; desegregation in housing and education; and recognition of the ethnic, racial, and cultural diversity of our communities. Language support for essential services is just as important. And that means language support for all, including smaller language communities.

We need to renew our commitment to improving the provision of language access in healthcare services for speakers of small minority languages. We can do this. ¡Sí se puede! Yes, we can! It is an effort consistent with the core values of our professions, whether as workers in health services, linguistic services, teaching, or administration. It is also a matter of poetic justice, a historical debt that needs to be paid, a morally appropriate resolution that will restore a sense of balance and harmony to our human service mission.

In the next few months, we expect the Office for Civil Rights of the Department of Human and Health Services to finalize regulations implementing Section 1557. It is a great opportunity to outline the procedural means for securing language support for every patient, not just for patients who speak major languages. Let's remain vigilant and hope that the Biden Administration addresses these issues.

Jaime Fatás-Cabeza is an associate professor at the Spanish and Portuguese Department, University of Arizona, in Tucson and a United States Court Certified interpreter and a medical interpreter and translator.

Section 1557 Updates in 2024

By Jaime Fatás-Cabeza, MMA, USCCI

On May 6, 2024, after this issue was sent to production, the Department of Health and Human Services' Office for Civil Rights published a final rule strengthening the implementation of Section 1557, the Affordable Care Act's nondiscrimination provision. The final rule is a substantial step forward that reinstates key nondiscrimination requirements repealed by the prior administration and also includes new prohibitions against sex discrimination and intersectional discrimination (discrimination "on the basis of race, color, national origin, sex, age, disability, or any combination thereof").

The National Health Law Program has posted an analysis of the 2024 final regulations, Questions and Answers on the 2024 Final Rule. It can be downloaded here: www.healthlaw.org

However, despite all of these promising developments, the final rule does little to acknowledge the particular challenges posed by the provision of language access for speakers of languages spoken by small communities, and does not recognize the need to develop resources that help develop and facilitate access for these communities. For instance, it only addresses Indigenous languages in the context of the need for relay interpreters in a revised definition of qualified interpreter for an individual with limited English proficiency. It states that specialized skills and vocabulary may be needed for less commonly spoken languages as well as dialects (which is a statement applicable to ANY language), recommends that a covered entity will need to engage in some form of analysis to identify the language access needs in their service area, and encourages covered entities to develop language access plans because they are often better prepared to provide individuals with LEP with meaningful access to their health programs and activities.

While these provisions re-state that federal policy requires the provision of linguistic access for all, shapeless recommendations and lack of clear requirements that directly address the language access needs of small minority languages in healthcare settings perpetuates the haphazard nature of linguistic access, a long-standing systemic problem that disproportionally affects these communities. Market approaches have proven insufficient to guarantee essential, universal access to these populations. Perhaps federal and state governments should consider a different approach: first, the enforcement of the existing laws and standards has often been lacking and should be reprioritized. Government entities should also develop plans for language access for at-risk communities/languages, leveraging and coordinating existing linguist professionals, creating incentives and opportunities for advancement, and wage increases to attract talent and increase retention that can be used collectively throughout the US.

Language Testing for Healthcare Interpreters of Small Minority Languages: Asking the Right Questions

By Sarah Stockler-Rex, MA, CHI-Spanish, Interpreting Quality and Training Manager at Cloudbreak Health

If you've worked in language access long enough, your fun party trick may be that you can rattle off the following excerpt of Section 1557 of the Affordable Care Act's requirements for qualified interpreters: "Proficient in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology and phraseology" (Office for Civil Rights, 2020).

Although this regulatory language is familiar to most of us, it deserves some closer examination. After all, what does it mean to be proficient? One definition from linguist Lyle F. Bachman (1990) summarizes language proficiency as "knowledge, competence, or ability in the use of a language" or simply "language ability" (p. 16). Note that the first definition includes both knowledge (receptive language skills) and competence (expressive language skills). Another definition of language proficiency describes it as a "measure of language ability described through performance observations" (Harsch & Malone, 2021, p. 33).

So we know that language proficiency is observable and even measurable. For high-stakes environments like healthcare interpreting, we turn to standardized language testing to measure and document this proficiency in a systematic way. Availability of standardized testing resources, however, varies widely across languages because of challenges we will explore in this article.

For healthcare interpreter positions, the assessment of interpreter readiness via language testing is essential; as we know all too well, language services provided by unqualified individuals greatly increase the possibility of errors, which have clinical consequences (Karliner et al., 2007; Nápoles et al., 2015).

For health care, we need to test more than general language proficiency in order to encompass the latter part of the 1557 requirement: "including any necessary specialized vocabulary, terminology and phraseology" (Office of Civil Rights, 2020). Therefore, to test an individual's ability to provide accurate interpretation in a medical setting, we turn to bilingual interpreting tests.

Passing a bilingual interpreting test to demonstrate both proficiency in all working languages and the ability to perform the principal task of an interpreter is the ideal scenario for interpreter language testing. However, these tests are not available in all languages, especially in small minority languages. For languages such as Spanish, Mandarin, and Arabic, for example, extensive test development and continual validation studies take place at the national certification level (Certification Commission for Healthcare Interpreters, 2022).

Such tests for languages with abundant resources and development history will continue to be the gold standard.

For small minority languages, however, we must examine all the available avenues to ensure those interpreters' language abilities and role readiness. At a bare minimum, an interpreter should meet base-level proficiency requirements of both English and the other working language(s) via general language proficiency testing when a bilingual healthcare interpreting assessment is not available or feasible.

The present article will explore and propose various solutions to the complicated nature of testing small minority languages, sometimes referred to as languages of lesser diffusion (LLD). To understand the solutions, we will first walk through an introduction to language testing to give readers a foundation of knowledge. Then, we will look at innovations being leveraged in various pockets of the interpreting profession which can be mirrored for LLD.

Introduction to language testing

This article has already mentioned two types of language tests: general proficiency testing and bilingual interpreting assessments (designated in the language testing world as "Language for Specific Purposes" testing; Grapin, 2017).

Whether testing an individual's readiness to interpret in medical settings via a bilingual interpreting test or confirming fluency by using a general language proficiency test, it is paramount to understand best practices in language testing to ensure that the assessment itself is of high quality.

When we speak of language testing, we speak of indicators of test quality. Key indicators are reliability and validity.

To know if a test is reliable, those designing the test should ask themselves the following questions: Would test-takers get the same or a very similar result on a different version of the test? On a different day? If the test were scored by another rater?

With respect to validity, tests themselves are not "valid" or "invalid"; rather, validity lies in the decisions and actions taken based on the test results. Test developers must ask themselves "Can the decisions from the test result be supported by the evidence from the test?" Think of validity like this: You may have a perfectly good test, but if it tests only an individual's ability to read text aloud, this test alone is not valid to judge their oral proficiency.

Note: See appendix for additional questions to pose when vetting language tests page 31.

Test quality and small minority language tests

Another test quality measure test developers must consider is practicality. Practicality takes into account questions of feasibility, such as the availability of experts of a given language for the test, including the possible number of qualified raters. Questions of practicality such as these are always a concern when it comes to testing speakers of small minority languages. For instance,

Language Testing for Healthcare Interpreters of Small Minority Languages

Introduction to language testing

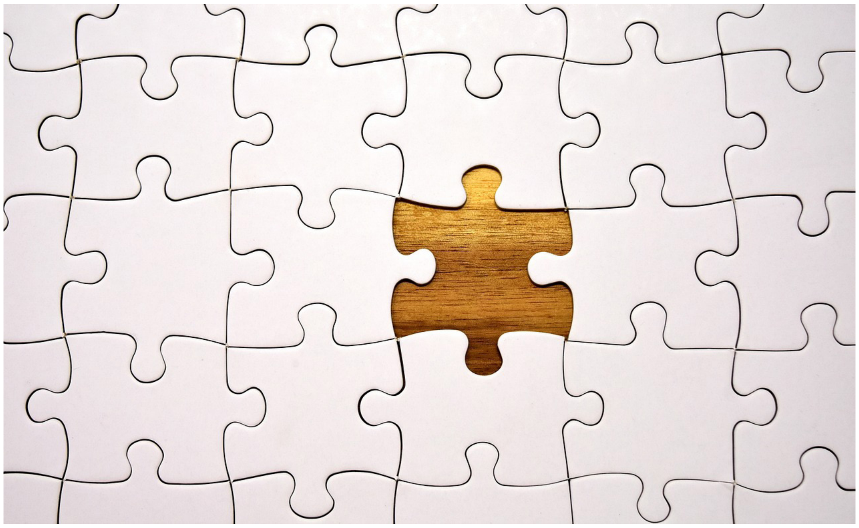
if there are only a few language experts, assessment best practices such as double-blind marking and anonymity of test-taker/rater identity to avoid bias in scoring may prove logistically challenging to implement. At a minimum, having very few raters for a language test can extend test result delivery timelines.

When a test is to be developed for a particular language, test development takes time. The typical test design cycle starts with defining the test purpose, the criterion (the scenario for which you're predicting language performance), and the construct (an operational definition that tells assessors what to look for; Green & Fulcher, 2021). Even if all these processes can be carried over relatively quickly from tests of other languages, test developers must still take the time to do the following tasks:

- task/item design and specification (writing the test content, prompts, etc.)
- evaluation and prototyping (gathering feedback on the test content from stakeholders outside the test development team)
- piloting and data gathering (sometimes multiple times)
- finalizing of test content

This validation process should also be repeated whenever test content is updated (Green & Fulcher, 2021). A small minority language naturally has fewer individuals available to carry out many of these steps.

An essential element of practicality is that there are individuals in need of interpreting services in various community settings, including in health care, who simply cannot wait for a test to exist to receive language services that have been fully tested and validated.



Piece of the puzzle missing

Potential solutions for small minority languages

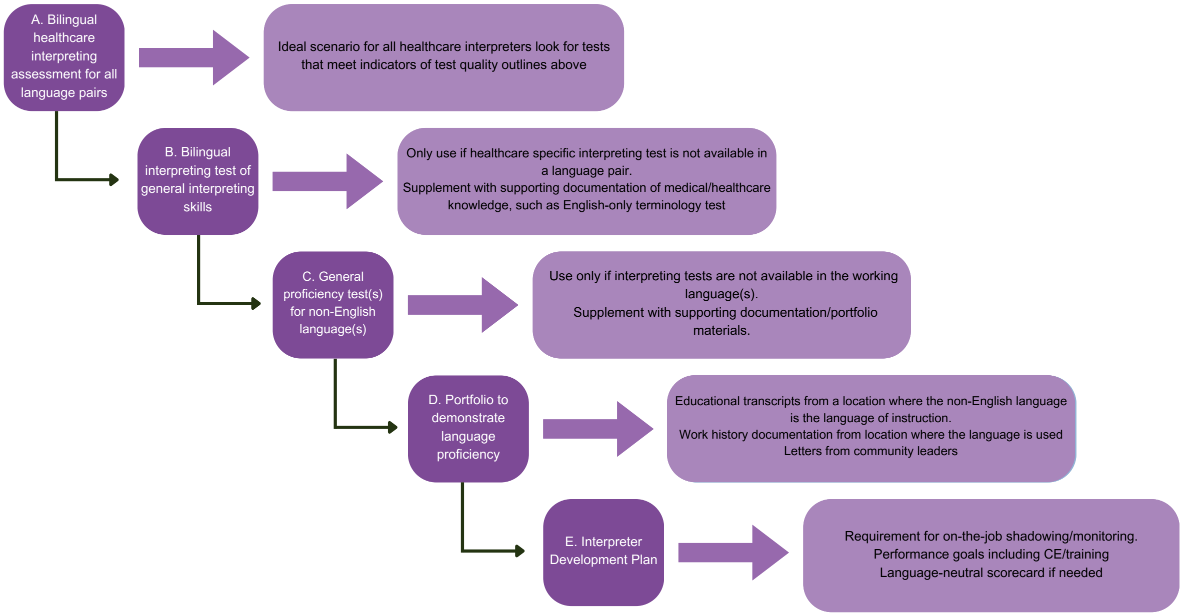
So, what are we to do? In the case of small minority languages, many language service companies and interpreting services departments have turned to a portfolio approach in the absence of a vetted language test. The portfolio of specific interpreters could include elements like educational transcripts or proof of work history from a country where the language in question is used, or even letters of recommendation from community leaders. However, if the job performed requires no use of this language, it may not be relevant for the assessment of the candidate's proficiency or skill in that language.

The purpose of the law and the true purpose of having interpreters undergo language testing prior to hire is to ensure role readiness. Verifying role-preparedness and quality of performance should not stop at the pre-hire screening phase, especially for these interpreters of languages who lack formal language tests.

As another possible solution, we can look to our American Sign Language (ASL) interpreter peers: Companies providing video relay services (VRS) commonly hire interpreters who may have borderline performance but show promise by putting an interpreter development

Language Testing for Healthcare Interpreters of Small Minority Languages

Potential Solutions for Small Minority Languages



plan (IDP) in place. On an IDP, the interpreter will undergo additional performance monitoring, meet specific performance goals set by their leadership team, and complete assigned training or continuing education modules in their first weeks or months of hire, with an aim to graduate from the plan.

The same skill development structure can be used for interpreters of small minority languages. Performance monitoring could be completed by a Quality Assurance team or framed as on-the-job shadowing by a peer or a lead interpreter. The experienced interpreter will preferably be qualified to interpret the IDP interpreter's language pair, but this doesn't have to be the case. Language-neutral scorecards can be implemented that incorporate observations on interpreter protocols in English, general flow of interpreted dialogue, and adherence to interpreter ethics and best practices. Similarly, feedback from patient surveys can be incorporated into the interpreter's coaching and skill development.

The flowchart above serves as a guide for testing for healthcare interpreters. Whereas (A) shows the ideal scenario, interpreter skill validation can move down the path and leverage options from B, C, and so on. Interpreters of small minority languages may need to start at C or even D, depending on test availability.

These outlined steps focus on the pre-hiring phase for interpreter roles, given that assessment and language testing typically occur at this phase as well (a possible exception being when an established interpreter wishes to verify competency in another language pair to be added to their repertoire).

The performance goals described in step E, or perhaps at a later step, could include interpreter certification. Both national certifying bodies of healthcare interpreters offer a written knowledge exam that can be leveraged by interpreters of all language pairs.

As of 2023, there is a newer testing innovation from CCHI (Certification Commission for Healthcare Interpreters): the monolingual interpreting performance exam. The English-to-English exam (ETOE™) is meant as a proficiency testing solution for those languages for which oral tests are not feasible to develop as a stand-alone certification. The ETOE™ exam assesses the interpreter's

Two sign language interpreters working for a school, 2007

professional knowledge and necessary cognitive interpreting skills in English only. Though still a recent addition, the ETOE™ exam should prove invaluable for the professionalization of interpreters who speak languages other than those for which an oral exam is available.

Note on bias in testing method

Small minority languages have unique histories that must be considered and further researched, including in regard to the bias that may be present in testing those who may not be accustomed to or exposed to formal testing. Indeed, this factor could be considered when interpreting scores of language testing and may be an impetus for an IDP when language test scores fall slightly below a targeted range but the candidate shows great promise in other interpreter skill areas.

While we continue the discussion on this topic, input from the affected communities will be key.

In summary, and planning for the future

This article describes the language testing process for interpreters and promotes validated methods to screen and test for necessary proficiency and interpreting skill.

We explore the factors that make it difficult to create a robust testing mechanism for the smaller language communities.

We describe practical methods for gathering background documentation to support hiring interpreters when full testing is not available. And we describe innovative mentorship development programs and the new ETOE testing program to foster professional development.

If they are to equitably provide language access to all patients, interpreters of both widespread languages and small minority languages should have equivalent support to ensure that their skill sets are sufficient to enable them to meet expectations for their role.

Because some of the proposed solutions are time- and resource-intensive, there is a need for federal- or state-level support to develop them.

Rather than accepting what cannot be done, let's continue to develop long-term strategies to develop a skilled interpreter cadre for every needed language. These skilled interpreters will in turn become future leaders in the interpreting profession and will help to create validated pathways for assessing both language proficiency and specialized interpreting skill in the small minority languages that they speak.

References

Bachman, L. F. (1990). Fundamental considerations in language testing. Oxford University Press.

CCHI [Certification Commission for Healthcare Interpreters]. (2022, October 31). Job analysis of healthcare interpreters. https://cchicertification.org/uploads/CCHI_Job_Analysis_Report_2022.pdf

Grapin, S. (2017). Language for specific purposes testing: A historical review. Columbia University Working Papers in Applied Linguistics & TESOL, 17(2), 1-8. https://doi.org/10.7916/D8GB3FZW

Green, A., & Fulcher, G. (2021). Test design cycle. In P. Winke & T. Brunfaut (Eds.), The Routledge handbook of second language acquisition and language testing (pp. 33-44). Routledge.

Harsch, C., & Malone, M. E. (2021). Language proficiency frameworks and scales. In P. Winke & T. Brunfaut (Eds.), The Routledge handbook of second language acquisition and language testing (pp. 33–44). Routledge.

Karliner, L. S., Jacobs, E. A., Chen, A. H., & Mutha, S. (2007). Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. HSR: Health Services Research, 42(2), 727–754. https://doi.org/10.1111/j.1475-6773.2006.00629.x

Nápoles, A. M., Santoyo-Olsson, J., Karliner, L. S., Gregorich, S. E., & Pérez-Stable, E. J. (2015). Inaccurate language interpretation and its clinical significance in the medical encounters of Spanish-speaking Latinos. Medical Care, 53(11), 940–947. https://doi.org/10.1097/MLR.0000000000000422

Office for Civil Rights. (2020). Section 1557 of the Patient Protection and Affordable Care Act. Retrieved February 16, 2024, from https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html

Appendix

Language Testing for Healthcare Interpreters of Small Minority Languages

Question	Test quality indicator	Why this is important
How often is test content updated?	Validity	If content is not updated regularly, test topics may be revealed in the community, leading to unfair advantages for certain test-takers.
How many raters score each test?	Reliability	Using double-blind rating as a standard practice improves inter-rater reliability and reduces the possibility of rater bias influencing scores. If a test is not marked by at least two raters 100% of the time, it's important to ask how potential rater bias is reduced/addressed.
How are language varieties/dialects handled?	Validity	Language tests should assess language use as closely to the authentic real-world environment as possible. It wouldn't be fair to judge against solely a "standard" language variety that is not likely to be used by many patients/participants in the real world or to completely exclude "nonstandard" varieties that will be encountered. Testing rubrics should account for this variation, and raters should be well-versed in the language's variations.
Is the test designed to assess interpreting skills? If so, is it healthcare-specific?	Content coverage	Best practice in language testing is to create an assessment that is as close to the real-world task as possible. For healthcare interpreters, we ideally want to employ a bilingual, healthcare-specific interpreting test that simulates the kinds of conversations interpreted in the role. Some tests are only "general" interpreting tests, or test only language proficiency. Both of these types of test may be leveraged when a healthcare-specific interpreting test is unavailable in a certain language pair, but they should be used with caution and in conjunction with other methods.
Have test developers measured a reliability index?	Reliability	Even without being a language-testing expert, one can ask this question to learn how committed the test developer is to reliability in their language test and get an idea of the expertise from the team.

English-to-English Interpreter Certification: A First Step in the Right Direction

By Jaime Fatás-Cabeza, MMA, USCCI

In 2023, the Certification Commission for Healthcare Interpreters (CCHI) began offering a new performance credential, the CoreCHI-Performance™ (CoreCHI-P™) certification, available to interpreters of all spoken languages. To obtain the new credential, candidates have to fulfill a language proficiency requirement in the language other than English; pass the CoreCHI™ written knowledge exam; and pass the ETOE™ (English-to-English) performance exam, which assesses cognitive interpreting skills.

The ETOE™ test is in a monolingual format to offer certification to interpreters of any language, including languages of lower incidence (limited diffusion), because of the unfeasibility of developing and maintaining a bilingual performance certification exam in these languages. The test measures cognitive interpreting skills via an English-only exam, combined with accreditation of language proficiency in a non-English language that allows for evidence-based employment decision-making.

To evaluate how effectively the new English-to-English oral interpreting test works with regard to accuracy and completeness, interpreters in Spanish, Mandarin, and Arabic, for whom there is a language-specific performance exam, took both tests. After extensive preliminary testing, CCHI concluded that the ETOE™ exam is a viable predictor of whether the candidate will pass or fail its bilingual Certified Healthcare Interpreter (CHI™) exam.

So far, over 140 candidates have obtained the new certification, including interpreters for Haitian Creole, Nepali, Navajo, Mixteco, and many other small minority languages. CCHI continues to monitor the new ETOE™ exam performance and adjust the testing parameters as needed, based on further psychometric analyses. The full report can be found here: https://cchicertification.org/uploads/CCHI_ETOE_Study_Report_May2021.pdf

CCHI deserves recognition for this impressive achievement. It is a significant first step toward offering certification to interpreters of small minority languages. It is a way to recognize their abilities and improve quality in the provision of services. However, the gold standard for interpreter language testing is a bilingual interpreting test taken to demonstrate both proficiency in all working languages and the ability to perform in clinical settings.

We should follow CCHI's lead and, whenever possible, persist in our efforts to increase the number of languages for which a bilingual interpreting test is available, to put interpreters of those languages on an equal footing with interpreters of hegemonic, dominant, and colonial languages. Developing bilingual healthcare interpreter performance tests in language after language will create chances for advancement and wage increases, attract talent and improve retention, and raise quality interpreting standards as a fundamental component of quality care.

Drastic, continued, and concerted effort is required of us in healthcare language access leadership to drive the development of high-quality bilingual testing for the languages our patients speak. Interpreter professional associations must develop the ability to coordinate nationally and form a common front to pursue general interests. We need to lobby state and federal government to require and fund training and testing of interpreters in the languages needed.

We need to assess existing resources, develop new ones as needed and feasible, and build networks for sharing of resources for small minority languages. We need to actively support small language communities that set up their own testing and training processes to develop professional interpreters. We need to look into the strategies used and the resources developed by existing suppliers of language testing services that have programs to test effectively and reliably across a wide range of languages.

Thanks to recent technological advances, the creation of materials and protocols to achieve these goals is within reach. Being able to locate people who speak, write, and teach in a language with a limited number of speakers is no longer just a dream. Futuristic possibilities are already here. Email, conferencing, and social media facilitate discussion and training across great geographical distance. Voice and video recording apps and automatic translators (and soon-to-be available automatic interpreters) are free. These technologies also make possible the creation and storage in data repositories of training and testing materials by and for the members of a particular language community, to be used as needed, and not only for profit. Let's put them to work.

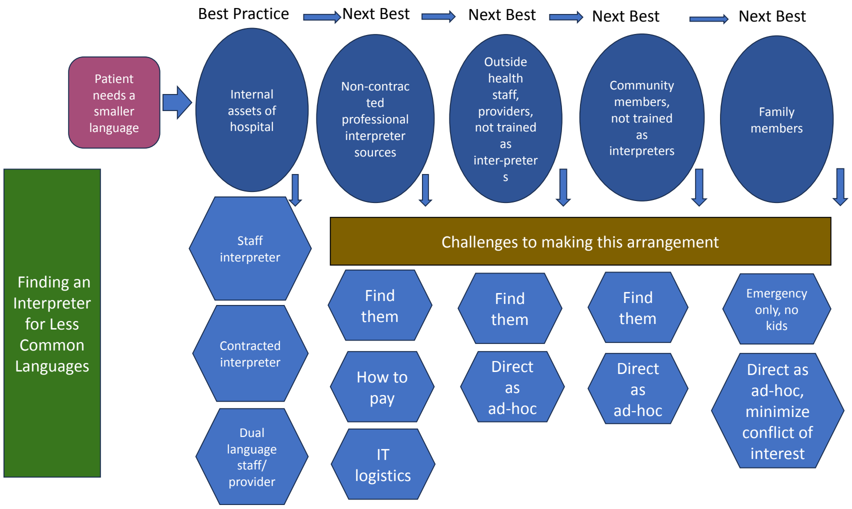
CCHI has taken the initiative and made an impressive contribution. Our interpreter professional associations should look into ways to support and expand these linguistic offerings and the development of bilingual healthcare interpreter performance tests. It is no small task, but we need to persuade ourselves that it can be done. We can do it—one language at a time. So let's start looking for the means to do it.

Jaime Fatás-Cabeza is an associate professor at the Spanish and Portuguese Department, University of Arizona, in Tucson, a United States Court Certified interpreter and a medical interpreter and translator.

The CCHI Certification Journey

Challenges in Pulling Together Effective Language Support

By Evelyn Guerra, B.A., Program Manager, Interpreter Services at Fred Hutchinson Cancer Center; Tatiana Cestari, PhD, CHI-Spanish, Director of Language Service Advocacy at Cloudbreak Health; Alejandra Loyola, BA, CHI-Spanish; Tracy Young, CHI-Spanish, RN, BSN, MA; and Linda Golley, MA, ACCESS Chief Editor



Providing language access requires multiple and innovative strategies on behalf of the interpreter services manager, especially for patients who use languages of lesser diffusion. Language service departments or those overseeing language services in healthcare organizations have the responsibility to provide language access services. To provide these services, they use various approaches (e.g., remote and on-site, staff and contracted interpreters, multiple vendors) for the majority of the language demands and needs of their organization. However, every so often, these departments have to "think outside the box" to find someone to interpret for individuals who use these languages that are more difficult to find.

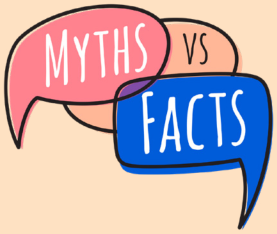
Evelyn Guerra shares some of the approaches her team has used to secure interpreters for patients who speak a language of lesser diffusion:

- **Determine whether the patient speaks an additional language** that might be more readily available among area interpreters. For example, if the patient is Filipino and the language is Ilocano, is it possible that the patient also speaks Tagalog? It's important to be culturally aware and sensitive when approaching them with this question, as there are geopolitical influences to consider. For example, asking a Ukrainian speaker if they also speak Russian may or may not be received as a good intention.

- **Pre-schedule** a telephonic interpreter. It's important to pre-schedule languages of lesser diffusion because getting an interpreter on demand can take the language company a long time or might even be impossible.

- **Connect with culturally based community groups** in the area to recruit interpreters or collaborate with resources they have for their members who speak limited English. For example, I've presented at community meetings for Marshallese speakers, handing out my business card with the offer to assist them with information on becoming a qualified interpreter, connecting them with agencies, and answering any questions they might have. I've also sought out assistance from PICA-WA (a local Pacific Islander organization) to get leads on interpreters and ideas about how we can collaborate to provide interpretation for patients who speak one of the myriad Micronesian languages.

- **Seek assistance/ recommendations from local nonprofit organizations** that work with clients who speak a language other than English. For example, I used to serve on the board of an organization that provides language and culture-specific assistance to parents of children who have a developmental and/ or intellectual disability. I confer with them often, as they are well-connected to local language communities and can recommend local leaders with whom I should speak.
- **Work with providers, nurses, MAs, and sometimes family members** if it will be necessary to use a family member or other ad hoc interpreter. I will guide participants regarding the interpreter's role, do a quick tutorial, and, if it is acceptable to the family, sit in on the appointment to provide support and vigilance on the interpreting process.



Myth:

It is the vendor's responsibility to fulfill all of the requests for languages of lesser diffusion.

Reality:

It is the healthcare organization's responsibility to fulfill the requests for languages of lesser diffusion.

Three Case Studies: Strategies used by other interpreter service managers

Editorial Group

The case of the patient using Mexican Sign Language and his family members using Spanish

This story describes how to work with three different interpreters because the family member and the patient speak different languages. A relay interpreter is needed for patient autonomy.

Our patient is a Deaf elderly woman from Mexico who signs Mexican Sign Language (MSL). Her son is her main caretaker; he speaks Spanish, speaks no English, and signs MSL with the patient.

At the patient's first visit, we put together a not ideal arrangement: a relay interpretation with one ad hoc (untrained) interpreter and one professional interpreter.

This first visit took place in the Emergency Room. There was no Mexican Sign Language interpreter available on demand, either via VRI or in person. So the son interpreted the patient's MSL into Spanish, and an in-person professional Spanish interpreter interpreted from Spanish into English for the care team.

At least there was one trained interpreter in the room to observe interaction between the patient

Patient Centered Care: Relay Sign Language Scenario

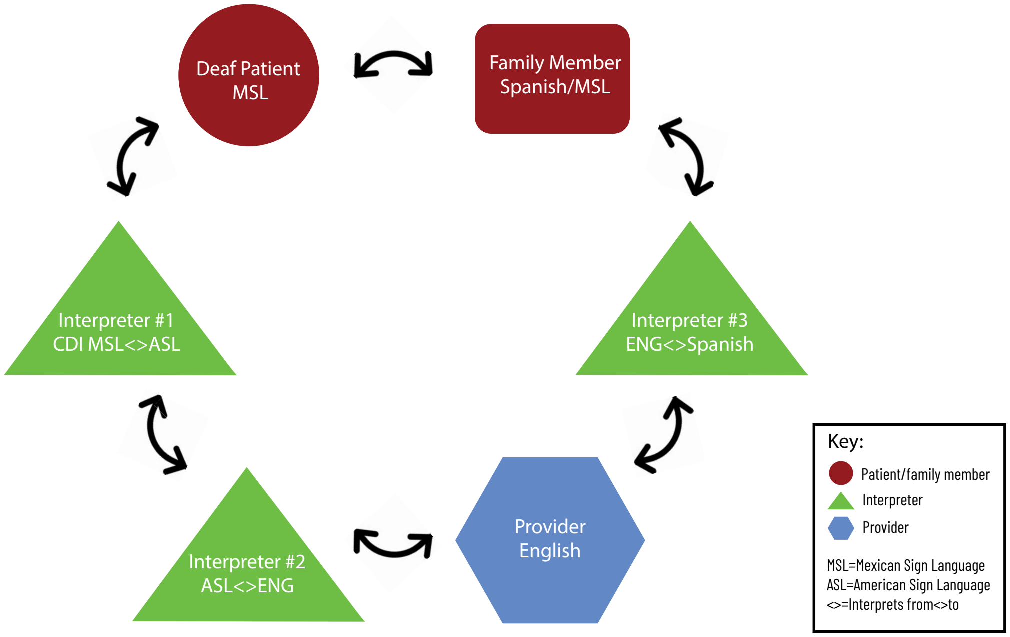


Diagram: Mexican Sign Language Relay interpreting

and the family member ad hoc interpreter. The trained interpreter could observe signing and ensure that the family member was not completely omitting information. We don't know whether the content was complete or accurate.

Another limitation of this interpreting arrangement was that the patient had to accept her family member's being in the chain of communication, and thus theoretically being able to change information in either direction to suit his own wishes about how the health encounter would unfold.

At subsequent visits, we achieved an ideal situation:
Follow-up appointments were scheduled at the clinic, and we had more advance notice. We needed to make sure language support was available both for the patient who uses MSL and for the caretaker son who spoke Spanish.

And we needed to provide direct communication between the patient and the provider without going through the son, to give the patient autonomy in making her own decisions and asking her own questions. **FUN FACT: This particular follow up doctor was a bilingual Spanish provider but we didn't have the son interpret to preserve the patient's autonomy.

Here is our communication design, which is represented in the accompanying diagram.

For the patient, who communicates using Mexican Sign Language, two remote interpreters were scheduled:
(#1) a Certified Deaf Interpreter* skilled in MSL <> ASL and
(#2) a hearing ASL <> English interpreter.

For the caregiver son:
(#3) an in-person Spanish <> English interpreter was scheduled.

The patient communicated with the MSL <> ASL interpreter, and then the ASL interpreter relayed the message to the provider in English. The in-person Spanish interpreter performed simultaneous side interpretation for the son while the patient and provider were conversing.**

The patient was ecstatic to have her own interpreter and some medical autonomy. The son was appreciative of all of the services, including the Spanish interpreter.

Sign language interpreter

*CDI – Certified Deaf Interpreter. The CDI is Deaf. The CDI interprets between the patient and an ASL interpreter.

The case of the patient speaking only a local African language

This story illustrates how persistent, persuasive, and personally committed an interpreter services manager must be to make sure that proper care will happen for patients from small language communities.

The patient was from a West African country. She spoke only a specific African language, no colonial languages, and no English, because she was disabled and could not go out. Her language is not named for this story to protect the patient's confidentiality given that hers is such a small language community. Mrs. X, we will call her, had a twisted artery in her left thigh. Blood supply to her left leg was restricted, so her leg was weak and would not bear her weight. Her local hospital had diagnosed the arterial malformation by x-ray and had referred her to the university hospital for angioplasty repair by interventional radiology. She had no interpreter for the diagnostic process.

She and her husband drove four hours to get to the surgical consultation.

Interpreter Services had meanwhile looked for an interpreter for the consultation and for the surgical procedure, which was already scheduled because the patient was from out of town.

No interpreter for the client's language was available locally. There had never even been a request for this language at any of the 10 hospitals in this major city. So the search began for a phone interpreter somewhere in the country. After quite a few non contracted language companies had been contacted, an interpreter was found in Maine, on the other side of the country from the patient. His time was immediately reserved.

The surgeon had never before undertaken a surgical case supported by a remote interpreter. Indeed, he had never liked remote phone interpreters for presurgical appointments in clinics, either. Therefore, for this consultation he refused to connect with the phone interpreter, and he spoke only with the husband, using very simple English.

The surgeon told the husband he would not do surgery because there was no interpreter available in person. The procedure would take many hours to perform, it would be in a radiation suite with the whole care team in protective lead aprons, and the patient would be sedated but awake so that she could obey instructions. There was only a corded phone at a spot far from the operating area in the room. Not possible, according to the surgeon.

The husband was very aware that his wife would be disabled forever without the surgery. He became quite angry with the surgeon for refusing to perform the procedure. He expressed his anger to the surgeon. At this point the surgeon's nurse alerted Interpreter Services to the impending cancellation of a critical procedure arising from the lack of an in-person interpreter.

The Interpreter Services manager went to the clinic immediately. She greeted the patient and her husband and assured them that surgery would proceed. She met with the surgeon and made it clear that refusing service because of the surgeon's preference for in-person interpreters was not an option. She told him that she had tested out mobile phone reception in the fluoroscopy suite for a different case and that there was no reason to think that an interpreter would not be able to communicate effectively with both the patient and the care team over the phone.

The surgeon agreed to proceed, with poor grace. On the next day, the Interpreter Services manager showed up at seven o'clock in the morning to manage the mobile phone connection for the succession of care team members who would care for the patient all day. The phone interpreter was very competent and very reassuring to both the patient and the husband as the patient was prepped for surgery.

Ten minutes before the patient was to be wheeled into the surgical suite, the surgeon appeared, to get final consent. He looked furious. But as he communicated with the patient via the phone interpreter, the surgeon was impressed with how well the conversation was going. At the end of this consent process, he addressed the Interpreter Services manager, who was holding the phone, and complimented her and the interpreter in front of the hovering nurses.

There followed a very long day for the Interpreter Services manager. She donned full radiation protective gear and stayed throughout the procedure, through recovery, and then through transport to the patient's room. The patient had a suspected pulmonary embolism in the evening, which luckily resolved. During all this, the manager facilitated care staff's talking with the patient via phone interpreter. She made sure the interpreter got rest breaks and that mobile phone equipment was rotated and charged. She went home at nine o'clock that night.

The surgeon was happy, the patient was happy, the husband was happy, and the Risk Management Department was happy.

The case of the patient speaking only a local Indigenous language from Central America

A nurse who was trying to communicate with a patient from Central America who spoke only an Indigenous language contacted several remote interpreting companies, and some of those companies contacted other companies, in efforts to find someone who could interpret for the patient. None of the companies could find an interpreter or even find records of the language in any of the resources available online.

A remote Spanish <> English interpreter, who was known for navigating complicated situations like this one, was assigned to the call in reserve, in case a relay arrangement could be achieved.

Luckily, the patient's companion (someone from the patient's community but not a relative) spoke Spanish fluently and also spoke the patient's language. Relay interpreting would be attempted.

Relay interpreting, as mentioned in the first case study above, involves one interpreter communicating with the patient, and a different interpreter communicating with the provider, and the two interpreters communicating with each other.

Choosing to involve an untrained community member as one link in the communication chain was not a decision made lightly or an ideal situation, but it was the only option available for communicating with the patient.

To prepare for accurate and complete transmission of information, the professional interpreter gave the ad hoc community interpreter a crash course on interpreting, making sure she emphasized the danger of editing or omitting any part of the message.

They proceeded to interpret. Right after the session, the interpreter documented all the efforts of both parties and recommended that the nurse document everything as well in the medical record.

The “Sharpening Our Tools” Symposium: A Celebration of the 10th Anniversary of the NCIHC’s Home for Trainers Webinar Work

The NCIHC Trainers Webinar Work Group (WWG) hosted the “Sharpening Our Tools” virtual symposium for interpreter trainers on January 26 and 27, 2024, in celebration of the 10th anniversary of the webinar series for trainers.

The Trainers Webinar Work Group was formed in 2012 to support interpreter trainers in organizing and presenting their materials. Every year the WWG presents up to six webinars. Topics vary widely, from how to help interpreters improve their English pronunciation, to how to incorporate buddy coaching into interpreter classes, to how to test what interpreters learn during a training. These past webinars (63 so far, and counting!) are all available in recorded format on the NCIHC website, and they are free to NCIHC members. Many of the sessions, but not all, are eligible for CEUs for certified interpreters.

The symposium included a keynote address, roundtable discussions, interactive educational workshops, and numerous opportunities for attendees to network with each other and discuss topics relevant to their field of practice. Over 130 speakers, attendees, and volunteer hosts—hailing from over 33 states (U.S.A.) and six countries—participated in the 2-day event. Participants included trainers/instructors whose time teaching interpreters ranged from less than a year to over 25 years. Curricular programs included short-course, certificate, bachelor’s, and master’s degrees.

NCIHC Home for Trainers Webinar Series
10TH
ANNIVERSARY

The attendees’ anonymous comments and responses to the post-symposium survey were exceptionally positive, and the post-symposium survey statement “I found the symposium to be a valuable learning experience” received a weighted average score of 4.79 with all respondents rating the statement as a “4” or “5 (high)” on a 5-point scale. Although this was the first event of this magnitude organized and hosted by the WWG, such a positive experience is a great incentive to continue organizing similar activities. Congratulations to all the participants and to volunteer group members Erin Rosales (chair), Rachel Herring, Jaime Fatás-Cabeza, Eliana Lobo, Jane Miller, Amanda David, Elena Langdon, and Marisa Rueda Will for an outstanding performance!

In the meantime, the work group continues to host new topics for interpreter trainers in the webinar series. The group is also accepting applications for new members who are interested in contributing to the group’s objectives and initiatives.

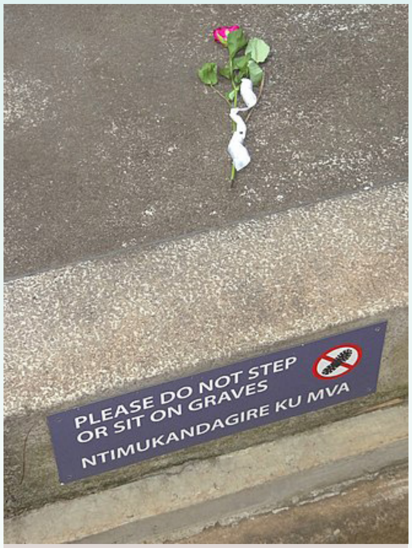
The Home for Trainers Webinar Work Group can be reached at trainerswebinars@ncihc.org.

The Experience of an Interpreter in Both Colonial and Tribal Languages

By Yannick Bayingana, Healthcare Interpreter

Introduction: Ensuring language access in healthcare is an indispensable component of delivering high-quality patient care. Although many healthcare systems have successfully implemented interpreting services for major world languages, the same cannot be confidently asserted for less common languages.

In an interview with Yannick Bayingana, a seasoned professional interpreter fluent in French, Swahili, and Kinyarwanda, we delve into the challenges confronted by patients from smaller linguistic communities when seeking effective language support in healthcare settings in the United States. Bayingana's insights extend to the ways in which the challenges to patients are transferred to their interpreters, whose interpreting role includes ensuring good communication between the parties.



The Languages of Rwanda
Official: Kinyarwanda, English, French, Swahili; Vernacular: Kinyarwanda; Foreign: English, African French; Signed: Rwandan Sign Language

ACCESS Editors: Yannick, please describe the multilayered linguistic landscape that your patients navigate.

Yannick Bayingana: I will use my own linguistic repertoire as an example. I am fluent in French, a globally prominent colonial language spoken by millions across Africa. I am fluent in Swahili, a lingua franca across East and Central Africa. And because of where my parents are from, I speak Kinyarwanda, a tribal language specific to the Rwandan community. The size of these three tiers of language communities varies significantly, with French and Swahili enjoying much broader usage than the more localized Kinyarwanda.

ACCESS Editors: You draw a very helpful distinction between a colonial language, a regionally based lingua franca or convenience language used across national boundaries, and a local tribal language. First let's talk about finding an interpreter. From the perspective of a patient from a former French colony in Africa who prefers a language other than French, how easy is it to secure an interpreter in his preferred language when seeking care here in the United States?

Yannick Bayingana: There are significant gaps in interpreter availability to match patient needs. Despite the well-established healthcare interpreting system in the United States, patients seeking interpreters for Kinyarwanda or Swahili often encounter obstacles in finding a proficient professional interpreter in their language. It is much easier to find a French interpreter, as there is a global network of French speakers.

ACCESS Editors: Secondly, even with a qualified interpreter, is there any difference in how fully a patient can communicate with an American provider, depending on whether the language he speaks is French, Swahili, or Kinyarwanda?

Regions of Africa

Yannick Bayingana: The patient who speaks Swahili or Kinyarwanda has much greater challenges in fully communicating with the care team than the patient who speaks French, even with an experienced and skilled interpreter. The communication barriers involve fundamental linguistic and cultural misalignments in communication frameworks.

ACCESS Editors: Ouch! First, it's hard to get an interpreter, and second, it is difficult to achieve good communication between medical English and either Swahili or Kinyarwanda. How do these challenges manifest to the patient? What have your patients experienced?

Yannick Bayingana: Patients requesting French interpreters generally experience prompt assistance, often from various Francophone regions. Their French interpreter may be from France, Canada, a Mediterranean African country, or a sub-Saharan African country. Conversely, those in need of Swahili interpreters may encounter appointment delays until a suitable professional is available. The situation is notably more intricate for Kinyarwanda speakers, who might be probed about other languages they speak before the clinic endeavors to locate an interpreter in the language requested.

My patients seeking support for non colonial languages frequently encounter discouragement or inadequate responses. Some patients abandon their quest for Kinyarwanda interpreters due to the scarcity of professionals. They accept a French interpreter even if their French is rudimentary. They stop even asking for Swahili or Kinyarwanda because of the pushback they get.

Here is one sad story. I was called to interpret in person in French. When I got there, the patient recognized from my name that I might speak Kinyarwanda, and asked me. I interpreted for him in Kinyarwanda. No one on the care team realized that we were not speaking French. Some language service companies dispatch interpreters claiming proficiency in numerous African languages who do not actually speak the requested language. Rarely, the patient and interpreter do both speak Kinyarwanda but come from isolated areas such that they cannot understand each other.

ACCESS Editors: So what can the patient do to get language support?

Yannick Bayingana: I have to underscore the critical importance of patients persistently advocating for their preferred language. If they truly can communicate fluently in French, they can accept a French interpreter. But if their best language for health topics is a regional or local language, they must advocate for themselves. They must refuse pressure from the care team to use a family member to interpret, or to have the person who gave them a ride come in to interpret. Unfortunately, my patients describe palpable feelings of hopelessness and oppression when they simply cannot get professional interpreter support.

ACCESS Editors: Now let's move to the topic of linguistic and cultural challenges for the patient who speaks Swahili or Kinyarwanda and is trying to get good communication going with the provider. Does one of your patients who speaks French experience the same challenges?

Yannick Bayingana: The language that the patient requests is a strong predictor for linguistic and cultural challenges. Imagine that the patient requests French. Two things are certain. The very fact that the patient is fluent in French indicates that she is educated and is familiar with modern topics. It is possible that she is also health literate with Western medical concepts. These capabilities allow her to interact with the content that may come up in a medical visit. Second, French as a European language has equivalent words for any of the English words used by the care team. There is an equivalent term in French for paranoia, or erectile dysfunction, or aortic aneurysm. As long as the French interpreter is well-versed in medical terminology, the patient will experience good technical communication.

And culturally, the patient who requests a French interpreter may also be OK with the American medical approach. Having studied French in school or college, or even in France, the direct, fast, impersonal, clinical exchange may suit her, or at least not surprise or discourage her.

ACCESS Editors: And how about linguistic and cultural compatibility for a patient who requests Swahili or Kinyarwanda?

Yannick Bayingana: This patient may have profound challenges communicating with the provider, even with an experienced interpreter. Linguistically, there are many terms used by the American provider for which there is no equivalent term in Kiswahili or Kinyarwanda—for example, the term and concept of hospice. And vice versa: The patient may try to convey a sensation, a concern, an experience, or an opinion that has no equivalent expression or even concept in English.

For good and productive communication to happen for this patient, both the interpreter and the provider have to be proactive, flexible, creative, and supportive. But what too often happens is that either the provider or the interpreter cuts corners at the patient's expense. The interpreter may hurry through and deliver content that makes no

Geographic-administrative extent of Swahili. Dark: native range (the Swahili coast). Medium green: Spoken by a majority alongside indigenous languages. Light green: Spoken by a minority

sense to the patient but looks fine to the provider. The provider may insist that the interpreter push for a yes or no answer from the patient, impatiently complaining that the interpreter must not know what she is doing.

Culturally, there is an even bigger challenge. The patient who speaks Swahili or Kinyarwanda expects to tell her story and have the provider listen. She does not expect to be asked a fast series of questions in an order that makes no sense to her. She expects to get an explanation of what is going on, and a recommendation of what needs to be done. She may not be comfortable with any direction to do self-care. She may not believe a diagnosis that involves things she cannot see, such as high blood pressure.

Even more fundamentally, there are many health topics which would be unacceptable for this patient to discuss for cultural reasons. If the provider was unaware of the cultural gap, the patient might stop listening or decide to not come back. I have had the uncomfortable experience of seeing doctors and nurses chastise patients for being noncompliant when the patient either did not understand their instructions or did not agree with them.

For example, some of my patients have become very uncomfortable with mention of HIV, mental health, addiction, disability, failing cognition, delayed development in children. A person with epilepsy may be thought to have a demon rather than an illness.

Again, with cultural gaps, as with linguistic gaps, it is essential for the provider and the interpreter to support the patient by helping her to tell her story and pursue her own goals. This is yet another reason to not force the patient to accept a French interpreter. With a patient who speaks Swahili or Kinyarwanda, the role of the interpreter becomes more intricate, necessitating an understanding of the cultural context to ensure seamless communication.

ACCESS Editors: You make a strong case for making sure that a patient has an interpreter in his preferred language rather than in a colonial language that he is less fluent in. And you have provided great examples of the linguistic and cultural gaps experienced by patients who speak less common languages here in the United States. We hope that you will become a trainer for interpreters who speak these smaller languages.

INTERPRETER SPOTLIGHT

A Day in the Life of Geri Hernandez

By Editorial Group

Our spotlight interpreter for this issue is Geri Hernandez, who is a healthcare provider and a healthcare interpreter. Let's get to know her.

ACCESS Editors: Thank you, Geri Hernandez. We are looking forward to hearing from you about how interpreting fits into the healthcare scene for people who speak Navajo.

ACCESS Editors: Take us into the world of your patients. What are some of the scenarios that you interpreted for just recently?

Geri Hernandez in her home

Geri Hernandez: I am delighted to introduce you to the patients for whom I interpret. All of these particular interactions were by phone, by the way. Cell phones are fairly new on the reservation. At first, there was some reluctance to use the cell phones. People who speak Navajo live across vast areas, mostly in the American Southwest.

One of my recent patients is an older man with cancer, whose doctor explained that he had a tumor that would need to be irradiated. When the man understood that irradiation was a form of focused burning, he asked the doctor if he could refuse the treatment. The doctor assured him that he could make his own decision about whether to have the treatment, but that if he did not have the treatment, the tumor might pop up in additional places over his body. The patient and his wife had to consider how to manage the treatment logistically and financially. They live 4.5 hours away from the clinic or hospital in Phoenix, Albuquerque, or Farmington, NM. They have to pay a relative for the gas for the trip, which is more money than they get in food stamps every month. And the relative has to take a day off work to drive them.

ACCESS Editors: You have cared for patients as a family nurse practitioner, so you were carrying the role of a provider. Now you work as a remote healthcare interpreter. Is it challenging to switch hats from provider to interpreter?

Geri Hernand: It is very challenging to remain within the boundaries of the interpreter, especially when the patient experiences conditions, unknown to the provider, that make it hard for him or her to manage their health, For example, I was interpreting by phone for an elderly blind man who lived in a one-room house with other people. To get to the outhouse, he held onto a rope between the house and the outhouse. Going outside at night was not best for his failing health. I wanted to recommend putting a chamber pot into the house and hanging a cloth around it for privacy just at night. But as the interpreter, I could not introduce the topic.

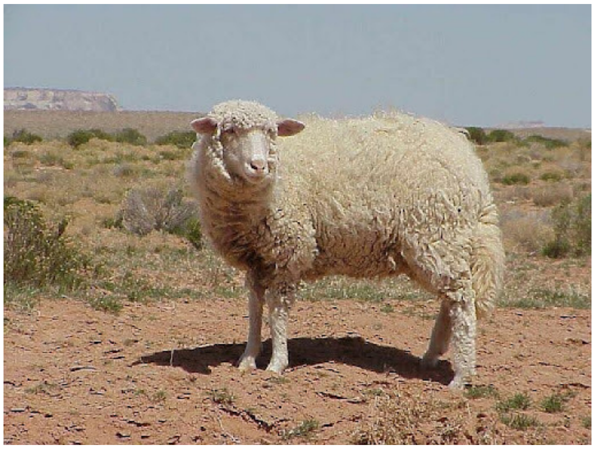
But when I was a nurse working on the clinic team, I was able to prevent some harm from happening to specific patients and was able to educate my coworkers on sensitive cultural practices.

ACCESS Editors: You are an elder now. Way past the time when many people retire, you continue to work for the community as a healthcare and court interpreter. Please lay out the bones of your two careers: that of healthcare provider and that of an interpreter. Later we will put meat on the bones and discuss what it is like to actually carry out these two roles.

Geri Hernandez: First I will tell you about becoming a healthcare provider. I lived with Grandma. My mom worked, and she had many babies. We were 13 siblings. As third oldest, I took care of the babies for Mom during the day after school. Besides that early experience of caring for other people, there were two strong factors which guided me into a healthcare career. One was a fascination with cleanliness, and two was a fascination with anatomy gained from butchering up sheep.

I was interested in illness in the community. I recall we kept water in an open family/communal washbasin, and periodically we changed the water. We needed to preserve water, which we hauled by horse-drawn wagon (and eventually in a truck) in a barrel. If one person had impetigo and attempted to wash it away in the water, then another family member would use the same water, and hence we would get cross contamination.

The public health nurse came to our dormitory/school to immunize the kids. The nurse used glass syringes. This was before we had disposable plastic syringes. She asked me to help her wash the syringes. It was an honor to be asked, and I definitely knew this was my destiny.



Sheep on the Navajo Reservation AZ

Grandma taught me how to carve up a sheep that we had butchered for food. As we processed all the parts of the body, Grandma would call out the name of the organs and tissues in Navajo. So I learned basic mammalian anatomy, which gave me a strong start for health studies later.

Once out of high school, I set myself the challenge of becoming a nurse. I have cousins, aunts, and grandchildren who are nurses, doctors, and veterinarians. I started off as a practical nurse. I became a registered nurse with an associate degree. I was challenging myself to learn more, so I received my family nurse practitioner title. This was a very difficult subject for me, so I pursued my bachelor's degree in nursing. Eventually, I got my master's degree in social work.

Hogan at Monument Valley Navajo Tribal Park

ACCESS Editors: You have a very strong drive to learn. What challenges did you face becoming a healthcare professional?

Geri Hernandez: People from my culture are not supposed to have any contact with dead animals or people. As children herding sheep in the desert, we were warned not to go near dead bones that we came across, whether they were animal or human remains. We were taught to be afraid of dead bodies. Upon entering nursing school, we needed to learn the names of human bones. I was apprehensive as a plastic human skeletal frame was shown to us. I reminded myself, "it is plastic" and repeated "it is plastic" as the teacher touched and named the parts of the skeletal system.

Dissection of biological specimens and autopsy of human bodies were also a challenge. However, thanks to my sheep-butchering experience, I was very good at skinning the cat specimens and dissecting them as we identified body parts. I was impressed to be able to observe an autopsy on a human corpse. It was fascinating to watch the doctor point out how large and dark the real liver was compared to the pink plastic liver model.

There were social challenges, too. As I returned to college for the baccalaureate degree much later in my career, I shared a dormitory room with three students that were my grandchildren's age. Students' male boyfriends were allowed in our rooms. Nightly they would set off fire drills as pranks. As we hurried out into the night, the students stared at me for wearing my hair rollers.

But on a more fundamental note, my many years of health provider education forced me out of my cultural safe space of not discussing topics related to death, serious illness, mental illness, sexuality, and so on. The clinical education plus the daily work of touching patients and discussing problems with patients has resulted in my being completely comfortable with any health topic. But coming from my background, I also understand why my patients are reluctant to use precise terminology for their own anatomy or to discuss certain topics.

ACCESS Editors: In addition to being a healthcare provider, how and why did you also become an interpreter? Please share your personal journey.

Geri Hernandez: We children were reared by our community to study hard on learning the English language and to help the Diné people who do not speak English to understand their health issues. (Pronunciation guide for the word Diné: https://forvo.com/word/din%C3%A9/)

And from there on forward in my life, there has always been a need to help community members speak with non-Navajo-speaking healthcare staff. As I performed my own healthcare provider duties, I also provided a language bridge between patients and colleagues.

When certification became available, I applied and received the scholarship to take the CCHI Core Certification Exam. (https://cchicertification.org/) I am proud to be a Certified Healthcare Interpreter (CHI).

ACCESS Editors: There is a layer of historical oppression that must be pointed out in any recounting of language challenges for Native American communities. May I ask you if you yourself were sent away to government boarding school to be isolated from your family and taught to learn English and forget the Navajo language?

Geri Hernandez: Yes, I was taken from my parents, along with all of my 12 siblings, and we were sent away, far from our home, to boarding school. My parents had to drive many hours to come and get us twice a year for holidays. Some road conditions remain unpaved to this day. We were punished at school for speaking Navajo. But I was the oldest in the family, and I was fortunately able to remember our community language to some extent. However, I am ever so sorry that I did not teach my own children the Navajo language. We children were punished for speaking the language. My mother before me had faced punishment, too. I did not want my children to face ill-treatment.

ACCESS Editors: Were you already interpreting for your family before you were sent to boarding school?

Geri Hernandez: Yes. The White man who ran the Trading Post would chat with people from my community as they came in to buy or trade for food, shoes, clothes, and gasoline. We kids would dry sheepskins and get paid a nickel for them at the Trading Post—enough to purchase a candy bar. As an example of how we were expected to interpret for anyone who needed it, one day the trader asked a young mother about why her child was in the hospital. I was about 8 or 10 years old. The young boy's mother tried to explain that he had undescended testicles. Human body parts/names are explained as vehicle parts: battery = heart, and as animal parts; hence, egg = scrotum. I recall putting my head down and mumbling the words. My best effort was to tell the trader that the child had eggs that did not come down.

ACCESS Editors: Thanks for sharing your personal experiences with us—they're quite remarkable. You have a tremendous amount of courage and determination.

Now I'd like to ask some questions that others might find helpful when interpreting for Navajo or other small languages. What are some examples of challenges for Navajo healthcare interpreters in particular?

Geri Hernandez: In general, the challenge is to explain the meaning of healthcare terms in a way that makes sense to people. Navajo does not have specific words for many concepts that we have words for in English. So it is not possible to interpret the register that most doctors and nurses speak, use. This is true whether I am wearing the bilingual provider hat or wearing the video remote interpreter hat.

ACCESS Editors: And in addition, health care is so technical these days. What are some examples of technological explanations that would make sense to the patient?

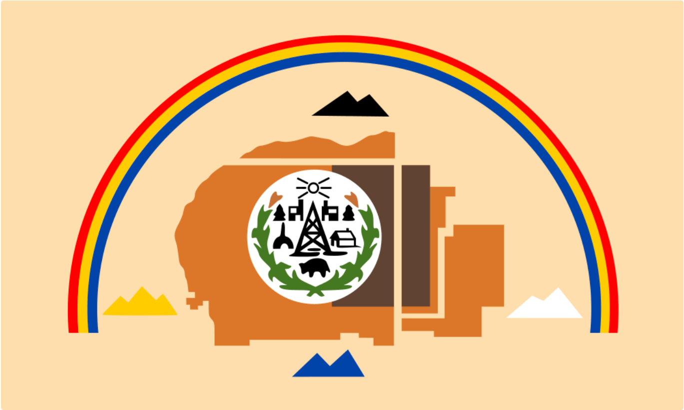
Geri Hernandez: Ah yes, when screening for safety before doing an MRI, we ask the patient whether she has metal plates in her body; we actually ask if she has long metal inserted into any of her bones. Metal in Navajo is beesh, which can be a knife. A concept surely to wonder: "Why is there a knife in me?" Further explanation is needed. Genetic medicine basic concepts are not so hard; we refer to ancestors, family traits. But to describe components of cells and genetic material, there are no comparable words. Here the provider leading the conversation has to be aware of the patient's level of understanding of anatomy and physiology.

But on top of that, there are some topics which are generally not discussed at all by people due to cultural taboos or shyness, so there is an extra layer of difficulty in engaging the person in the conversation. In order to have a successful conversation with a patient from my community, the provider and the interpreter have to tune in to the patient's comfort zone.

For example, contraception is a tricky topic, although much less so now than with the older generations. Each generation chooses to have fewer children if contraception is available. Kids are expensive. It is best to use the term "spacing" instead of "contraception." Sexuality is a private matter, and most people have a hard time talking about their reproductive goals or their sexual practice. On that same note, patients will need a very gentle approach to discussing gender identity, sexual preference, sexual abuse, desire for fertility treatment, desire for vasectomy or tubal ligation, menstruation problems, menopause, sexually transmitted disease, and erectile dysfunction. I had a patient once tell me as the interpreter that he did have erectile dysfunction but not to tell the doctor. The patient was embarrassed, and I empathized with him.

ACCESS Editors: Let's touch on translation. You perform translation as well as interpretation. Navajo does exist in written form, but for your Diné patients who predominantly speak in Navajo, how familiar would you say they are with Navajo in written form? If your patients were given health information translated into written Navajo, would they read it?

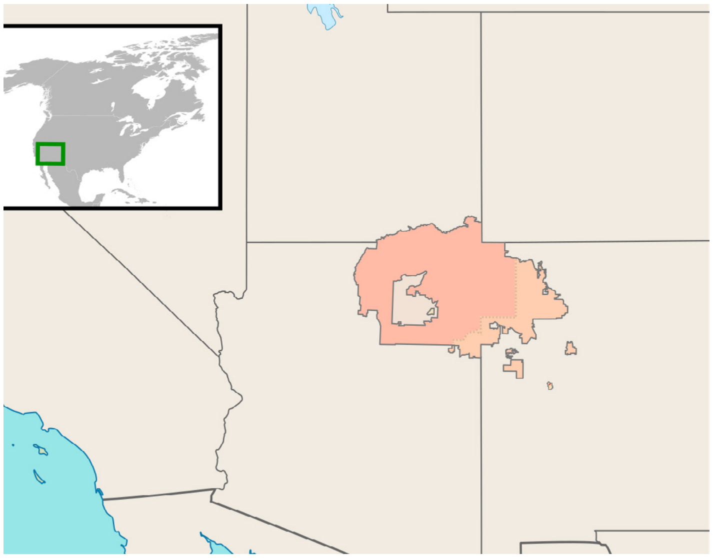
Geri Hernandez: Yes, there are materials in Navajo language. Some use terms that are technically in Navajo but that most people would not know. It is a great challenge, and a worthy challenge, to translate useful meaning into Navajo materials. I do not have very good sources to use when I translate. My most used source is the Christian Bible in Navajo. There are books available written in Navajo; even I have a difficult time reading them. The materials are available honing in on diabetes. I have been seeking material on mental health issues. I go through the text to find references in plain language that my patients can relate to. I find that patients understand explanations related to the natural world. For example, in information about radiation treatment for cancer, which causes burns to healthy tissue as well, I explain the radiation as similar to getting a very strong sunburn, with burn damage to the body. The same with anatomical drawings of the body for patient education. It may be easier to explain a human body function using animal physiology as the example, as many patients have seen the internal organs and tissues of animals that they eat or take care of.



https://en.wikipedia.org/wiki/Navajo_Nation#/media/File:Navajo_flag.svg

ACCESS Editors: Walk us through this concept of meeting the patient where she is culturally. What would a successful encounter look like?

Geri Hernandez: We need to begin by saying that the patient will be very uncomfortable if we call him by his/her name, [with] a strong handshake from the provider, and [with] direct eye contact during the conversation. We greet one another by relationship. I tend to deviate from calling patients by name and say shima or shiyazh: "mother" or "son." In clinic or hospital setting, to determine level of awareness/consciousness, patients are asked to say his/her full name. To call oneself by their own name is arrogant. The saying goes: "Your ears will dry up." They say their name with reluctance. Direct eye contact is frowned upon in our culture; this is seen as being too aggressive. In Diné, our goal with a handshake is to gently place a hand onto the other person, not to hold on and shake the arm. . . Our Diné patients look downward during encounters. Many providers think that they are not interested and not listening. . . Our way is opposite from the dominant Anglo society.



https://en.wikipedia.org/wiki/Navajo_Nation#/media/File:DineBikeyahBe'el-yaigii.svg

ACCESS Editors: Mental health can be difficult to explain and to interpret, because meaning and nuance are key. There are no lab tests that can provide a diagnosis, and no surgery that can provide a cure. Language must be used, and language only has meaning in a cultural context. If the patient and provider do not share a similar cultural background, it takes a lot more discovery to make sure that communication is happening effectively. Would you agree?

Geri Hernandez: Yes, mental health is also difficult to discuss with members of my community, for cultural reasons. We are taught to be strong in mind, to always be positive and not hone in on negative things. When my dad passed, my mom's healthcare providers encouraged her to get some mental health support for her grief and loss. My mom refused the referral. It might have been effective to describe counseling to her as a way to rebalance and tap into positive thoughts as the family reshapes when a person passes away.

In standard medical processes, there are many questions that patients are asked about "depression" or whether the person ever thinks about hurting herself or hurting someone else. These questions are also viewed by my community as negative thoughts which are to be avoided or ignored. Thus, these questions will rarely elicit an honest response. Phrasing the questions differently might be effective.

ACCESS Editors: We have so many healthcare processes related to prevention, in which we talk about the bad things that happen if we do not take certain measures. How do your patients relate to prevention measures?

Geri Hernandez: There is a culturally based fear that my people have about encouraging bad luck. This prevents some from writing an advance directive, getting immunized against the flu, or wearing a seat belt or bike helmet. A patient may zone out while the provider goes over the elements of consent for care, hoping to not hear about possible negative effects of the proposed treatment plan.

When a patient is dying and has zero possibility of regaining brain function, healthcare providers introduce the idea of taking the person off of life support. This is very unpopular in my community. Here again, the culturally aware provider and the skilled interpreter can present the information in a way that is palatable to the patient so that he will interact with it.

ACCESS Editors: You have woven a picture of a holistic health model. In a holistic model, the healthcare provider often is part of the patient's community and knows her patients' lives and what challenges they face. Providers who are not from the community do best for the patient by teaming closely with their interpreter to make sure that full communication takes place.

Geri Hernandez: Yes, teaming between the provider and the interpreter is important. The provider who is not from the community should ask the patient what aspects of the proposed treatment plan sound good and what aspects do not sound good. That way the patient can speak up about cost of travel, difficulty in accessing care or meds, home conditions that make self-care difficult, and so on.

ACCESS Editors: You are guiding us into the world of health beliefs as your patients see it. Thank you. Our whole purpose is to make health care available, understandable, accessible, useful, and welcoming to every person. Can you tell us one more take-away for our readers related to a Diné patient?

Geri Hernandez: The most important principle is to preserve the patient's dignity. Next is to listen to what she is saying; discuss and build a plan or approach that is comfortable to the patient.

https://en.wikipedia.org/wiki/Miss_Navajo#/media/File:Crystalyne_Curley.jpg

I taught my clinic staff to be careful of the clothing and hair of our patients. One of our male patients had his entire clothing removed by staff for an urgent procedure while he was barely conscious. Some men in our community wear a special symbolic thong under their clothing, which only they should ever remove (loss of dignity). So the removal of this thong made our patient very stressed.

You may have heard the news story just now of a different male patient, with hair that he had never cut his whole life, whose hair was cut off by hospital staff in preparation for a procedure. This man was elderly and in a semi-comatose state. It was primarily the family that was shocked at the cutting of his hair. It is best to save the hair and give [it] to family members to dispose of the hair properly. Some providers are recognizing the importance of the need for proper disposal.[1]

Many of my patients feel that the dose of medication that they are prescribed is too high, so they take smaller doses than prescribed. Here it is critical to listen to what they are saying and to realize that they are in charge of their own bodies and will do what they think is safest for themselves.

For many of our patients, the interaction with the healthcare system is difficult on many levels. People have a lot of stress from traveling many hours to get to care or a pharmacy. Many types of care are not covered by insurance or Medicaid, but are essential for health, such as dental, mental care, and addiction recovery services. Many patients report receiving low-quality, ineffective, or dangerous supplies, such as insulin needles which bend easily. Many patients are prescribed a brand name of drug instead of a generic because their doctor is convinced that the generic does not work for them, only to have the pharmacist dispense the generic instead. So remember to build a plan or approach that is comfortable to the patient.

References

1 Kottke, J. (2023, December 9). Colorado medical team cut 65-year-old Lakota man's hair without permission, family says. NBC News. https://www.nbcnews.com/news/us-news/colorado-medical-team-cut-65-year-old-lakota-mans-hair-permission-fami-rcna128898.

ORGANIZATIONAL SPOTLIGHT

CIELO (https://mycielo.org/)

By Editorial Group

Comunidades Indígenas en Liderazgo (CIELO) is an Indigenous women-led non-profit organization that works jointly with Indigenous communities residing in Los Angeles. One of our priorities is to fight for social justice through a cultural lens. Our fight for social justice includes ending gender-based violence, providing language access rights, cultural preservation, and reproductive justice. CIELO is a link, a resource, and a liaison for migrant Indigenous communities residing in Los Angeles.

Mental Health Interpreting Is Culture Based

By Eva P. Stitt, PhD, M.Ed., Behavioral Health Coordinator and Behavioral Health Interpreting Program Manager, Virginia Department of Behavioral Health & Development Services

One day, I received a message from a clinical supervisor who was looking for an Otomi interpreter. As with other requests for interpreting in languages of lesser diffusion (LLD), my first action was to forward the request, blind copy, to a dozen colleagues in the language service industry. Their responses varied from "What is Otomi?" to "That is difficult to secure" to "Let me connect with the ethnic group to outsource the interpreter." Fortunately, the third response worked, and an Otomi interpreter was secured, although the interpreter was not trained in the context of U.S. interpreting standards.

The service of a competent interpreter is crucial to ensure effective communication between two people who do not use the same language but are compelled to talk, such as in legal, healthcare, and human services settings, where miscommunication may lead to misdiagnosis, improper or delayed medical treatment, and inability to provide appropriate and necessary services and programs. At its worst, it could lead to breaking up a family, or it could cause permanent physical or mental health damage or death.

> *There are wounds that never show on the body that are deeper and more hurtful than anything that bleeds.*
>
> *Laurell K. Hamilton*

Such is the case of Cirila Baltazar Cruz, a limited English proficient (LEP) immigrant who speaks Chatino, an Indigenous language in Mexico. She was brought to the hospital by a police officer who saw her in labor. During her hospital stay, she communicated with a social worker through an interpreter who spoke Spanish but not Chatino. Cirila delivered a healthy baby girl, but two days later, the newborn baby was legally taken away from her on allegations that as an LEP individual, she was "deemed unfit" and that the baby was "neglected," or that there would be "developmental' problems" because she could not communicate with the baby in English. The case was brought to court on the grounds that she was not provided with adequate language interpretation, thereby depriving her of the right to be heard and to challenge the allegations made against her. Cirila got her baby back after a year of legal wrangling (Court of Mississippi, 2013; Flatow, 2014; "Lawyers: Partial deal," 2014; "Mexican immigrant sues," 2014; Southern Poverty Law Center, 2010). That critical foundation time during which the mother and her baby were separated can't be brought back, so both mother and baby suffered unimaginable and irreparable emotional and psychological damages.

These cases are but two of many involving individuals who speak a language of limited diffusion. Finding a qualified interpreter, especially for mental health cases, is very difficult, because a mental health assessment is highly dependent on communication; that communication is highly dependent on culture. There is a scarcity of trained, qualified interpreters in mental health settings, and standards for mental health interpreting have not yet been established.

Fifteen years ago, the National Council on Interpreting in Health

Care (NCIHC) led a national open discussion about mental health interpreting. Topics such as "Mental Health Interpreting: What's Different from Standard Medical Interpreting?" were discussed in 2007, followed by "Training Mental Health Interpreters" in 2008. At the 2008 NCIHC Membership Meeting, a brief but meaningful discussion regarding mental health interpreting ensued. However, there was a hiatus. In 2023, the importance of mental health interpreting was again brought up during the NCIHC Annual Membership meeting.

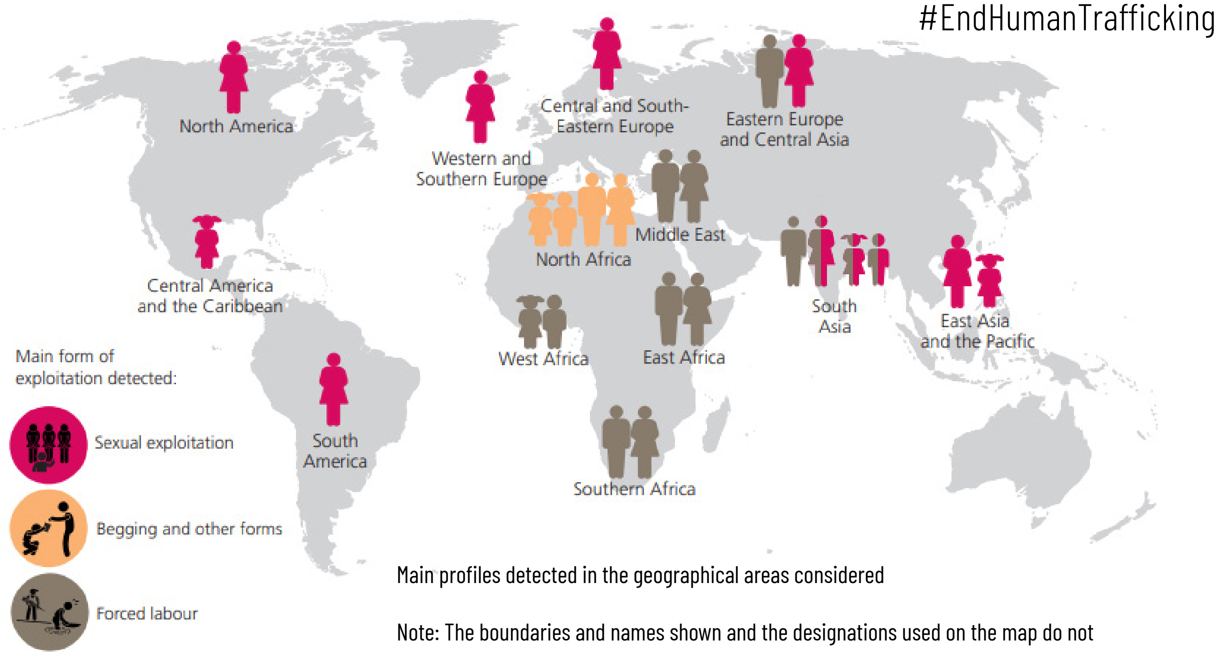
Portrait of woman in distress

Interpreters are more than just bilingual speakers. They use complex brain processes to work in tandem with audiovisual senses and psychomotor skills to render a faithful conversion and to deliver messages from one language to another, from one culture to another. Anthropologist Edward Hall postulated the concept of intercultural communication based on the cultural view of the speaker. Using his theory, accuracy in mental health interpreting must be based on the speaker's intent, because the words expressed have their roots in the culture that the individual came from. In fact, some words in English have no direct equivalent word in other languages, and vice versa. Research also shows that it is through language, via the lens of the individual's culture, that symptoms are expressed—that language is a medium through which many aspects of treatment are delivered (Swartz et al., 2014).

> *NCIHC could start by emphasizing that mental health interpreting is a separate specialty, requiring special training.*
>
> *NCIHC, 2008 Open Call*

Albert Mehrabian came up with a 7-38-55 rule in communication; it applies especially when the person is expressing feelings and attitudes. These numbers represent the three elements of personal communication: 7% words, 38% voice and tone, and 55% body language. Example: Individuals diagnosed with depression may have very few words to verbally express themselves, but their behavior, which is culture based, conveys meaning to the clinician. In contrast, someone who suffers from severe anxiety with compulsive talking may speak for long hours, or even for days, without stopping. What they say may not be coherent, but it needs to be interpreted nonetheless. Individuals who have undergone traumatic experiences may speak with long pauses or be unable to finish

Main forms of exploitation and profiles of detected victims, by subregions, 2016 (or most recent)



Main profiles detected in the geographical areas considered

Note: The boundaries and names shown and the designations used on the map do not imply official endorsement or acceptance by the United Nations.

United Nations Office on Drugs and Crime (2018).

expressing their thoughts. However, their voice and tone means a lot to a mental health professional. Given this ratio, a lot of meaning (93%) is not transferred when interpreting is based on words alone (Stitt, 2022).

Understanding the work of mental health professionals allows interpreters to customize their interpreting based on the intent of the speaker, cultural nuances, language variation, and setting (in-patient, out-patient, crisis situation, forensic, restoration order, intake interview, psychological or psychiatric assessment, medication review, etc.), because the interaction between a mental health professional and a person with a mental illness is different from an interaction between a general healthcare professional and a person with a physical malady (Hlavac, 2017). Even the NCIHC (2008) believes that the "interpreter may need to take a different role and help providers understand the traditional practices and understanding of mental health". The American Psychological Association (2002) puts the responsibility for ensuring the interpreter's competence and professionalism on its own licensed members. Because there are relatively few interpreters trained specifically for mental health practice, psychologists and healthcare institutions may need to assist in providing specialized interpreter education (Seawright & Seawright, 2009). The most practical approach is to develop a culture-based curriculum to train mental health interpreters who use any language, including a language of lesser diffusion, to become competent in the area to which they are providing the service.

The United States Department of Justice (2002) provided federal guidance on the competence to interpret in any setting and of any language pair, as follows:

- "Competency to interpret . . . does not necessarily mean formal certification as an interpreter, although certification is helpful."
- Interpreters must "demonstrate proficiency in and ability to

communicate information accurately in both English and the other language and identify and employ the appropriate mode of interpreting."

- Interpreters must "have knowledge of both languages of any specialized terms or concepts peculiar to the entity's program or activity and of any particularized vocabulary and phraseology used by the LEP person . . . [and] understand and follow confidentiality rules to the same extent the recipient employee for whom they are interpreting and/or to the extent their position requires."

- Interpreters must "understand and adhere to their role as interpreters without deviating into a role as counselor, legal advisor, or other roles." (p. 41461)

Mental health is a specialty of care, and the training of interpreters in mental health settings is crucial, because any language, whether spoken, written, or in another form, is at the heart of mental health care. Dr. Robert Pollard (1997), a well-known psychiatrist who is also a mental health interpreter, summed it up: "In mental health, communication is the key to diagnosis, and communication is the key to treatment". In reality, this applies to any specialty in health care; however, it is critical in mental health.

Summary

Treatment and care in a mental health setting is highly dependent on communication that is culture based, is language specific, and follows certain protocols and standards to ensure accuracy and better outcomes. Interpreters providing services in mental health settings, especially those individuals who speak the languages of lesser diffusion, should have specialized training to be effective in their roles and responsibilities, because the individual's well-being and healing depends on their accuracy and completeness to convert the messages from the mental health professional to the individual and vice versa.

References

Court of Mississippi. (2013, May 23). In interest of minor Cerila Baltazar Cruz v. Jackson County Department of Human Services (2013) NO. 2010-CA-01119-SCT. Retrieved July 18, 2023, from https://caselaw.findlaw.com/court/ms-supreme-court/1632058.html

Flatow, N. (2014, March 13). Judge who took away immigrant's baby said lack of English would cause 'developmental' problems. ThinkProgress. Retrieved May 25, 2022, from https://archive.thinkprogress.org/judge-who-took-away-immigrants-baby-said-lack-of-english-would-cause-developmental-problems-509d02bf0166/

Hlavac, J. (2017). Mental health interpreting guidelines for interpreters. Monash University. https://static1.squarespace.com/static/571683f922482e219db7b3ae/t/5a86f0f64192028861457cda/1518792951958/Mental_Health_Interpreting_Guidelines_fo.pdf
Lawyers: Partial deal over lost custody of immigrant baby. (2014, March 13). Clarion Ledger. Retrieved July 18, 2023, from https://www.clarionledger.com/story/news/2014/03/13/lawyers-partial-deal-over-lost-custody-of-immigrant-baby-/6373985/
Mexican immigrant sues after newborn seized by Mississippi agency. (2014, March 12). Mercury News. Retrieved July 18, 2023, from https://www.mercurynews.com/2014/03/12/mexican-immigrant-sues-after-newborn-seized-by-mississippi-agency/

NCIHC [National Council on Interpreting in Healthcare]. (2007, Dec 7). Mental health interpreting: What's different from standard medical interpreting. https://ncihc.memberclicks.net/assets/calls/NCIHC%20Open%20Call%20Summary%20120707.pdf
NCIHC. (2008, February 8). Topic: Training mental health interpreters. https://ncihc.memberclicks.net/assets/calls/NCIHC%20Open%20Call%20Summary%20020808.pdf
NCIHC. (2008). NCIHC plenary session 2008. Retrieved June 3, 2022, from https://www.ncihc.org/index.php?option=com_content&view=article&id=59
NCIHC. (2023). Languages of limited diffusion. Retrieved July 17, 2023, from https://www.ncihc.org/languages-of-limited-diffusion

Seawright, R. H., & Seawright, B. K. (2009). Working with foreign language interpreters: Recommendations for psychological practice. Professional Psychology: Research and Practice, 40(5), 444–451. https://doi.org/10.1037/a0016788

Southern Poverty Law Center. (2010, Aug 12). Cirila Baltazar Cruz, et al. v Mississippi Department of Human Services, et al. Retrieved July 20, 2023, from https://www.splcenter.org/seeking-justice/case-docket/cirila-baltazar-cruz-et-al-v-mississippi-department-human-services-et-al
Stitt, E. (2022). Virginia behavioral health interpreting curriculum. Blue Dragon.
Swartz, L., Kilian, S., Twesigye, L., Attah, D., & Chiliza, B. (2014). Language, culture, and task shifting—An emerging challenge for global mental health. Global Health Action, 7. https://doi.org/10.3402/gha.v7.23433
United States Department of Justice. (2002, June 18). Guidance to federal financial assistance to recipients regarding Title VI prohibition against national origin discrimination affecting limited English proficient persons. Federal Register, 67(117). https://www.govinfo.gov/content/pkg/FR-2002-06-18/pdf/02-15207.pdf

Linguistic Violence: Its Various Forms and Expression, Recounted by an Indigenous Interpreter

By Odilia Romero, Executive Director, and co-founder of CIELO (Comunidades Indígenas en Liderazgo)

Editorial note on the terms "Latino" and "Hispano"
Colonization by Europe of the rest of the world took place from the fifteenth century onward. Not only did the colonizing countries dominate their colonies by military and economic means, they restructured the social fabric and imposed their own language and norms on entire civilizations. Spanish conquerors started by misnaming the Caribbean Islands the "West Indies" after India, which is what they were trying to get to. The colonial settlers of the Americas from Portugal and Spain were called Latinos because they spoke Castilian Spanish and Portuguese, which were derived from Latin. Likewise the term "Hispano" refers to Spain.

Zapotec as a language is indigenous to the Oaxaca area and has no linguistic connection with Spanish. Neither should a person descended from an Indigenous line of ancestors who originally came to the Americas from Asia, be referred to as "Latina" or "Hispanic."

I have been a medical interpreter for more than 20 years. I know how problematic it is to translate and interpret medical terms in a foreign language. I have done this exercise many times, from Zapotec to Spanish, and from Spanish to English. I know the struggles that interpreters face firsthand, as a professional and also in a personal way, because I was a monolingual Zapotec child when I arrived in the United States at the age of 10. I'm very familiar with the racism that is experienced by everyone who does not speak a colonial language. I'm well aware of the linguistic violence that we experience from institutions, and also of the great efforts that Indigenous communities make to overcome this violence.

This article is divided into two sections. The first section is a reflection on the power structures in health care and on how this hierarchy affects patients from Indigenous communities. I will refer to my own stories and personal experiences to explain the nuances of language while interpreting. In the second half, I will recount language violence behaviors that I witnessed in specific cases during my years interpreting in the medical area.

Why I was compelled to become a professional interpreter

I became an interpreter out of necessity. It was never a career choice.

Up to the age of 10, I was in a universe where everyone spoke Zapotec—in my community of origin in San Bartolomé Zoogocho in the highlands of Oaxaca. In 1981 I arrived in Los Angeles. I began to experience language violence on day one at school and in my daily life. No one knew that I spoke my community's language. It was assumed I was Latina, and that I spoke Spanish, which I did not. Identity is important to recognize. When identity is confused or denied or ignored, this is cultural violence. When a person's language is denied or ignored, that is linguistic violence.

I gave birth to my first daughter in 1988, when I was 16. Before going into labor, I was asked to fill out and sign some forms. The documents were written in English. At that time

I did not fully understand English or Spanish. When I asked about the content of the forms, a nurse explained to me that they were a consent to be sterilized, after which I would not be able to bear more children. The nurse advised me against signing the documents because I was too young. I did not sign.

I was lucky. I did not understand the meaning of the word "sterilization." Signing that form would have meant that I was agreeing to something that I did not understand. I did not know whether they meant to cut my Fallopian tubes or extract my uterus. Years later I read that the same hospital was called out for sterilizing many women of color against their will.

The second experience with the power struggles in health care that urged me to continue my training and keep training other interpreters was the birth of my second son: I wasn't allowed to register him as a Zapotec child —and believe me, I tried. The hospital personnel kept telling me that I was "Hispanic." So, despite my arguments against this label, my son had to be entered into the system as Hispanic/Latino.

This disconnect was just another aspect of an obstetric episode which felt cold, confusing, and adversarial. Women are asked intrusive questions, are examined by machines, and have to listen to doctors speak at them in a highly technical, foreign language. The experience of giving birth is very different in an Indigenous town. We have midwives to walk us through the whole pregnancy and birth process.

Another experience happened decades later at the age of 43, when I was already a professional interpreter for Indigenous languages. I was diagnosed with breast cancer. Although I was already a trained interpreter, understanding the vocabulary of my treatment was an issue, because it was very specific and technical. "We need to operate to know how advanced the cancer is," doctors told me while presenting a lot of information about different types of cancer and different paths for its treatment. It was hard to understand. But I made my best effort and healed.

Through this experience, I learned a lot about how specific medical terms are. Every time I went through a procedure or a study, I kept thinking to myself: "How can I say X-ray in Zapotec, or chemotherapy, or cross-sectional scan, or MRI?" These questions led me to investigate medical terms and linguistics.

I learned that many of these words do not exist in Indigenous languages. The interpreter has to:

- use neologisms, newly minted words
- make comparisons to something the patient understands
- borrow the medical term from the colonial language and insert it into the Indigenous language

I had to struggle to be heard when I developed symptoms. I had to visit five doctors to find out I had breast cancer. Some doctors told me not to worry. Another one told me that my symptoms were from coagulated breast milk and that I only needed to apply a warm, wet cloth to my breast to remove it. But I kept feeling unrest, and my newborn son kept refusing to be breastfed.

I was fluent in three languages by this time. I spoke Zapotec, English, and Spanish. Despite the fact that I now had a voice and I knew my rights, I felt that my opinions and feelings were irrelevant to my doctor, a White man. I had to visit a mobile clinic to get a mammogram and a proper diagnosis. I was treated by a Korean woman, who also helped me schedule the procedures I needed: a biopsy, surgery, and post-operative care.

However, I encountered other people who continued to ignore me along the way. When I was anesthetized for the biopsy, I warned the doctor that I was still sensing pain. He responded that it was something psychosomatic and proceeded to cut me. I felt everything. I felt when he cut through my breast, and when he removed the skin. At this moment the problem was not that I was not able to communicate. I was explaining myself in English, but he wasn't listening. This happened despite my being trilingual. It did not matter that I was a professional interpreter voicing my concerns and exercising my linguistic rights.

This is how I learned how intimidating a male doctor who had no knowledge of my culture—and was willing to entirely disregard it—could be. I was trilingual and had a terrible experience. So imagine what happens with someone who does not speak English or Spanish, who did not grow up in the U.S., and who is not familiar with the healthcare system. In the case studies which I present next, the specific challenges for Indigenous patients are indicated, showing how the health system perpetuates linguistic violence against them.

But first I will complete my own story. It was up to us, the Indigenous community, to create the language bridge. After having been through much self-training and self-education to become an interpreter, I realized that there are no official and specialized programs for training Indigenous interpreters. We had to create our own. We created CIELO (Comunidades Indígenas en Liderazgo). We have been training Indigenous interpreters through the foundation of a nonprofit organization that exists to serve Indigenous displaced communities. (See sidebar in this issue about CIELO, page 53.)

Indigenous Patient Case Studies From My Work as a Professional Interpreter

Here is a selection of cases that I was involved with as a professional interpreter. Each one allows me to shed light on particular problems that arise when interpreting Indigenous languages, and on culturally competent strategies for the interpreter to better connect the patient to the care team.

I'm going to start with the definition of linguistic violence, because it is relevant to and intertwined with my case studies: linguistic oppression is "a normalized form of discrimination justified using widely held beliefs about linguistic superiority" (Hacherl Writing and Research Studio, 2023, para. 10).

Case study 1: Healthcare teams think Indigenous people speak bizarre languages that do not deserve professional interpretation

Los Angeles is a diverse city, recognized as having rich cultural communities from many places. I had a case of an Indigenous man who spoke Zapotec from the highlands. He was healthy at 95, but he had to go to a hospital after he fractured his hip. From the moment he set foot in the hospital, it was assumed he was Latino. He did not have an Indigenous interpreter of his language. The hospital personnel and the nurses assumed he spoke Spanish just because they saw him praying the Hail Mary. We, his community advocates, sent emails and called the hospital to request an interpreter for him, but our pleas were ignored. On a visit day, his family arrived and found him restrained, with his hands tied. When they questioned the nurses, they were told that the patient would get violent—that he hit or slapped the nurses—when they tried to take blood samples or administer intravenous serum. But the man was not violent. He was scared, not understanding the procedures because nobody was explaining anything about his treatment to him in his language. The doctor said that his patient spoke in a bizarre language, implying that this language spoken by the patient was his own invention, that there was nobody else who spoke the same language. The doctor believed that the patient was perfectly able to speak Spanish and was just being difficult. After all, he could pray the Hail Mary in Spanish!

These assumptions are perfect examples of linguistic violence behavior that Indigenous people face: Some people assume our languages are extinct or bizarre. Others assume that a patient is fluent in a colonial language and is capable of understanding medical and specialized terms in it, just because the patient speaks a few words of it. (Please see the article titled "The Experience of an Interpreter in Both Colonial and Tribal Languages" page 40.)

This man died. Other than his hip fracture, he was a healthy man when he went to the hospital. After his surgery, he was unable to comply with the physiotherapy because nobody gave him instructions in his language. As a consequence, he did not move much, and clots formed in his legs. He had to go back to the hospital for a second procedure. The treatment did not work. He lost one leg. He got depressed, and, one month after the amputation, died of sadness. He never understood what happened, what went wrong. He went to the hospital to heal, and that did not happen.

Indigenous interpreters training.

This outcome could have been prevented by having a Zapotec interpreter present. This man could not express his pain or follow his doctor's instructions. His family made several requests for an interpreter, but the hospital refused to get one, arguing that the patient was calm when the family was present to interpret. But interpreting was not the responsibility of the family. It was the hospital that carried out the linguistic violence behavior.

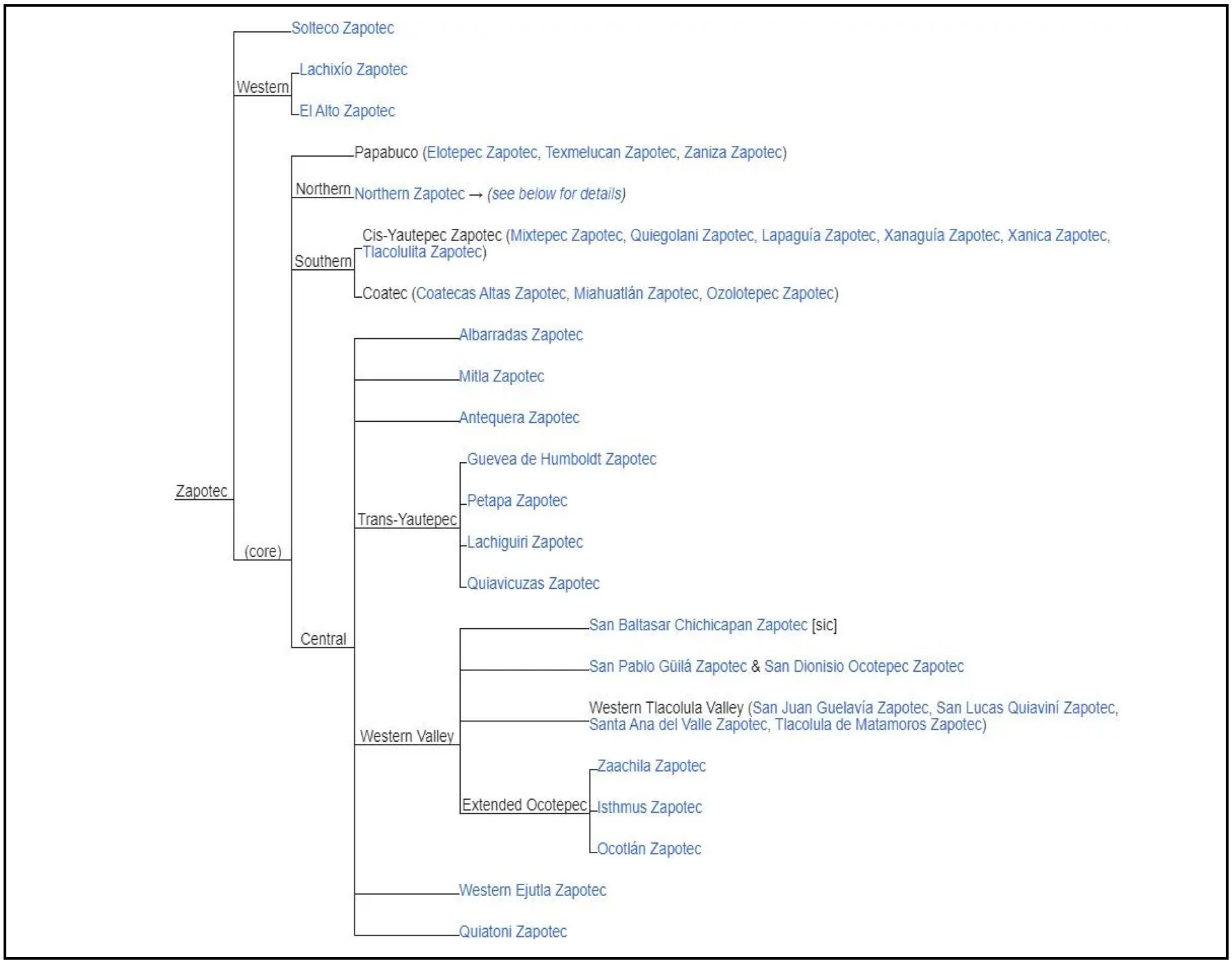
The patient's name was Don Marcial. In honor of his memory and to raise awareness about linguistic violence, the clinic that referred him to the hospital painted a mural. But this gesture is not enough. The family has suffered a loss, and the years they could have spent with Don Marcial can't be replaced. We cannot just keep talking about diversity while ignoring language access and language rights.

Case study 2: There's no good decision-making about one's health when there's no understanding

I'm a witness of linguistic violence enacted against Indigenous women. This is a case that I will never forget. It's a case about a sex-change procedure that a Zapotec intersex child (born with both male and female genitalia) went through. I was hired to interpret from English to Spanish, and the parents told me that they had not had any interpreter other than one for Spanish since the beginning of the process. By talking to them, I quickly realized that Spanish was not their first language—it was Zapotec.

I immediately informed the surgeons and their team of the situation and advised that the parents needed a Zapotec interpreter for the rest of these surgical encounters. However, right before the surgery, the doctors asked the parents if they fully understood what was about to happen to the child. The parents could only respond with their limited understanding that their child's clitoris was going to be cut because it was too large. One could see the confusion on their faces.

The procedure for informed consent becomes more complex because the healthcare personnel is used to asking aggressively: "Do you know



Overall family tree and Central Zapotec branch

what procedure is being performed?," "Did you understand?," "Repeat what I just said." It was important to have effective communication before the parents were crying at the Operating Room. Was the family/child being railroaded into a standardized treatment for intersex condition?

Again we see linguistic violence, because Spanish was imposed as a language on the parents, who were Zapotec speakers. It is also a common misconception, especially among English speakers, to assume that people will understand them if they speak s-l-o-w-l-y. If a person is not fluent in a language, like Spanish, communication will not be made more efficient by these means.

How can people make decisions about their health or their family's health if there's no understanding?

Case study 3: Absence of language support can result in a fatal delay of care

I was an interpreter for a mother who refused to authorize a biopsy for her daughter who had liver disease. The first time I met the mother, she had two Spanish interpreters who gave me a few precedents about the case and were very emphatic about the fact that the mother did not want to authorize her daughter's biopsy. I was supposed to interpret in Zapotec.

When I met the lady, I realized she barely spoke Spanish. "I don't know what a biopsy is; I only want them to cure my daughter," she told me when I interpreted the doctor's words and told her "Your daughter needs a biopsy."

Following my ethics code, I asked the doctor whether I could intervene to ask the lady if she spoke another language. The lady responded that she needed Chinanteco. I advised the doctor to request a Chinanteco interpreter, but the answer was: "We don't have one."

The doctor explained, in Spanish, how a biopsy is performed. He offered details: he was going to cut a tissue sample and run tests to learn whether her daughter had an immune issue and determine the best treatment going forward. To explain better, the doctor also made a drawing of the procedure.

The lady finally agreed to the biopsy, and the doctor concluded that the daughter had an autoimmune disease. The next week I ran into the doctor, who said to me, "I want to congratulate you for your good interpretation, because we had insisted on doing the biopsy for a while and the mother kept refusing." But it was too late, and the daughter died. If the mother had worked with a Chinanteco interpreter from the beginning and had given prompt permission for the biopsy, might earlier treatment have been successful?

Case study 4: Missed name cues are lost opportunities, and repetition does not equal understanding

Case #4 highlights the need of the patient who speaks an Indigenous language to receive the appropriate language support. Also, interpreters need to be alert to the patient's need for Indigenous language support.

This case involves a baby girl who had lung failure and arthritis. The hospital had requested me as a Spanish interpreter. When I read the girl's name, I immediately realized that she might need a K'iche interpreter because her last name was Ixch . . . (full name not disclosed to protect patient privacy).

This case illustrates how patients get themselves into a catch-22 situation. They stop requesting an interpreter in their Indigenous language because in the past they have asked but were not provided with one. This case was a great example because the administrator pushed back when I advocated for the patient to receive a K'iche interpreter.

The parents of the girl told us that they did not need an interpreter because they had never been provided one. The social worker was very concerned that without adequate language support, the parents would not be successful in caring for their daughter.

The baby was born with a serious health issue. The diagnosis was complex, and because of language barriers, vital medical information was not reaching the parents.

When the parents finally received the assistance of a K'iche interpreter, they learned that their daughter was going to die. The parents felt betrayed because they had just realized the severity of the situation and would have taken measures appropriate to their culture if they

San Bartolomé Zoogocho

San Bartolomé Zoogocho

Municipality and town

Location in Mexico

Coordinates: 17°14′N 96°14′W

Country	Mexico
State	Oaxaca
Area	
• Total	22.96 km^2 (8.86 sq mi)
Population (2005)	
• Total	381
Time zone	UTC-6 (Central Standard Time)
• Summer (DST)	UTC-5 (Central Daylight Time)

had known earlier. “Why did you not tell us about this before? If we had known, we could have reached out to a healer to help us.”

This case illustrates linguistic violence in that the family was heavily impacted. Here, the Spanish interpreter who had worked with the parents before I did inadvertently contributed to the unfortunate outcome. That interpreter had told the care team, “This family was excellent; they understood everything and repeated my words.”

But repeating does not mean understanding. That’s another misconception behind linguist violence. I teach interpreters this point during trainings by speaking in Zapotec and making them repeat after me, which they do successfully. Then I ask them if they understand what I said, and of course they don’t. This is how I show them that rote repetition does not ensure understanding.

Case study 5: A patient’s not showing emotion can be dangerously misinterpreted

Sometimes linguistic violence can occur when there is no verbal communication with the patient and/or when the patient appears to not be participating in the visit or conversation. I also want to mention that there are variations within Indigenous languages that can impose communication challenges, and the parties need to discuss whether they can communicate effectively with the interpreter available.

A woman from Oaxaca had her children taken away because the social worker believed that she was not taking proper care of them. The social worker’s concern was that the mom did not seem to be engaged and was not able to articulate her care for them. The social worker said that the mother looked confused and that she did not express any emotion. She concluded that the parents lacked the capacity to take care of their children. The children were not at the U.S.- recommended height and weight parameters.

The family verified that they spoke Zapotec, but I soon realized that their dialect was not the same as my own. We discussed whether it would be better to try to find a perfectly matched interpreter. All parties involved agreed that in this case, it was very important for me to interpret for them as opposed to their not having an interpreter at all.

During custodial court proceedings, it was said that the mother was irresponsible and that she was endangering her son. Now that the mother could communicate via interpreter, she was able to protest: “I have raised so many children, and now you’re telling me I don’t take care of them. I gave him the medicine from what I understood from the instructions you gave me.”

To be clear, the removal of the children from the home had a very damaging effect on the family. The father recounted, “At the hospital, I was told that a person that spoke my language would come. Someone who will pass your word. But when we arrived nobody was there, and we were caught like animals. They took my children as if they were little animals and took them away. Then they went to the school and took my other children. They said that my boy hid under a table, screaming and biting, and that the girl was so afraid that she peed and pooped her pants. When we got to our house, it was surrounded by police, as if we killed someone."

Many medical tests followed. The judge ruled for the family, saying that the children could return to their parents. According to medical tests, it was concluded that one of the children had a growing illness and that the mother had not done anything to harm the child. The tests also showed that one of the boys was a great artist but had autism. It is important to note that during the medical tests, interpreter services were few and far between for the studies and the psychological evaluations: I interpreted in just a few sessions.

Culturally, emotion is shown in various ways and may not be perceived by other cultures. Regarding the mother's lack of emotion when separated from her children, the father explained: "Tears came out from her eyes like the rain in your hometown holiday," referring to the heavy rain season during the summer.

https://mycielo.org/

Reference

Hacherl Research and Writing Studio. (2023, March 10). Q. As an instructor, how can I help tackle language oppression? Western Washington University. Retrieved February 17, 2024, from https://askus.library.wwu.edu/faq/321135#:~:text=Language%20oppression%20is%20a%20normalized,often%20goes%20unnoticed%20and%2

Odilia invites you to check out her TED Talk.
She continues to advocate via multiple modalities.
Her training website link is below.

https://www.youtube.com/watch?v=8WoAoOYoSmw

Cultural Humility in Sign Language Interpreting: Promoting Ethical and Effective Communication Access

By Corey Axelrod, Founder and CEO, 2axend; and Shawn Norris, Ed K-12 | NIC | CoreCHI-P, Coordinator of Interpreting Services | ADA/Section 1557 Coordinator, UF Health St. Johns

Similar to individuals who speak languages other than English, Deaf, DeafBlind, and hard of hearing individuals are members of a linguistic and cultural minority group that is often marginalized and disenfranchised. However, unlike non-English speakers who may be connected to specific regional, racial, or ethnic groups, members of the Deaf community are part of this minority group regardless of their location. This distinction underscores the pervasive nature of the Deaf community's marginalization, as their identity as a minority group does not hinge on geographical, racial, or ethnic affiliations.

Along the topic of marginalization and disenfranchisement, Deaf, DeafBlind, and hard of hearing individuals often are not positioned in healthcare settings to actively and effectively participate in their own care or the care of loved ones. This is often the result of myriad long-standing communication barriers that exist in healthcare settings, as well as healthcare professionals' lack of cultural awareness and sensitivity. These two issues are intrinsically connected and contribute to misunderstandings, misdiagnoses, increased readmissions, decreased throughput, and adverse healthcare outcomes for Deaf, DeafBlind, and hard of hearing persons in healthcare settings.[2]

Communication Needs and Preferences

The one-size-fits-all approach has never been, nor will it ever be, appropriate with respect to Deaf, DeafBlind, and hard of hearing individuals.

Each individual may have communication preferences and needs, many of which may change from one situation to the next. These preferences and needs may be contingent on a variety of factors, including the person's primary language, level of education and socioeconomic status, level of hearing, the use of hearing aids and/or cochlear implants, environmental acoustics, and the type of encounter.

Preferred communication methods for individuals within this diverse community may include having an in-person or video remote interpreter, relying on real-time captioning (also known as communication access realtime translation – CART), using hearing aids or cochlear implants to hear, lipreading, and writing/typing back and forth. Additionally, Deaf and hard of hearing individuals may benefit from having access to video relay service, captioned telephones, notification systems, and closed captions on televisions.

In the Deaf and hard of hearing community, there are an estimated one to two million American Sign Language (ASL) users. In healthcare settings, these individuals may prefer to use a hearing ASL-English interpreter to facilitate communication between both parties. It is important to note that certain ASL users may also speak for themselves and may or may not prefer to have a sign language interpreter present to facilitate patient-provider communication.

With respect to the above, Corey, one of the authors of this article, has varying communication needs and preferences that are primarily contingent on the type of encounter he has with healthcare professionals. It is important to note that Corey is bilingual—although ASL is his primary and preferred language, he uses hearing aids and generally speaks for himself during healthcare-related visits. Some examples of specific types of encounters and Corey's corresponding needs and preferences follow.

- For a 1:1 doctor's office visit with his primary care physician, Corey is able to understand his physician and generally does not need an interpreter.

- For 1:1 visits at an urgent care facility, he prefers an in-person interpreter, but Corey is amenable to video remote interpreting (VRI).

- At appointments with new specialists (e.g., for his sons or himself), he prefers an in-person interpreter, but he is amenable to VRI.

- In hospital settings where it can be highly stressful and/or difficult to navigate communication because of multiple individuals being involved in conversations (e.g., during hospital rounds), Corey prefers an in-person interpreter. VRI is generally not preferable as there are often barriers that impede an interpreter's ability and, subsequently, Corey's ability to follow the conversation.

Corey's experience differs from that of his late father, a bilingual individual who was profoundly Deaf and used ASL as his primary and preferred language. Corey's father, Rick, generally preferred to have an in-person interpreter for all healthcare-related appointments and visits, especially for those related to his diagnosis and treatment of multiple myeloma, a cancer of the bone marrow. However, there was the occasional exception that included routine blood draws or chemotherapy sessions where there was very limited interaction; during these interactions, lipreading, gesturing and/or pen and paper were generally sufficient.

Alternatively, in his everyday work as the coordinator of interpreting services and Section 1557 & ADA coordinator, Shawn, the other author of this article, has encountered a variety of situations with his healthcare organizations' consumers and patients. Some examples follow.

- Some patients or companions of the patient prefer VRI for some appointments, in-person for others, and writing notes in other situations.

- Some patients were traumatized by hearing individuals, and when they were not medicated, using ASL-English interpreters became a trigger and necessitated the use of Deaf interpreters.

- Some patients were on long-term stays, and only staff interpreters were ideal because of patients' language deprivation during their upbringing and the unique signing system they used.

- Patients who are fluent in other sign languages, like those who are recent immigrants, may need to work with a Deaf interpreter if an interpreter for the specific signed language and English language pair is not available.

- Those who became deaf later in life or are hard of hearing have expressed a preference for lip reading with providers whom they were familiar with, while with others, they would need captioning services in real time (CART) or oral transliteration.

- Individuals who identify as DeafBlind may request interpreters who are trained and qualified in tactile interpreting, while others need close vision interpreting.

Sign for "interpreter"


VITAL SIGNS

HEALTH CARE ACCESS FOR DEAF, DEAFBLIND, AND HARD OF HEARING PATIENTS

Vital Signs Video Advocating for Deaf Health Access
Watch on YouTube https://www.youtube.com/watch?v=xr-mlkuTBa4

- Other cases included missing digits on hands arising from illness, trauma, or congenital conditions, which may require other accommodations.

Existing Gaps in Healthcare Access
Healthcare organizations can do much to address the long-standing communication barriers and ensure all have access to effective communication. Measures taken can include reviewing and updating accessibility-related policies and procedures, along with making sure their respective organization has the full breadth of auxiliary aids and services to satisfy the Deaf and hard of hearing community's overarching communication needs and preferences.

This includes ensuring that their organization works only with qualified interpreters, defined as

> *someone who is able to interpret effectively, accurately, and impartially, both receptively (i.e., understanding what the person with the disability is saying) and expressively (i.e., having the skill needed to convey information back to that person) using any necessary specialized vocabulary.* [3]

The authors of this article support the idea of interpreters' having certification and, if applicable, licensure as a minimum for entry to practice in healthcare settings.

Furthermore, in healthcare organizations, there needs to be more of a push for robust training and systemic change designed to address the absence of cultural humility as it pertains to healthcare professionals interacting with Deaf, DeafBlind, and hard of hearing individuals. The phrase "cultural competence" is often used interchangeably with "cultural humility"; however, the two terms are not synonymous. Cultural competence suggests expertise in a specific culture, whereas cultural humility is defined as one's willingness to assess oneself and one's limitations accurately, the ability to acknowledge gaps in one's knowledge, and openness to new ideas.[4] This approach cultivates person-centered care, as it positions healthcare professionals to consider Deaf, DeafBlind, and hard of hearing patients' desires, needs, emotions, and other pertinent extenuating circumstances as they deliver healthcare services to this population.

The Role of Interpreters

The discussion regarding cultural humility should also extend to those professionals who provide interpreting services for Deaf, DeafBlind, and hard of hearing persons in healthcare settings. An ASL-English interpreter[5] is an individual who is hearing and who interprets the spoken message to ASL and vice versa. In contrast, a Deaf interpreter collaborates with the ASL-English interpreter by providing interpreting, translation, and transliteration services, using ASL and other visual and tactual communication modalities used by Deaf, DeafBlind, or hard of hearing individuals.

It is important to recognize the distinction between a Deaf interpreter and an ASL-English interpreter. Deaf interpreters are specialized interpreters who are Deaf, possess native or near-native fluency in ASL, and have a deep-rooted understanding of the cultural and linguistic nuances necessary to facilitate effective communication.

ASL-English interpreters have the privilege of having auditory access whereas Deaf interpreters can use "Deaf-same," an ASL-based term that helps create a sense of connection in which the Deaf interpreter can inform the consumer that they understand firsthand what it is like to be Deaf because they are also Deaf. Ultimately, having a Deaf interpreter team that includes an ASL-English interpreter is generally better for ensuring that effective communication and cultural mediation occur during patient-provider interactions.

Interpreting With Cultural Humility

Although ASL-English interpreters may have extralinguistic and intercultural expertise, they should never speak on behalf of a Deaf, DeafBlind, or hard of hearing individual. That is, unless the Deaf, DeafBlind, or hard of hearing consumer gives the interpreter permission to do so during an interpreting encounter. ASL-English interpreters, as well as Deaf interpreters, hold a critical responsibility to uphold the communicative autonomy of the individuals they serve. Achieving this requires a deep commitment to cultural humility, independent of an interpreter's lived experiences, training, or expertise.

An exception to the rule should not be made for interpreters who are children of Deaf adults (CODAs). Many CODAs are deeply embedded in the Deaf community, embracing the values imparted by their families. Embracing cultural humility enables interpreters who are CODAs to acknowledge the importance of their background, skills, and knowledge while ensuring the agency of the Deaf, DeafBlind, or hard of hearing individuals they interpret for.

Interpreters who are CODAs may have a different upbringing and immersion in the Deaf community than interpreters who are not CODAs; experiences may include seeing their parents experience systemic oppression because they are Deaf, DeafBlind, or hard of hearing individuals, as well as having to interpret for their parents from a young age in a variety of settings, including health care. Although interpreters who are CODA may possess a profound understanding of and connection to the Deaf community, this does not qualify or permit them to speak on behalf of the Deaf, DeafBlind, or hard of hearing individuals they serve.

The Deaf community is diverse, with a wide array of cultural nuances, degrees of acculturation, and individual experiences. An interpreter cannot possibly encapsulate all these aspects with authority. Instead, by adhering strictly to their role, interpreters practice cultural humility, thereby empowering the Deaf, DeafBlind, and hard of hearing individuals they work with.

There may be instances where a Deaf, DeafBlind, or hard of hearing individual requests the interpreter to convey certain cultural or linguistic nuances for the benefit of a hearing counterpart. However, it remains within the Deaf, DeafBlind, or hard of hearing individual's purview to supplement or clarify this information as they see fit. Acting on behalf of a Deaf, DeafBlind, or hard of hearing individual based solely on an interpreter's experiences could not only cause harm to the individual and other parties but also risk damaging the reputation of the interpreting profession at large and the profession's relationship with the Deaf community. The interpreting field is built on trust. Overstepping this trust because of an overestimation of one's knowledge or abilities can have far-reaching consequences.

This tendency to overestimate one's abilities is not exclusive to interpreters who are CODAs—it is also prevalent among those who are not CODAs. Most of the ASL-English interpreting community comprises individuals who did not grow up using ASL as a heritage language, a contrast to what one would typically observe in spoken language interpreting, in which interpreters may share cultural and religious beliefs similar to those of the people they interpret for. This collective dynamic has sometimes led to tension and misunderstandings between ASL-English interpreters and the Deaf community.

Many Deaf, DeafBlind, or hard of hearing individuals express frustration over what they perceive as a deficiency in interpreters' ASL fluency, in terms of both understanding and expressing the language. Furthermore, there's a sentiment that some interpreters lack what is often termed a "Deaf Heart"—a phrase used by the Deaf community among its members to validate individuals who are not Deaf and have proven themselves to be worthwhile and trusted allies. An interpreter who embodies a "Deaf Heart" can demonstrate this through cultural humility, exceptional interpreting skills, and active engagement with the broader ASL community beyond their professional duties.

A recurring concern is the impression that ASL-English interpreters are exploiting the Deaf community. Although this is not universally the case, such feelings are exacerbated when interpreters display a lack of cultural humility. In some instances, the Deaf community may perceive this type of behavior to be a form of oppression toward Deaf, DeafBlind, and hard of hearing individuals.

Strategies for Improvement

The level of cultural awareness and sensitivity among healthcare providers significantly influences the outcomes of interpreting sessions for Deaf, DeafBlind, and hard of hearing individuals. When providers possess a deep understanding of Deaf culture and exhibit sensitivity to the unique experiences of these individuals, it facilitates a more inclusive and respectful healthcare environment. Conversely, a lack of cultural awareness and sensitivity can lead to misunderstandings and a diminished sense of trust and safety for the Deaf, DeafBlind, or hard of hearing individual.

ASL-English interpreters and Deaf interpreters often encounter situations in healthcare settings where they must navigate the delicate task of interpreting ableist language. Phrases like "your child has normal hearing" or terms such as "hearing impaired" can inadvertently perpetuate microaggressions toward Deaf, DeafBlind, and hard of hearing individuals. In these scenarios, interpreters face the challenge of accurately conveying the speaker's message while ensuring that it is apparent to the Deaf, DeafBlind, or hard of hearing individual that these are the words and perspectives of the other party, not the interpreter's own views. This distinction is crucial for maintaining the interpreter's impartiality and upholding the professional standard of conveying messages faithfully, without personal bias.

Interpreters are crucial in these interactions, serving as vital links for language and cultural understanding. Through strategies like pre-session briefings, they can inform healthcare providers about their role, and with post-session debriefings, they can highlight and resolve any communication challenges. This approach enables interpreters to contribute to a healthcare environment that is more attuned to the cultural and linguistic needs of Deaf, DeafBlind, and hard of hearing individuals, ensuring their dignity and identity are respected.

Ultimately, driving organizational change to meet the language and cultural needs of Deaf, DeafBlind, and hard of hearing individuals requires a concerted partnership between healthcare organizations and the very patients they serve.

A part of this work should include creating a separate patient and family advisory council (PFAC) that is specific to Deaf, DeafBlind, and hard of hearing community members and their family members. Considering that members of this population also have other personal, cultural, and experiential intersections, it is paramount to ensure seats are available in other PFACs. Frequently, this group is categorized alongside the broader disability community; this practice is not necessarily conducive to success, as Deaf, DeafBlind, and hard of hearing individuals have the combination of a disability that is associated with a unique culture and language and also have different language needs than those of other language users and those who have disabilities.

Healthcare systems should also establish dedicated liaisons for the Deaf community on their language access and patient experience teams. These advocates can drive meaningful changes by educating staff about Deaf culture and ASL and pushing for integrating these advocates into healthcare delivery. This approach addresses the healthcare disparities that the Deaf community often faces, which are rooted in communication barriers and a lack of cultural humility. By aligning policies with both legal requirements and the cultural and linguistic needs of the Deaf community, healthcare providers can bridge these gaps. Such advocacy ensures that Deaf culture is respected and that communication with Deaf, DeafBlind, and hard of hearing patients is effective, paving the way for more equitable healthcare outcomes and a more

Vital Signs Video Advocating for Deaf Health Access
https://www.youtube.com/watch?v=xr-mlkuTBa4

positive experience for these individuals within the healthcare system.

Enterprise-wide training in healthcare settings should extend beyond merely informing staff about accessing interpreting services and other accommodations. It's crucial that this training also cover effective engagement with interpreters and the nuances of culturally sensitive interactions with Deaf, DeafBlind, and hard of hearing individuals. Implementing mandatory training modules in the healthcare system's Learning Management System (LMS) is an excellent starting point. However, it's important that such training, particularly on cultural humility, be either led by or developed in collaboration with experts from the Deaf, DeafBlind, and hard of hearing community. These experts bring essential cultural and linguistic insights that can enhance the training's effectiveness.

Furthermore, healthcare organizations often collaborate with external vendors, such as language service providers and Video Remote Interpreting (VRI) companies. It's equally important that these partners' staff and contracted interpreters undergo training in cultural humility. This training ensures a consistent standard of care and respect across all interactions involving Deaf, DeafBlind, and hard of hearing patients, fostering a more inclusive and understanding healthcare environment.

Addressing the intricate landscape of healthcare access for the Deaf, DeafBlind, and hard of hearing community requires a nuanced understanding of both linguistic competence and cultural humility. The community's persistent healthcare disparities underscore the urgent need for systemic change. By fostering a healthcare environment where Deaf culture and ASL are integrated into every facet of care, from policy to practice, we can begin to address the barriers that have historically marginalized these individuals. It is through the concerted efforts of healthcare providers, administrators, language service companies, interpreters, and the Deaf community itself that we can achieve a standard of care that is not only accessible but also respectful and empowering, ensuring that every individual has the opportunity to participate actively and effectively in their healthcare journey.

Interpreter Takeaways

- **Cultivate cultural humility:** Continuously engage in reflective practice and pursue education to deepen your understanding of the diverse experiences within the Deaf community.

- **Pursue certification and specialization:** Aim for professional excellence by obtaining relevant certifications and specialized training, particularly in healthcare interpreting.

- **Understand your role:** Acknowledge the distinction between ASL-English interpreters and Deaf interpreters and the unique contributions both bring to healthcare settings.

- **Respect patient autonomy:** Uphold the autonomy of Deaf, DeafBlind, and hard of hearing individuals by ensuring message fidelity and impartiality and not speaking on their behalf without explicit consent.

- **Engage in professional collaboration:** Work in partnership with healthcare providers, facilitating clear and effective communication and understanding between them and patients while respecting the boundaries of your professional role.

Healthcare Provider Takeaways

- **Implement comprehensive training:** Develop and mandate ongoing training programs about Deaf culture for all healthcare staff, ensuring effective communication takes place in the context of the Deaf community and the nuances of working with interpreters.

- **Ensure access to qualified interpreters:** Establish policies that guarantee the use of trained and qualified interpreters.

- **Embrace Deaf-Centered Approaches:** Adopt person-centered care principles that consider the specific needs, preferences, and autonomy of Deaf, DeafBlind, and hard of hearing individuals, ensuring their active participation in their own care or the care of loved ones.

- **Foster systemic change:** Advocate for and implement systemic changes within your organization to address and reduce healthcare disparities faced by the Deaf community.

- **Collaborate with the Deaf community:** Engage directly with Deaf, DeafBlind, and hard of hearing individuals to understand their needs and preferences and involve them in developing and reviewing healthcare policies and practices.

When Determining the Communication Modality, Consider...

- sensory impairments, such as being DeafBlind.

- situational factors, such as high-stress or emotional circumstances, including mental health crises, experiences of sexual abuse and trauma, and end-of-life discussions, that may necessitate specialized communication support.

    - legal or mental health constraints, including individuals under the Baker Act or housed in Behavioral Health Units (BHU), where communication may be restricted or monitored.

    - patients in critical care settings (e.g., Surgical Intensive Care Unit – SICU, Medical Intensive Care Unit – MICU, Post Anesthesia Care Unit – PACU) who may be unstable or under intensive care, affecting their ability to communicate.

- cognitive limitations or physical disabilities that challenge traditional communication methods.

- impairments arising from the influence of medications, alcohol, or other substances that can alter cognitive and communicative functions.

- age-related considerations, such as minors or children with developing language abilities, requiring tailored communication approaches.

- nontraditional ASL users, including:

    - individuals who acquired ASL later in life, potentially leading to unique communication needs.

    - people with cognitive or physical challenges that prevent full use of standard ASL interpretation.

    - individuals exhibiting atypical language use or fluent in sign languages other than ASL.

References

2 Panzer, K., Park, J., Pertz, L., & McKee, M. M. (2020). Teaming together to care for our Deaf patients: Insights from the Deaf Health Clinic. JADARA, 53(2), 60-77. https://nsuworks.nova.edu/jadara/vol53/iss2/3/.

3 See more at ADA Requirements: Effective Communication.

4 Lekas, H.-M., Pahl, K., & Fuller Lewis, C. (2020, December). Rethinking cultural competence: Shifting to cultural humility. Health Services Insights, 13. https://doi.org/10.1177/1178632920970580.

5 The term "ASL-English interpreter" is used in this text to refer to individuals often known as ASL interpreters or hearing interpreters. This designation is chosen to explicitly recognize the bilingual and bimodal nature of their work, encompassing both ASL and English. It's important to note that although ASL-English is a primary focus, interpreters may also work with other languages, including Spanish, and various signed languages, reflecting the diverse linguistic needs in the communities they serve.

Journey of Discovery - Additional Resources

Let your fingers do the walking through the landscape of healthcare language access for patients who speak languages of smaller diffusion

Many of the articles in this issue of *ACCESS* include supporting scholarly references. But here we present a further selection of resources for your journey of discovery. We cite them informally.

These items are short. Some are written, some are visual, some are video. You are invited to click through every item, like walking through a museum, or you can scan for topics that fill a knowledge gap for you.

We have included short descriptive notes about some items.

The sections are Maps, Languages, Culture, Stories, and Efforts to Improve Language Support.

Language Maps for Patients Seeking Healthcare in the U.S.

Alaska Native Language Map (Krauss, 1982) |
https://www.researchgate.net/figure/Alaska-Native-Language-Map-Krauss-1982_fig1_287646402

Languages of the Caribbean – Wikipedia
https://en.wikipedia.org/wiki/Languages_of_the_Caribbean

Map. Asia Pacific Regional Reference Map: Major Language Families in Asia-Pacific – Papua New Guinea | ReliefWeb
https://reliefweb.int/map/papua-new-guinea/asia-pacific-regional-reference-map-major-language-families-asia-pacific

List of Languages of Australia/Oceania by Countries – Nations Online Project
https://www.nationsonline.org/oneworld/oceania_languages.htm

Scroll down for extensive and useful list. Languages of Asia – Wikipedia
https://en.wikipedia.org/wiki/Languages_of_Asia

Hmongmap. Hmong, Mien language map
https://www.languagesgulper.com/eng/Hmongmap.html

Chinese, Tibetan, Burman language map
https://www.languagesgulper.com/eng/Tibetomap.html

Map and description of: Languages in Central Asia – Kalpak Travel Blog
https://kalpak-travel.com/blog/languages-central-asia/

Central Asia. Languages and dialects of the Eastern Middle East.
https://mapsontheweb.zoom-maps.com/post/134917937236/languages-and-dialects-of-the-eastern-middle-east

Indoaryanmap. India, Indo Aryan languages
https://www.languagesgulper.com/eng/Indoaryanmap.html

Dravidian languages – Wikipedia South Asia, southern India plus
https://en.wikipedia.org/wiki/Dravidian_languages

Maps, regional and tribal. Languages of Africa – Wikipedia
https://en.wikipedia.org/wiki/Languages_of_Africa

https://en.m.wikipedia.org/wiki/Languages_of_Africa#/media/File%3AMap_of_African_languages.svg

Nigermap, languages of Southern Africa.
https://www.languagesgulper.com/eng/Nigermap.html

Map of named Indigenous Peoples. PBS.
https://www.pbs.org/newshour/classroom/app/uploads/2014/11/A-global-map-of-indigenous-peoples.pdf

Infographic of percentage of Indigenous Peoples per continent. Dangers to survival.
https://www.dw.com/en/land-loss-threatens-indigenous-communities-worldwide/a-44997211

Languages

Indigenous Love Words Project – YouTube
Charming video of people saying "I love you" in their languages.
https://www.youtube.com/watch?v=Zvt4Eba_EJM

Languages of the United States – Wikipedia
Includes the signed languages
Languages of the United States – Wikipedia

African languages are the fastest growing in the United States | World Economic Forum | Nice stats and graph.
https://qz.com/africa/1723269/african-languages-are-fastest-growing-in-the-united-states/

Hawaiian language – Wikipedia (endangered)
https://en.wikipedia.org/wiki/Hawaiian_language

Pidgin and creole. What Is a Pidgin Language?
https://www.tomedes.com/translator-hub/pidgin-language

Native American languages HUB. Many references to both individual languages; also about language and language preservation.
http://www.cheyennelanguage.org/langlinks.htm

How a cosmic collision sparked a Native American translator's labor of love | MPR News | Lovely language story. Science, physics, translated into Native language on principle.
https://www.mprnews.org/story/2019/03/31/npr-cosmic-collision-native-american-translator

Cultural Aspects of Language

We're kanaka maoli. | Voices of Wisdom | Strong statement about a People's name for itself being different from what outsiders and conquerors call them.
https://hawaiianvoicesofwisdom.com/were-kanaka-maoli/

Chapter about Native American Languages, textbook
https://americanindian.si.edu/nk360/code-talkers/native-languages/#:~:text=The%20Importance%20of%20American%20Indian%20Languages,-Play%20Narration%20Your&text=Although%20most%20American%20Indian%20people,now%2C%20many%20are%20still%20spoken.

Indigenous Peoples' culture and language HUB
About Us | Cultural Survival

Video: Describes how each language has words for what is valued.
Can saving languages save nature? – BBC Ideas
https://www.bbc.co.uk/ideas/videos/can-saving-languages-save-nature/p0fh50s5

'I can't say my own name': The pain of language loss in families – BBC Future
https://www.bbc.com/future/article/20230608-what-happens-when-you-cant-speak-your-parents-native-language

Indigenous Languages Open Up a Window Onto the Natural World | Sierra Club
https://www.sierraclub.org/sierra/language-indigenous-environmental-knowledge

Patient Stories About Not Having Language Support or Culturally Competent Care

Navajo family sues Farmington hospital after man died without interpreter (krqe.com)

Colorado medical team cut 65-year-old Lakota man's hair without permission, family says
https://www.nbcnews.com/news/us-news/colorado-medical-team-cut-65-year-old-lakota-mans-hair-permission-fami-rcna128898

Interpreter Stories

CCHI YouTube. Honoring Interpreters of Native American & World Indigenous Languages, Community Conversation #13 - YouTube
https://m.youtube.com/watch?v=B02IJkn28x0

Interview with Odilia Romero of CIELO about her own story coming to Los Angeles at age 10. Describes how code of ethics did not make sense. Her language did not have the words needed to interpret technical meaning. The intro is in Spanish, but the rest is in English.
ATA SPD Podcast, An Interview with Odilia Romero – ATA SPD's Podcast | Podcast on Spotify
https://open.spotify.com/episode/1Qkx8GY9BoXONODsEjDudJ
Odilia Romero's TED Talk
https://youtu.be/8WoAoOYoSmw?si=f5BDB1efpGJWuYjD

Government, Organizational, and Community Efforts to Improve Language Support

The Indigenous Interpreter®: A Training Manual for Indigenous Language Interpreting – Cross-Cultural Communications
https://www.cultureandlanguage.net/products/tii-manual

Mayan League Launches New Program for Indigenous Language Interpreters to Address Crisis at the U.S./Mexico Border | Cultural Survival
https://www.culturalsurvival.org/news/mayan-league-launches-new-program-indigenous-language-interpreters-address-crisis-usmexico

Translation Commons video. Indigenous Interpreters in Mexico – YouTube
https://m.youtube.com/watch?v=0RKF1fRSSTo

The Largest Global Gathering of Indigenous Leaders Begins Today at the UN. Here's what you need to know. | Native News Online | Quote from this article: "We are going to the UN because in our countries they do not listen to us."
https://nativenewsonline.net/currents/the-largest-global-gathering-of-indigenous-leaders-begins-today-at-the-un-here-s-what-you-need-to-know

Strong policy content.
https://www.thelundreport.org/content/indigenous-language-interpreters-welcome-new-health-care-rules-say-more-work-needed

Biden admin releases first plan to support Asian American, Pacific Islander, and Native Hawaiian communities | Yahoo! News | Specifically mentions right to language support if needed.
https://www.yahoo.com/news/biden-admin-releases-first-plan-003703444.html

FEMA fires group for nonsensical Alaska Native translations
https://www.yahoo.com/news/bizarre-phrases-riddle-aid-documents-061403187.html

Editorial Collective Mentorship

By Alejandra Loyola, BA, CHI-Spanish

Alejandra Loyola

My name is Alejandra; I have been an interpreter for over 10 years. This profession has given me so many opportunities, and I think it was time for me to give something back. I was encouraged by my boss and mentor, Tracy Young, to volunteer for an interpreting organization. After looking at all the work groups NCIHC had to offer, I decided there was something here for me. Tracy invited me to their journal meetings and to read previous volumes to help me decide if this group was for me. I observed a few meetings before committing to the work group. They were well on their way working on their third volume. I was fascinated from day one, but also intimidated. Every single one of its members is full of knowledge and amazing skills; I was afraid I was not going to live up to these expectations. I couldn't have been more wrong. Everyone was very welcoming, kind, and humble. They have taken me in and are always open to hearing my thoughts and ideas. I was put to work right away, and they included me in everything. In the last few months I have learned from every single member. I was also fortunate enough to have met and worked with Dr. Eva Stitt. I'm excited and proud to be part of this volume, and I can't wait till it's published. I will share it with everyone I know, because I know all the hard work, time, and love it took to bring it all together.

As an interpreter, I believe it's crucial to be involved in an organization like NCIHC. The work, research, and time spent on each committee is invaluable for our profession. It also helps connect us with other interpreters in and outside of the U.S. and work together for a common goal. This is the first time I volunteer in an interpreting committee, and the experience has given me the confidence to volunteer in other organizations. It has allowed me to broaden my knowledge and use skills that I have tucked away after graduating college—for example, reading and editing some of the articles as well as doing research to find additional resources, contacting authors, and structuring the issue. I've also had the chance to create diagrams and work with these amazing editors that are allowing me to sharpen my skills. I'm grateful to every single member of the journal work group, and I want them to know that I feel very blessed to be part of this team and I can't wait to be part of many more journal issues.

Access

the NCIHC Journal

Thank you for reading ACCESS, the NCIHC Journal!

CLICK HERE
to return to the table
of contents page