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**Development of Medical Interpreting
in the United States
~From Oral Histories of Medical Interpreters~**

Doctoral Dissertation

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ABSTRACT

Title

Development of Medical Interpreting in the United States From Oral Histories of Medical Interpreters

With globalization proceeding apace, resulting in the increased movement of people across national borders, countries around the world are searching for ways to ensure that their societies remain harmonious despite the different languages, lifestyles and cultures of people. Medical institutions find it necessary to ensure accurate and speedy communication between patients and medical professionals, but only a limited number of countries have professionally trained medical interpreters to facilitate communication in medical settings. This study will attempt to clarify the process of development of medical interpreting in the United States, where medical interpreting services have long been provided at no cost to patients based on federal law.

Chapter One outlines the situation in Japan and other countries around the world. In Japan, the number of foreign residents has been increasing steadily since the immigration control law was amended in 1990. Recently, however, the number of foreign visitors has grown dramatically, but the development of medical interpreting has just started. Some local governments have taken the initiative to train interpreters and build their own systems to employ them, but there has yet to be a national blueprint for doing so. In Europe, known historically as a destination for refugees and immigrants, most medical institutions rely on volunteers or bilingual staff for interpreting. With medical interpreting becoming an international issue, this study has chosen the United States, an advanced country in this area, as the place for field research. This study aims to analyze oral histories of medical interpreters in order to identify stakeholders who subjectively contributed to developing the profession and to figure out what roles they have played in the process.

Chapter Two reviews the research literature with a focus on communication in medical settings. I found that physicians have written numerous papers on themes ranging from language and cultural barriers, and ethnic disparities to access to health care and the challenges facing medical interpreting services. Most of them shed light on issues through the viewpoints of physicians, and medical interpreters have merely been the targets of such studies. I discovered only a few research studies conducted by medical interpreters themselves. Since many countries classify medical interpreting as

a kind of community interpreting, I have primarily reviewed papers authored by linguists and researchers on interpreting studies. Most of their work has involved discourse analysis in medical encounters, and development of medical interpreting as a profession has been treated as a secondary issue. As a result, I decided to clarify the entire development process, from the 1970s when the first in-house medical interpreters were employed until today, by identifying how stakeholders, including medical interpreters, were involved in the process.

Chapter Three describes my methods. Oral history (OH) has been used by a variety of researchers in the fields of history, anthropology, sociology, and others. The number of oral histories told is uncountable, including narratives of entering the United States by minorities, or student projects to record family stories. Oral histories are considered to be highly useful in research, and this study uses the method to analyze subjective narratives on private issues such as how people became medical interpreters and what challenging experiences they can recall. Due to a lack of written materials regarding the beginning of medical interpreting, I searched for the initial members of medical interpreters associations to obtain materials they have preserved. At the same time, I asked them to introduce me to others. I tried my best to recruit targets with different countries of origin and ethnicity. I have kept in touch with them even after the interviews, during the process from transcribing the recorded interviews to writing up each one's oral history. My close contact with them enabled me to confirm details. Since oral histories have been criticized due to the unreliability of peoples' memories and misinterpretation of their meanings, I confirmed with several targets about incidents they experienced together and have meticulously checked their narratives with written materials.

Chapter Four first provides general information about a total of 29 OHTs who worked between 1979 and 2013, then outlines each OHT's oral history and finally provides four themes found from their oral histories: 1) Advocacy, 2) Stakeholders, 3) Perspectives on the Profession, and 4) Motivations upon analysis of OHTs' accounts and materials. The targets, who I call Oral History Tellers (OHTs), come from 20 countries and speak 25 languages apart from English. Some speak less common languages such as Khmer, Hmong, Tibetan, Nepal, and Navajo. Fourteen of them were immigrants, five were refugees, and one was a resettler. Seven married U.S.-born citizens and six studied abroad in the U.S or another foreign country. A total of eight were the first staff interpreters at their institutions to promote medical interpreting services by educating

bilingual staff and volunteers. Ten assumed management positions as directors or coordinators of interpreting services. Since the services are unfunded mandates and medical institutions have to pay all costs without reimbursement, the medical interpreters with management posts had to make the utmost effort to decrease the total cost. A total of 17 have worked as professional trainers, while six were the initial group members of the Massachusetts Medical Interpreters Association, the world's oldest professional group for medical interpreters, founded in Boston, Massachusetts, in 1986. They recounted how a small group of in-house interpreters gathered to share difficult cases and challenging issues at work, before developing their circle into a professional association. Professional associations publish their own technical standards, including codes of ethics and standards of practice, in order to establish minimum requirements to be professionals. OHTs told how these associations took the initiative in advocacy activities to secure professional status for medical interpreters and created employment opportunities by collaborating with a wide variety of stakeholders. Individual motivation to become a medical interpreter varied depending on each person's ethnic roots, family environment, language and the cultural barriers they experienced. Despite such differences, their primary role as practitioners has been to work as a bridge to facilitate communication between medical professionals and patients. In their narratives, they commonly said, "I want to help patients in need" and "I feel happy every time I hear patients' thanks." Those who started to work in the early stage of medical interpreting, when society as a whole didn't recognize them as professionals, recalled how difficult it was to deal with the opposition of physicians. They have been untiring in trying to win the respect of their coworkers. APPENDIX (p.156~299) provides 29 OHTs' oral histories numbered in chronological order (1-29) according to when the person started to work.

Chapter Five focuses first on the civil rights movements of the 1960s, which broadly changed social values in the United States. OHTs remembered how Asians, Hispanics and Native Americans carefully observed the civil rights movement of African-Americans, which motivated them to demand equal rights to public services for their ethnic groups. Medical interpreting services gradually came to be considered an important tool for securing equal access to health care for people with limited English proficiency (LEP). Under such circumstances, many stakeholders became involved in the process of developing medical interpreting. This study highlights the coincidence of the influx of immigrants in the 1970s and the introduction of informed consent as a standard practice due to a series of malpractice cases across the country. Together, these

two factors caused physicians and medical professionals in general to give importance to medical interpreting.

I examined stakeholders' roles based on the accounts of OHTs and the literature and materials they provided. The federal government enacted laws and encouraged state governments to comply with them, establishing two main agencies for this purpose: The Office of Minority Health and the Office for Civil Rights under the Department of Health and Human Services. State governments have varied in their language policies, and they all implemented measures at their discretion. OHTs recounted that the enactment of laws created jobs for them and led society to recognize their professional status to a considerable extent. However, the legal status of professional medical interpreters has not been secure enough in that the laws stipulate that LEP patients must be able to secure meaningful access to health care. It does not state they should be provided with professional interpreters. United States' policy has been consistent in trying to ensure equal access to health care for the entire population, but it allows bilingual staff, volunteers or anyone who are competent to interpret.

Physicians played an important role in conducting studies that encouraged policy makers, government agencies, and foundations to promote medical interpreting. OHTs referred to specific physicians who worked closely with professional medical associations to help enact state laws regarding medical interpreting or who supported medical interpreters at work. The positive stance of physicians helped medical interpreters secure status as members of the health care team. Some foundations which questioned ethnic disparities in health care outcomes played an important role in funding demonstration projects of medical interpreting and large-scale surveys or research. The development of medical interpreting in the United States is characterized by the positive involvement of foundations as financial supporters.

Professional medical interpreters associations played an important role as advocates for the profession. Their bottom-up approach to building their certification testing systems deserves particular attention. They have taken the initiative in overcoming technical issues by gathering hands-on knowledge from practitioners. They have served as clearinghouses to disseminate crucial information for newcomers to the profession. They have developed standards such as the code of ethics and standards of practice to ensure good practice. All the technical groundwork was established by them.

In regards to chronological development, the initial stage of medical interpreting was characterized by the presence of native-English-speaking founders and leaders. But upon obtaining English fluency, members with refugee and immigrant origins joined the leadership. Such diversity has enabled these associations to develop culturally- and linguistically-appropriate interpreting. In their individual oral histories, OHTs with refugee and immigrant origins describe how they made decisions because they knew the profession would enable them to take full advantage of their language and cultural backgrounds and to work as a cultural bridge. A common contribution by medical interpreters has been as educators at work by showing physicians and others how to work efficiently with them. Many have been professional trainers of fledgling interpreters.

This study discusses several factors behind the development of medical interpreting services: Legislative framework, civil empowerment, professional medical interpreters associations' initiative in publishing standards, advocacy movements, and collaboration with multiple stakeholders. This multiplicity of factors has produced the synergy needed to promote the social status of medical interpreters in the United States. Most of the practitioners at the initial stage of medical interpreting have retired and their whereabouts are unknown, and most of the resources from that time have been lost, so many of the interviewees and stakeholders I contacted have strongly requested that I preserve their accounts for future generations. Their narratives mirror their dedication, their rationale for choosing the profession, and their strategies to overcome challenges at work. I have dared to write in English, rather than my native Japanese, believing that this study will fulfill their expectations and enable me to share heretofore untold stories of pioneers in this field, complete with their practical knowledge, with potential stakeholders and aspiring interpreters around the world.

This study provides a new perspective by analyzing chronologically the stories of 29 medical interpreters, covering the time from the inception of the profession to the present day. Their subjective accounts identify not only stakeholders who promoted the development process, but also the challenges that medical interpreters have faced at work. This study expects to serve as a lesson for many countries searching for ways to establish a system of medical interpreting as well as for Japan, where people are just starting to call for building a system that takes into account the many and diverse issues that interpreters face.

To my brother Takao Noda with ALS, and his family, Yoko and Takahiro

難病を乗り越える最愛の弟、孝男と支えてくれた家族、陽子と誉宏へ

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LIST OF ABBREVIATIONS

CCHCP	The Cross Cultural Health Care Program
CE	The California Endowment
CCHI	The Certification Commission for Healthcare Interpreters
CHIA	The California Healthcare Interpreting Association
CLAS Standards	National Standards for Culturally and Linguistically Appropriate Services in Health Care
DHHS	The Department of Human Health Services
DoN	The Determination of Guidance Program/Process(see P.109-110 * ³)
EDC	Education Development Center, Ltd.
ERIL	Emergency Room Interpreters Law
IMIA	The International Medical Interpreters Association
IOM	The Institute of Medicine
LEP	Limited English Proficiency
LJP	Limited Japanese Proficiency
MAA	Mutual Assistance Association
MMIA	The Massachusetts Medical Interpreters Association
MA	State of Massachusetts
NATI	The Nebraska Association of Translators and Interpreters
NBCMI	The National Board of Certification for Medical Interpreters
NAATI	The National Accreditation Authority for Translators and Interpreters
NAJIT	The National Association of Judiciary Interpreters and Translators
NCIHC	The National Council on Interpreting in Health Care
NE	State of Nebraska
OCR	The Office for Civil Rights
OHT(s)	Oral History Teller(s)
OMH	The Office of Minority Health
OMH	The Office of Mental Health
OPH	The Office of Public Health
RWJF	The Robert Wood Johnson Foundation
U. S.	The United States of America
VOLAG	Volunteer Resettlement Agency
WA	State of Washington
WKKF	The W. K. Kellogg Foundation

CHAPTER ONE:

INTRODUCTION

1-1. Background

According to the data from the United Nations, “Six out of every ten international migrants under the age of 20 resided in developing regions. …Today, about six out of every ten international migrants reside in the developed regions” (The United Nations, 2013, p. 1). Undoubtedly, peoples’ movements have been a world phenomenon. Consequently, countries are under pressure to deal with people or visitors with different language and culture. Addressing issues of access to public services, especially to health care should be one of the challenges not only for medical society but for entire society. Researchers have documented that several organizations have worked to deal with issues of medical interpreting (e.g., Bischoff et al., 2003; Fortier*, 1997; Garber, 2000; Mikkelsen, 1996; Pöchhacker, 1997; Riddick, 1998; Roat*², 1999/2000; Roberts, 1997).

The National Council on Interpreting in Health Care (NCIHC)*³ defines interpreting as “the process of understanding and analyzing a spoken or signed message and re-expressing that message faithfully, accurately and objectively in another language, taking the cultural and social context into account” (The National Council on Interpreting in Health Care, 2002, p. 18). This definition is also used for medical interpreting in this study, while stakeholders are defined as organizations, institutions, and individuals who have worked to develop medical interpreting as key players in initiating and/ or promoting medical interpreting as a practice and/or services, or promoting it as a profession in the United States.

This study analyzes development of medical interpreting by identifying key stakeholders and clarifying their roles on the development process in the United States. With a huge diversity in conditions in every aspect from a social, historical, and cultural perspective, findings on the development of medical interpreting in one country can't be entirely adopted by other countries. However, findings on "Who" has worked to develop medical interpreting in the United States, "How" they have accomplished this, and "What" roles they have played are expected to serve as lessons for other countries. My hope is that in other countries, including Japan, potential stakeholders start debating "Who," "How," and "What" roles to play to develop medical interpreting depending on their own tools and human resources at hand.

Chapter One begins with an introduction to Japan, the country I have been observing as a practitioner and researcher, followed by a look at the present situation in the United States, where medical interpreting services have been provided at no cost to patients with Limited English Proficiency (LEP) regardless of their language, and then finally describes some countries historically known as destinations of immigrants and refugees.

1-1-1. Medical Interpreting in Japan

A revision of the Immigration Control Act in 1990 attracted unskilled foreign workers, including those called Nikkeijin*⁴, to fill a shortage of cheap labor. Local governments and some grass-roots organizations spearheaded an effort to help patients with Limited Japanese Proficiency (LJP) (Sellek, 2001). But few medical professionals

documented problems of foreign residents in health care (Hirano et al., 1996; Yamamura & Sawada, 2000). Society as a whole didn't recognize the presence of LJP populations. However, after the Great Hanshin Awaji Earthquake in 1995, in which LJP residents rushed to hospitals for treatment, several non-profit organizations across Japan have emerged and dispatched bilingual volunteers to hospitals (Iida, The Yomiuri Shimbun [Newspaper], October 15, 2009). The percentage of LJP populations reached 2% and the number of nationalities stood at 190 (The Ministry of Justice, Immigration Bureau, 2011; Nanzando, 2006). Several stakeholders have been taking the initiative since 2006 (Nanzando, 2006). A graduate school started to provide a minor course in medical interpreting (Hori, 2006). The number of foreign residents in Japan grew steadily to a peak of 2,217,426 in 2008 (The Ministry of Justice, 2011). Researchers articulated a need for medical interpreters based on the demographic data (Lee, 2009). Nationwide stakeholders formed an association of medical interpreters to advocate for the profession in 2009 (Kirikuri, The Sankei Shinbun [Newspaper], 2009; Nakamura & Takesako, 2009). This association, named The Japan Association of Medical Interpreters (JAMI), developed a code of ethics (Minokawa, The Nagasaki Shinbun [Newspaper], 2011, p.28) upon learning about similar codes in other countries. The Ministry of Foreign Affairs created a "Visa for Medical Stay" in 2010 (The Ministry of Foreign Affairs of Japan, 2010). As a result of the relaxation of requirements for visa issuance, the number of "new entries" in 2010 increased to 7,919,726, a gain of 1,800,332 (29.4%) from a year before (The Japan Tourism Agency [Agency under the Ministry of Land, Infrastructure, Transport, and Tourism], 2010). Medical interpreters were deemed necessary because of medical tourism (Aoki, The Japan Times [Newspaper], 2012).

A study conducted in Gunma Prefecture, which had one of the largest populations of foreign residents in Japan, found 75% of pediatric practitioners had difficulty in communicating with LJP patients and proposed that medical interpreters be educated (Takahashi, et al., 2010). Researchers concurred by highlighting the need to educate both medical professionals and medical interpreters (Iida, 2011; Serizawa, 2007). Aichi Prefecture, also known for its high number of foreign residents, formed a multiple stakeholders' association and started to dispatch medical interpreters in five languages in 2012. These medical interpreters previously took training courses sponsored by the prefectural government (Aichi Medical Interpretation System Promotion Association Office [Brochure], 2012). Other prefectural governments also initiated training at their discretion (Nakamura & Minamitani, 2013). A questionnaire survey found medical interpreters who lacked training were unsure of their roles and had a poor understanding of medical professionals (Ito et al., 2012). Qualitative research disclosed that volunteers at non-profit organizations voiced similar concerns over role definitions (Nadamitsu, 2008/ 2011; Nakamoto, 2007). Another interview study focused on medical interpreters with immigrant origins employed by hospitals and found they had several difficulties (Tanaka & Yanagisawa, 2013). An interview study on pioneering medical interpreters in the United States found that their challenges were similar to those of the current medical interpreters in Japan (Takesako & Nakamura, 2013). Many children have been serving as interpreters for non-Japanese-speaking families. A booklet on a conference organized by MEDINT [a Kobe based study group for medical interpreting in multiple languages] entitled *Tsuuyaku wo Ninau Kodomotachi~ Iryou-Tsuuyaku to Komyunike-shon* [The

Symposium on December 8 in 2012, Children Playing the Interpreter's Role for Communication in Medical Settings] has been disseminated to raise awareness of the mental health of these children and the potential risk of misinterpretation (The Japan Times [Newspaper], June 26, 2013). This event drove a Spanish speaking community to issue an edition titled, “¿Deben nuestros hijos asumir el rol de intérpreters médicos? [Should our children assume the role of medical interpreters?]” on “Latin-a” [the name of the informative magazine as originally written] in just one week after this bulletin arrived at their editorial office (Oshiro R. A. & Oshiro F., 2012). Osaka University decided to educate professional medical interpreters for its hospital with an aim to treat both national and international patients with LJP and has already established a minor course named, Medical Interpreting at the Global Collaboration Center for Graduate Program for Advance Interdisciplinary Study (Osaka University, 2007). Additionally, it decided to educate international-minded human resources, too (Center for Global Health, Department of Medical Innovation, Osaka University Hospital, Osaka University & Ministry of Education, Culture Sport, Science and Technology [Booklet], March 10, 2014).

The emergence of medical interpreters association with its own code of ethics and recent initiatives by some prefectural governments as well as by universities strongly suggest that Japan has potential stakeholders. In early February 2014, one such stakeholder, the Ministry of Health, Labour, and Welfare, announced a plan to appropriate a budget of “146 million yen (\$1.429 million) in fiscal year 2014” (Tsuji, The Asahi Shimbun [Newspaper], February 7, 2014) so 30 medical facilities would have coordinators and medical interpreters in place by the time of the Tokyo Summer

Olympics in 2020. This move by the government is expected to prompt medical institutions to search for candidates for medical interpreting services. However, because medical interpreting is still in its initial stages in Japan, a system of professional education of medical interpreters has NOT been established yet. Japan first needs to learn from other countries about how to address current challenges and to start building an appropriate system by using the human resources at hand.

1-1-2. Medical Interpreting in the United States

The United States has been providing medical interpreting services to LEP patients who can't communicate in English at no cost to them. Without accurate and smooth communication in medical settings, LEP patients can't be provided crucial information on their health issues. As a result, medical interpreting services have been considered an essential tool for equal access to health care. Title VI of the Civil Rights Act of 1964, which prohibits discrimination, President Clinton's Executive Order (EO) 13166, and the Policy Guidance were issued to ensure free interpreting services for LEP patients in 2000 (Federal Register, 2000). States have followed these federal laws and have tried to implement them despite significant policy differences among states. The states of Washington and Oregon certify their own medical interpreters, while the state of California has been known for having the most language-related laws, including the most comprehensive one which not only covers hospitals but also health insurance plans (Ladenheim & Groman, 2006). The state of Massachusetts urged hospitals to offer medical interpreting services through a policy guidance (The Determination of Need Program, DoN) as early as 1989 (See p.109-110*3). It enacted a state law for medical interpreting (Emergency Room Interpreter Law, ERIL or the Act of 2000) in 2000. ERIL

influenced other states (Chang & Fortier^{*1}, 1998; Perkins, 1999; Rodriguez, Boston Globe [Newspaper], March 12, 2002; Winsor, 2002/2003).

The United States also has the world's oldest association of professional medical interpreters, established in 1986, and the largest, with over 2,000 members [the International Medical Interpreters Association (IMIA), initially named the Massachusetts Medical Interpreters Association (MMIA)], (see <http://www.imiaweb.org/about/history.asp>). The country has also had associations and/or groups since the 1990s, including the California Healthcare Interpreting Association (CHIA; see <http://www.chiaonline.org/?page=Mission>) and the National Council on Interpreting in Health Care^{*3} (NCIHC; see <http://www.ncihc.org/history>). These associations^{*3} have been working to establish standards for best practice and serving as a clearinghouse of information indispensable for medical interpreters or medical interpreting. They also have been organizing conferences and seminars. Recently, they have been offering on-line presentations, so-called Webinar presentations, to offer hands-on information by experts for educational purposes to members and/or viewers (e.g., Bendana, 2013). The United States does not have a federal certification system for medical interpreters, but has two certifying bodies: The National Board of Certification for Medical Interpreters (NBCMI) [see <http://www.certifiedmedicalinterpreters.org/>] and the Certification Commission for Healthcare Interpreters (CCHI) [see <http://www.cchicertification.org/>]. Both were established after many years of lobbying by professional associations and several stakeholders. The number of medical interpreters in the United States is unknown because there has not been an official survey. But a survey by IMIA in 2010 collected

responses from 1,083 medical interpreters in 46 states working in 48 languages, including Spanish, the most documented language (60%). Although close to a majority of respondents (527) worked at hospitals or other medical centers, a considerable number (118) worked for agencies. The survey found that many worked on a per-diem basis. More than one third worked for an hourly wage of \$15-25 (The International Medical Interpreters Association, 2010).

1-1-3. Medical Interpreting around the World

A scarcity of medical interpreting is not unique to Japan. The United Kingdom, Italy, the Netherlands, and Germany jointly launched in 2005 the “BICOM Project – Promoting Bilingual and Intercultural Competencies in Public Health.” That was a multinational team composed of multiple stakeholders, including medical professionals, researchers, experts in public health, and ad-hoc interpreters. This team shared experiences through discussions to mitigate language and cultural barriers to ethnic minority populations. Their findings disclosed that the countries commonly relied heavily on ad-hoc interpreters and lacked for medical interpreting (BICOM Partners/Grundtving 2 Learning Partnership, 2007).

Regardless of challenges and policies, countries have been searching for ways to improve medical interpreting. For example, Belgium took the initiative earlier than other countries by adopting MMIA’s Standards of Practice (The Massachusetts Medical Interpreters Association & Education Development Center, Inc., 1996/2007) to educate medical interpreters (Verrept*⁵, 2008). Recently, Belgium has been searching for ways to support the system financially (Verrept*⁵, 2010[Presentation]). The Taiwanese

government^{*6} has built a database to localize interpreters to help foreign spouses from Vietnam, Indonesia, Thailand and Cambodia who married Taiwanese. However, its current challenge is to improve medical interpreters' skills (Yang, Oct. 23, 2010 [Presentation]). The Fu Jen Catholic University (Graduate Institute of Cross-Cultural Studies) decided to establish a course of medical interpreting and has been searching ways to establish a system to educate professional medical interpreters for the hospital which will be newly constructed to treat both national and international patients with limited language proficiency (Personal communication^{*6}, February 14/ 16/ 17/ 19/ 20, March 10, 2014). In Hong Kong, the Racial Discrimination Bill was passed on July 10, 2008, after years of debate by stakeholders, including lawmakers, leaders of ethnic communities, and advocacy organizations. Hong Kong Baptist University, Center for Translation started its Medical Interpreting Course (130 hours training and 20 hours practicum at hospitals in Urdu, Punjabi, Hindi and Nepali) in a tie-up with social services centers. The course organizer developed its own standards upon learning about those developed in the United States and the United Kingdom (Leung, 2011 [Presentation]). On the other hand, in Israel, researchers have been warning against the use of ad-hoc interpreters. Some stressed the need for professionally trained medical interpreters (Seidelman & Bachner, 2010). Recently, the Israel government has adopted the American standard as reported by the media: "Health Ministry-director-general Dr. Ronni Gamzu, adopting the ideal of 'cultural competence' that has become the rule in the US and many other countries, issued a directive on Monday explaining new language requirements for the health system" (Siegel-Itzkovich, The Jerusalem Post [Newspaper], 2011). Consequently, the new bill was signed on February 3, 2011 (Personal communication^{*7}, April 11-13, 2012).

In summary, as shown previously, countries have taken different measures and reached a different extent of development by tackling different challenges. Belgium adopted the Standards of Practice from the United States and educated medical interpreters. Israel learned “cultural competency” from the United States and enacted it into law. The United States has had a long history of medical interpreting and has ensured the provision of medical interpreting services at no cost to LEP patients under federal law. With these cases in mind, an analysis of the development process in the United States is expected to serve as a lesson for fledgling countries aspiring to introduce medical interpreting or improve the status quo by enabling them to learn in advance about challenges and ways to overcoming them. In addition, it is expected to provide some knowledge about stakeholders and their roles in order to help existing stakeholders in each country consider what to do and whom to approach to develop medical interpreting further.

CHAPTER TWO: LITERATURE REVIEW

Medical interpreting has been considered a tool to facilitate communication in medical settings and a part of community interpreting.

2-1. Communication in Medical Settings

2-1-1. Anthropologists

Anthropologists have generally recognized that communication through an interpreter is indispensable to deal with health beliefs and health behavior by ethnic groups (e.g., Clark, 1959; Harwood, 1981). They have helped medical students learn about diverse cultural norms and beliefs by teaching courses in medical anthropology at universities across the United States since the 1970s (Castro & Farmer, 2007). Among them, Kaufert*⁸ has been analyzing cultural challenges for medical interpreters (Kaufert*⁸ & Koolage, 1984; Kaufert*⁸, Koolage et al., 1984; Kaufert, J.*⁸, Koolage, Kaufert*⁸, P. al., 1984; Kaufert*⁸ et al., 1985; O'Neil et al., 1988). Through video recordings of the encounters, he clarified how the socially, clinically, and culturally complex nature of communication caused misunderstanding and conflict (Kaufert*⁸, 1990; Kaufert*⁸ & O'Neil, 1991). He has been instrumental in promoting medical interpreting in the United States, not only because of the number of studies he has conducted, but more importantly because of his direct involvement in the activities of professional medical interpreters in the United States. In the middle of the 1990s, when medical interpreters considered role definition the most important issue for good practice, there was a series of conferences at the national level in the United States (The Cross Cultural Health Care Program & Society of Medical Interpreters [Cover letter of

the Fourth Meeting of the National Working Group on Interpretation in Health Care], 1998). He participated in these conferences, and his insights served as a theoretical framework when the cultural broker role was discussed (The National Working Group on Interpretation in Health Care [Attendants list], 1994/1998).

Despite a main focus on Native Canadians, his findings on cultural aspects of medical interpreting have greatly influenced other researchers, including Verrept^{*5}, a medical anthropologist and the current head of Belgium's federal project of medical interpreting. Verrept^{*5} also participated in one of these conferences (The National Working Group on Interpretation in Health Care [Attendants list], 1998). He wrote, "The health advocates [interpreters with Moroccan and Turkish origins] are to play four roles, which are the roles that have been described by Kaufert^{*8} and Koolage (1984)" (Verrept^{*5} & Louckx, 1997, p. 68).

2-1-2. Community-Based Medical Professionals

The oldest paper found, by using keywords [communication/barriers/translation/interpret./English language (Dec.25,2009)] through Ovid Medline, a search tool developed by the U. S. National Library, is entitled, "Using an interpreter effectively[:] A guide to avoid mishaps and misunderstandings" (Richie, 1964, p.27). It is important to note that the author was a public nurse with prior experience of working abroad, including in Nigeria and South America. Her foreign experience enabled her to be aware of communication difficulties and to be one of the earliest medical professionals to author a paper on medical interpreting.

Professionals in public health or with close contact with communities had the opportunity to be keen observers of ethnic communities. Social workers observed that interpreters played three major roles, as an interviewer, tool, and go-between, and they stressed the confidentiality and quality of interpreters (Bloom et al., 1966). In the early 1980s, the Office of Disease Prevention and Health Promotion, Public Health Service of the Department of Health and Human Services took the initiative in dealing with ethnic minority populations by holding discussions with representatives from each ethnic community (The Office of Disease Prevention and Health Promotion, 1987). Registered nurses articulated the need for cultural intervention by interpreters (Muecke, 1983; Lipson et al, 1983).

Putsch^{*9}, a community-based physician, dedicated himself to dealing with issues of medical interpreting services by conducting research and organizing the first-ever national conference for aspiring professionals in medical interpreting services in the 1990s (Kaufert^{*8} & Putsch^{*9}, 1997; Kaufert^{*8} et al., 1999; the National Working Group on Interpretation in Health Care [Attendants list], 1994/1998; see the National Council on Interpreting in Health Care (NCIHC) [<http://www.ncihc.org/history>]; the Cross Cultural Health Care Project, 1994). Based on his clinical experiences with a wide range of refugees from Southeast Asia and Navajo patients, he argued that medical interviews with patients from diverse cultural backgrounds would be extremely challenging unless physicians learned how to work with interpreters properly and efficiently. At the end of the article, he added three guidelines: “Address your patients directly. ...Use short questions and comments...Use language and explanations your interpreter can handle” (Putsch^{*9}, 1985, p. 3347-3348). As a result of a search by the

Web of Science, a search tool for citations designed by Thomson Reuter, I found, as of May 8, 2013, that Putsch's paper (Putsch^{*9}, 1985) had been referred to over 85 times by a wide range of researchers. Given that articles on medical interpreting were scarce in the 1980s and that this paper was published in the *Journal of the American Medical Association*, a major scientific periodical, Putsch's paper surely awakened many physicians who were searching for ways to address issues regarding communication in cross-cultural encounters (e.g., Buchwald et al., 1993; Solomon, 1997). MMIA's founders read his paper and developed some training videos, "the Bilingual Medical Interview, Part I & Part II", for primary care training programs of medical professionals at the Boston City Hospital and the Boston University in 1987. Another paper, entitled "Concept Paper," served as a resource for the practice and education of interpreting services by covering theory, federal policy, and interpreting models for educational purposes (Putsch^{*9}, 2002). Thus, community-based medical professionals have disseminated information concerning medical interpreting and medical interpreters to others facing LEP patients.

2-1-3. Physicians and Researchers

Psychologists and psychiatrists were the earliest physicians to conduct research on cross-cultural communication (e.g., Ervin, 1964; Del Castillo, 1970; Keiv, 1968; Lin, 1983; Lurie & Lawrence, 1972; Marcos, 1973/1979; Sabin, 1975; Westermeyer, 1987; Yamamoto et al., 1968). Westermeyer observed psychiatric interactions with interpreters, and presented several models of interventions by interpreters, including the "Black Box" or "Two-Way Model", in which interpreters only serve as message converters (Westermeyer, 1987, p. 77). The number of papers increased drastically in

the 1990s because the physicians who faced difficulty in communicating with LEP patients started to conduct research. I classify papers authored by researchers into the following themes: Cultural Barriers, Access to Health Care and Ethnic Disparities, Language Barriers, Interpreting Services, and Medical Interpreters as Targets of Research.

2-1-3-1.Cultural Barriers

There are a huge number of papers on cultural barriers. For example, the traditional folk healing system for patients from Latin America such as ‘curanderos’ [traditional healers] and ‘el mal de ojo’ [black eye] hampered physicians from treating these patients, as highlighted by researchers (e.g., Clark, 1959; Keiv, 1968; Maduro, 1983). These terms or practices couldn’t be understood without medical interpreters who were well versed in the relevant cultural beliefs. The disclosure of diagnoses also has been challenging due to cultural differences or different views on medical care from people in the United States. Consequently, physicians have relied on medical interpreters for cultural intervention (e.g., Cronkright, et al., 1993; Dohan & Levintova, 2007; McPhee, 2002). Several federal agencies and a joint organization for Hispanic health issues worked to develop a guide book with a focus on cultural competency (National Alliance for Hispanic Health, 2001).

2-1-3-2. Access to Health Care and Ethnic Disparities

Cultural awareness caused physicians and ethnic advocacy groups to discuss ethnic disparities in health care (e.g., Chin, 2000). They began to conduct research to reveal that access to care for LEP patients was unequal (e.g., Ginzberg, 1991;

Perez-Stable et al., 1997). Some researchers with ethnic backgrounds underscored their identity in the titles of articles such as, “Are Latinos less satisfied with communication by health care providers?” (e.g., Morales et al., 1999). Ethnic disparities influenced infant mortality rates (e.g., Poma P. A. & Poma, A. E. 1999). Since every textbook describes several roles such as the cultural broker role and message conversion role (e.g., The American Translators Association, July 10, 2004; the Cross Cultural Health Care Program, January 1999; Saint Anne’s Hospital, Nov. 12, 2005; the University of Massachusetts of Medical School, 2010), aspiring interpreters became professional only after learning these roles through training courses. Thus, medical interpreters have recognized the importance of intervening and have been helping LEP patients to narrow the gap in access to health care.

2-1-3-3. Language Barriers

A large-scale study disclosed that language barriers would cause ethnic disparities in health care (e.g., Weech-Maldonado et al., 2001). A major foundation sponsored a symposium on language barriers attended by hospital administrators and federal agencies. Presenters at the event stressed the need for interpreting services to address disparities in health care (Chang & Fortier^{*1}, 1998). As requested by Congress, the Institute of Medicine, an influential organization in medical research, published a report titled, “Unequal treatment: Confronting racial and ethnic disparities in health care.” This report clearly stated that medical interpreters would be a key in overcoming language and cultural barriers (The Institute of Medicine, 2002), so it impacted the healthcare industry as a whole.

Another report titled, “To Error is Human,” revealed the seriousness of medical errors in the United States (The Institute of Medicine, 2000). It warned hospitals to be careful in addressing the safety of LEP patients. The Joint Commission, an accreditation organization, found that LEP patients suffered more serious harm than English-speaking patients and at higher rates (Divi et al., 2007). This accreditation organization issued standards with stricter rules for hospitals in order to improve medical interpreting services (Arocha & Moore, 2011). As a result, expectations for hospitals to employ skillful and competent medical interpreters have gradually grown.

2-1-3-4. Interpreting Services

A large number of studies have determined the importance of medical interpreting services. Researchers reviewed the literature so those interested in this topic could refer to them (e.g., Flores, 2004; Jacob et al, 2001; Karliner et al, 2007). A group of physicians reviewed over 25,000 records and found the provision of trained medical interpreters’ services provided intensity of services at emergency departments and reduced patient return rates (Bernstein et al., 2002). However, hospitals were poor providers of medical interpreting services (e.g., Baker et al., 1996; Flores at al., 2008; Hornberger et al., 1997; Ramirez et al., 2008). A few researchers focused on cost issues (Bowen & Kaufert, 2001; Hornberger, 1998), and showed that improvements in interpreting services would reduce total medical costs (Jacob et al., 2007). Despite that, private practitioners found that providing interpreting services was too expensive and complained it was not fair for such services to be an unfunded mandate (Gadon et al., 2006).

Others argued, by presenting cases of past lawsuits, that a lack of language services would lead to costly litigation or settlements (Quan & Lynch, 2011). By reviewing the literature through PUBMED, the U.S. National Library of Medicine's premier bibliographic data base, and the Web of Science, Thomson Reuters' searching tool for books, academic journals, and other bibliographic data base, I found only a few papers on this theme. One of them referred to litigation by a man who became a quadriplegic and received damages of \$71,000,000. The case, which occurred in 1983, resulted from the misinterpretation of the Spanish word 'intoxicado' [nauseous in Spanish but interpreted to mean intoxicated due to drug overuse] (Harsham, 1984, p.289). Flores's quotation of a "\$71 million" lawsuit sounded the alarm for academia, and many researchers mentioned this case when they studied inaccuracies or mistakes by interpreters because of a paucity of papers on such lawsuits. The other case concerned the death of a girl who couldn't be treated due to a lack of interpreting services, although she had been interpreting all the time for her parents, who didn't speak English. Researchers referred to this case to show that the provision of interpreting services was indispensable (Chen et al., 2007). Despite a number of papers focusing on errors made by medical interpreters, there have been few documented cases of lawsuits as described before. It is important to note that in the United States, the extent to which interpreting services are available has been investigated when patients have filed a complaint with the Office for Civil Rights (OCR). Some legal experts argue OCR has not been effective in enforcing the law due to a lack of manpower (Bonastia, 2006; Fortier*¹ et al., 1998; Perkins & Vera, 1998). Accreditation organizations, such as the Joint Commission, have had more influence on hospitals' decisions to provide interpreting services (Arocha & Moore, 2011).

2-1-3-5. Medical Interpreters as Targets of Research

Researchers have questioned the lack of professionally trained medical interpreters (e.g., Betancourt & Jacob, 2000; Cambridge, 1999; Kuo et al., 2007; Woloshin et al., 1995). Some found untrained medical interpreters, such as ad-hoc and family interpreters, posed a threat to the care of LEP patients (e.g., Garcia et al., 2004; Hunt & de Voogd, 2007). Social workers voiced the need to use ad-hoc interpreters that have received appropriate training (Hernandez, 2010). Few researchers found that interpreters caused problems in communication between physicians and LEP patients (Aranguri et al., 2006 ; Rosenberg et al., 2007). Some compared interpreting methods and found remote simultaneous medical interpreting resulted in fewer mistakes (e.g., Gany, 2007).

Researchers have interviewed medical interpreters with a variety of aims. Some asked interpreters' perspectives on methods and found that they deemed telephonic interpreting to be satisfactory but that video medical interpreting would improve the quality of communication (e.g., Price et al., 2011). Others asked them for insights on difficulties in communication with physicians (e.g., Hudson, 2005). A group of physicians conducted discourse analysis and identified the types and frequency of errors of medical interpreters (e.g., Flores et al., 2003; Laws et al., 2004). They also found that medical interpreters who had over 100 hours of training made mistakes with a lower risk for patient health outcomes (Flores et al., 2012). Others discovered the existence of power struggles between physicians and interpreters (Kaufert*⁸ & Putsch*⁹, 1997; Norris et al., 2005). Avery*¹⁰, a researcher on cross-cultural communication with

experience as a volunteer interpreter, has been working closely with several professional medical associations, and authored reports on interpreters' roles based on their discussions (Avery*¹⁰, 2001). She co-authored the Standards of Practice (The Massachusetts Medical Interpreters Association & Education Development Center, Inc., 1996/2007).

Linguists recorded conversations to analyze roles played by interpreters (e.g., Davidson, 2000; Dysart-Gale, 2005; White & Laws, 2009). They have worked with professional medical interpreters associations and/or groups. For example, Downing, who had conducted research on Hmong refugees as early as in the 1980s (Downing & Sharon, 1981), worked closely with NCIHC to do field research regarding language services, and described the advantages and disadvantages of interpreting models (Downing & Roat*², 2002). Angelleli, who worked closely with CHIA and NCIHC, demonstrated the visibility of medical interpreters based on discourse analysis of more than 300 interactions, in addition to interviews (Angelleli, 2004b). Hsieh, who volunteered to work as a medical interpreter, wrote her dissertation on the roles of medical interpreters (Hsieh, 2004 [Dissertation]). Since then, she has been writing papers on medical interpreting (Hsieh, 2006/ 2007/ 2008,/2009; Hsieh et al., 2010; Hsieh & Kramer, 2012).

2-1-4. Medical Interpreters as Authors of Papers

This section focuses on academic works written by medical interpreters, few of whom have authored papers. Días-Duque has articulated the challenges at work and provided practical knowledge on how to work with medical interpreters (Días-Duque,

1982). Cashman, one of the four founders of MMIA, conducted a survey and found that the provision of an interpreter increased the number of patients treated and improved their satisfaction (Cashman, 1992). Haffner, the founder of CHIA, authored a paper on the complex nature of medical interpreting for Latino patients who believe in healers and folk medicine (Haffner, 1992).

Several authored papers for the American Translators Association. Liesche shared stories of challenging experiences in helping patients hovering between life and death (Liesche, 1995). Compared with court interpreting, in which interpreters' roles are clearly defined, Villareal found medical interpreting in mental health settings was challenging because of the ambiguous boundaries for interpreters (Villarreal, 1997). Roat^{*2}, who was instrumental in establishing NCIHC and has been working as a medical interpreting trainer and consultant, wrote about the state certification system that has been established in the state of Washington (Roat^{*2}, 1999). She also outlined legal mandates required under Title VI of the Civil Rights Act of 1964 and described the situation of medical interpreting around 2000 (Roat^{*2}, 2000). She authored a book offering a wide range of information useful for medical interpreters (Roat^{*2}, 2002-2010). Allen, a board member of CHIA, provided her insight into professionalization in the state of California by referring to a joint initiative for certification by the professional medical interpreters association in early 2000 (Allen, 2003). Kelly authored a book on telephone interpreting (Kelly, 2008) and took up the issue of certification (Kelly, 2007a). She outlined things to consider by medical interpreters who also do translation (Kelly, 2007b) and wrote about phone interpreting in medical settings (Kelly, 2007c). A discussion on certification at a forum was reported (The American Translators

Association, 2007). Espondaburu shared some knowledge on how to convey bad news to patients and their families based on her long experience (Espondaburu, 2009).

In summary, most of the studies have been conducted primarily by physicians in various ways, with a focus on medical interpreting services or medical interpreting as a tool for communication with LEP patients. They have encouraged further studies. However, physicians rarely focused on development of the profession itself. Their work indicates that they have been involved in the development process through their academic activities, but the question remains as to how they have actually been involved.

On the other hand, medical interpreters, who are one of the three parties (i.e., patient, physician, and medical interpreter) in medical interpreting encounters, have voiced perspectives only on their roles as practitioners in medical settings. It is important to note that they have not described what roles they have played in the development process of medical interpreting. Compared with the magnitude of the number and thematic variety of papers authored by physicians, the number of papers written by medical interpreters seems too few. In addition, most of the papers were intended merely to provide some general information or technical information to their peers. It is essential not to limit attention to their roles as mere practitioners. Researchers should begin to pay attention to the active or creative roles they may have played in the entire process of development. Researchers should understand how the United States has developed medical interpreting services at no cost to LEP patients by focusing on subjective accounts by medical interpreters. Although development at the

state level in the states of California and Washington has been reported to some degree and for a limited period (Chang & Fortier^{*1}, 1998; Fortier^{*1}, 1997; Fortier^{*1} et al., 1998; Roat^{*2}, 1999), the process at the national level has not been studied yet. With this in mind, this study aims to show how medical interpreting services started, how they developed, and who was involved in the development process.

2-2. Community Interpreting Profession

There are several categories of interpreting professions ranging from conference interpreting and business interpreting to community interpreting. Community interpreting is considered “the oldest ‘type’ of interpreting in the world” (Roberts, 1997, p. 7). Medical interpreting is deemed a type of community interpreting practice according to linguists (e.g., Garber, 2000; Mikkelsen, 1996; Pöchhacker, 1997; Roberts, 1997). In addition to medical interpreting, legal and public service interpreting are considered kinds of community interpreting (Roberts, 1997). Angelleli compared conference, court, and medical interpreters regarding perspectives on visibility. She found the visibility of medical interpreters was stronger than that of the others (Angelleli, 2004a).

Medical interpreting has attracted international attention from linguists, who commonly consider it an emerging field for research (e.g., Pöchhacker & Shlesinger, 2005). However, most of their attention has been focused on discourse analysis of the interactions among physicians, patients and medical interpreters (e.g., Bot, 2007; Dubslaff & Martinsen, 2007; Garcés, 2007; Leanza, 2007; Merlini & Favaron, 2007). Despite a limited number of papers, some linguists have written about the development

of community interpreting in their own country. According to Corsellis, some incidents involving non-English-speaking people in court settings raised public awareness of the need for language services, causing community interpreting to begin in the United Kingdom in the 1980s. Some aspiring candidates obtained grants from a private charitable foundation and from a multi-ethnic pool of interpreters to form a professional association, the Association of Community Interpreters (Corsellis, 1997/2008). On the other hand, Carr documented how multi-disciplinary stakeholders, including hospitals, a community college, and a city health agency, launched a pilot project through a grant from a research foundation to develop a model for the rest of a province in Canada (Carr, 1997). Penney and Sammons reported how the Inuit had developed a community interpreting program for speakers of their language (Penney & Sammons, 1997). Pöchhacker documented how one hospital in Vienna, Austria, started to employ an in-house interpreter in Turkish in 1989, while other hospitals were still relying on practically any staff, including some clerical and cleaning workers (Pöchhacker, 1997).

Bell and Chesher showed how the National Accreditation Authority for Translators and Interpreters (NAATI), Australia's national certification testing system, has been established since the 1970s (Bell, 2000; Chesher, 1997). Blignault et al. documented the chronological development of medical interpreting services in the state of New South Wales, Australia. They interviewed 18 interpreters and one officer on their perspectives about the challenges at work (Blignault et al., 2009). Garrett traced NAATI back to groups of interpreters employed by hospitals in New South Wales in 1980. Those hospitals were funded by the state government and supported by the Galbally Report, a governmental paper issued in 1978 which mandated equality of

opportunity and the right to maintain and express one's culture, ethno-specific service development and self-help or voluntarism (Garrett, 2009). Chesher documented development in community interpreting in Australia by highlighting that ethnic communities and professional associations of interpreters and translators played an important role in prodding the government to prioritize language issues (Chesher, 1997).

From these studies, researchers have found that every country has been different in terms of the style and extent to which they have developed medical interpreting. Researchers have also discovered common elements behind the profession's development: the collaboration of multiple stakeholders, demographic changes mostly from a drastic increase in immigrant populations around the 1980s, and the establishment of standards and training courses. In Australia, for example, if hospitals hadn't acted in parallel by hiring interpreters, the nation might not have been able to establish a national certification system. Similarly, in Austria, without the pioneering achievement by the first hospital to employ in-house interpreters, the development process would most likely have been delayed. More importantly, without advocacy activities by ethnic communities, professional interpreters, and translators associations, the government could have delayed in moving forward, according to Chesher (Chesher, 1997). Regardless of the country, establishing a profession for court, medical, or community interpreting requires a certain combination of stakeholders or some social component such as a demographic change in population.

In the United States, court interpreting started before medical interpreting through the enactment of the Court Interpreter' Act (Public Law 95-539) in 1987, with

some states soon following the federal initiative (Benmaman, 1997). The Administrative Office of the United States Courts (AOUSC) began to test court interpreters in federal courts. Gonzáles, a pioneering advocate of language access for LEP populations and a professor of English at the University of Arizona, established a model for federal legal interpreting certification testing through the Federal Court Interpreter Certification Examination (FCICE) and started to certify federally certified court interpreters in Spanish, Navajo, and Haitian Creole (González et al., 1992). In addition, she founded the Institute for Court Interpretation in 1983, and created the Medical Interpreter Training Institute at the university in 2002 (The National Center for Interpretation, the University of Arizona).

Regarding medical interpreting, however, Fortier^{*1} documented the collaboration of stakeholders in the 1990s in the state of Washington and other vanguard states. She illustrated how a collaborative approach by the federal or state governments with other stakeholders had developed the medical interpreting system (Fortier^{*1}, 1997, see also Chang & Fortier^{*1}, 1998, and Fortier^{*1} et al., 1998). In the literature, medical interpreting has gained far less attention than court interpreting. It seems vital for researchers to analyze how the United States has developed medical interpreting services, who have been the main stakeholders, and what roles each stakeholder has played in the process. I try to cover the development process by tracing back from its inception until the present day. By focusing on the subjective accounts of medical interpreters, I also try to analyze how society has changed since hospitals started to employ the first in-house interpreters.

In summary, several countries have developed community interpreting in diverse ways. The literature indicates that in each country stakeholders played definite roles in development. They also have established standards and training courses. With such differences and commonality in mind, I will try to present a development model upon identifying stakeholders and their roles in the development process in the United States so that these findings will enable Japan and other nations starting out on this road to identify what to do as a nation and who are potential stakeholders.

CHAPTER THREE: RESEARCH OBJECTIVES AND METHODS

3-1. Objectives

The general objective is to figure out the development of medical interpreting in the United States by analyzing oral histories narrated by medical interpreters.

Specific objectives are:

- 1) To identify who has been working on the development process as stakeholders.
- 2) To identify what kinds of roles they have played during the development process.

3-2. Expected Outcomes

1) Although the findings are specific to the United States, clarification of stakeholders and their roles is expected to help stakeholders present in other nations learn what roles to play to overcome challenges and improve the status quo.

2) The literature shows that the process has not been fully analyzed yet. The findings are expected to become lessons for policy makers in fledgling countries in this field such as Japan in implementing measures to advance the development process by using the resources at hand.

3) Perspectives of medical interpreters on their roles in the development process have not been voiced yet. Their accounts described in this study are expected to encourage medical interpreters in other countries to consider what roles they can play to develop medical interpreting. To be able to share the outcomes with as many stakeholders as possible in the world, this study has been written in English rather

than my mother tongue (Japanese).

4) Their witness accounts are expected to serve as evidence of “Who” has worked to develop medical interpreting in the United States, “How” they have accomplished this, and “What” roles they have played. The findings are expected to uncover what has not been disclosed through the literature.

5) The findings include written materials (e.g., newsletters, flyers, brochures, reports, and agendas of meetings written and/or preserved by some interviewees of this research), most of which have nearly been lost because of the passage of over 35 years. Though sometimes unreliable, the materials they provided have been important in enabling me to get close to the process by identifying stakeholders’ activities, and to recollect documents with historical value with a difficulty in recovering them in mind. Four interviewees were members of the committee that drew up the Standards of Practice (The Massachusetts Medical Interpreters Association & Education Development Center, 1996/2007), one of the important documents for medical interpreting practice which has served as a model for other standards. Its originality deserves attention.

6) This study includes findings from some important materials such as the Bilingual Medical Interview, Part I & Part II(training videos) developed in 1987, which have enabled me to compare the original best practice techniques with those used at present. Any differences found on these and other videos are expected to demonstrate how and who put these technical changes into practice.

7) This study includes interviews of medical interpreters who pioneered medical interpreting services at hospitals in the United States. They are expected to reveal information about stakeholders whose whereabouts are unknown following their

retirement. The passage of time poses a risk to all of us. For future research purposes, this study is expected to provide crucial information that can't be recovered once lost*¹¹.

3-3. Targets

This study targeted individuals who have been working or used to work as medical interpreters to figure out how medical interpreting started and developed. I interviewed relevant individuals such as members of professional medical interpreters associations, primarily MMIA because it was the world's oldest association for medical interpreting. I located some pioneering individuals who had founded the association in 1986, as well as members of IMIA, the U.S.-based successor organization to MMIA founded in 2007 which became the world's largest association of medical interpreters. I took advantage of being a member myself to select individuals through a professional network, in-house, per-diem interpreters, and managers of interpreting service sections at hospitals. I learned hospitals' policy on medical interpreting services from these managers, and perspectives of freelance interpreters who work on-call or are dispatched by agencies. I have made special efforts to recruit those who started to work in the early days in order to trace back to the inception of medical interpreting, and to recruit others over the passage of time until recent days. I recruited medical interpreters from a variety of associations, including some exclusively focusing on medical interpreting and others with members who work in various fields from medical to court interpreting and translation. I recruited medical interpreters from different states to cover a wider area. I tried my best to increase the number of working languages, especially minority languages, and to recruit those who have regular jobs that work as medical interpreters only on weekends, to reflect the survey results (The International Medical Interpreters

Association, 2010).

3-4. Methods

3-4-1. Oral History

Oral history is a method well applied by a wide variety of scholars including historians, anthropologists, sociologists, community leaders for ethnic history publications, and school teachers for students' projects (e.g., Hoffman, 1996; Janesick, 2010; Ritchie, 2003; Saga, 1995/2002; Yow, 2005). Oral history methods have been taught by teachers at schools and/or universities, and students have collected oral history accounts from a wide variety of interviewees (e.g., Ball & Wlodarski, 2011; Busby, 2011; De La Torre & Estrada, 2001; Levin, 2011; Mills et al., 2011; Norkunas, 2011; Ross, 1998; Valk et al., 2011; Zieren, 2011). The literature indicates there are a large number of oral histories that are primarily fact-finding in nature, in which individuals who witnessed specific events or changes that those events brought about were interviewed to deepen the understanding of those events (e.g., Cave, 2008; De La Torre & Estrada, 2001; Hughes, 2006; Lewis et al., 1977; Saga, 1995/2002). There are also a large number of oral histories which have revealed untold stories or autobiographies narrated by those who had not been given the opportunity to speak before. These works have provided new insights into stereotypes by portraying a humanistic understanding of people (e.g., Baumel, 2000; Bozzoli, 1998; Kamp, 2001; Kase, 2007; Kerr, 2003; Lock, 1993; Pipher, 2002; Polishuk, 2005; Rickard, 2003; Welaratna, 1993; Westerman, 1998; Wigginton, 1998).

The literature that most inspired me has been Torikai's study which

spotlighted five pioneering individuals in simultaneous interpreting in Japan. Torikai writes, “The aim of the present study is to highlight this invisible presence, making them visible by collecting the living memories of diplomatic interpreters through life-story interviews” (Torikai, 2009, p. 25). Torikai chose this method “to explore the presence of pioneering interpreters in Japanese contemporary history as individuals, feeling their own feelings, saying their own words” (Torikai, 2009, p.175) and analyzed their roles. I will focus a spotlight on pioneering medical interpreters and stakeholders to analyze their roles in the process of medical interpreting with Torikai’s approach in mind. I also learned from Allen & Daugherity, who recollected oral accounts of multiple stakeholders to recover “organizational and individual records of the civil rights era” (Allen & Daugherity, 2006, p.29) to understand the Supreme Court’s decision on school discrimination in 1965. The National Aeronautics and Space Administration (NASA) has been documenting thousands of oral history accounts of staff, ranging from astronauts to engineers, who have been involved in space programs with an aim to learn lessons for future programs (Launius, 2003).

On the other hand, some researchers have stressed the subjective nature of this method (e.g., Lewis et al., 1977). Hareven compared oral histories from weavers of Nishijin textiles in Kyoto, Japan, with those of Amoskeag Mill’s workers in the United States, and she uncovered a commonality between apparently different groups of workers (Hareven, 2002). The interviewees authorized her to write their real names in the book. By following Hareven’s approach, I encouraged medical interpreters to voice their subjective perspectives on activities in the context of development of medical interpreting either at working places (i.e., hospitals) or areas where they work (i.e.,

states or regions). I also draw on another study by Durán, who collected oral histories from gang members by using his own insider viewpoint as a former gang member and an outsider viewpoint as a researcher. In this way, Durán uncovered the race-related background for becoming a gang member of people who had been frustrated by a hostile environment in communities (Durán, 2013). I followed Durán's approach to take advantage of my professional identity as a medical interpreter to build a rapport with the targets, and to analyze their accounts as a researcher. Thus, their subjective accounts shed a light on their challenges to create this profession and on the presence of other stakeholders. They are expected to provide some vital information on their working environment (i.e., attitude of medical professionals, hospital policy on services, budget for staffing), how their working environment has changed, and why these changes were brought about during specific periods and at specific places. Those who work in different states and/or during different periods are expected to clarify how differently development has been facilitated. From now on, I call the targets oral history tellers (OHTs) in order to make a clear distinction with interviewees of other types of qualitative research. OHTs are numbered from OHT 1 to 29 (See Table.1) in chronological order from when they started to work as a medical interpreter. When OHTs refer to other OHTs, their names won't be revealed. Only their numbers will be given for conciseness.

3-4-2. Interview Procedure

The targets have been located in the following ways. I met OHT 20 at the 10th Annual National Conference on Medical Interpreting organized by MMIA on November 11, 2006, where I also met OHT 19, then the group's newly appointed president. OHT

20, who hosted me during the field work, introduced me to OHT 26. I conducted preliminary interviews with OHT 20 and 26 on general perspectives of their profession in 2006 and conducted oral history interviews in 2010. OHT 20 introduced me to OHTs 1, 2, 4, and 12 in 2010. OHT 1 presented the medical interpreting system of her hospital to visitors, including myself, during a series of hospital tours organized by MMIA's Annual Conference in 2006. I interviewed OHT 1 at IMIA's Annual Conference in 2010. OHT 1 then introduced me to OHTs 3 and 13. During the interview, OHT 3 talked about OHT 5's contribution to the development of the Standards of Practice (The Massachusetts Medical Interpreters Association & Education Development Center, Inc., 1996/2007). OHT 3 recalled how she worked with OHT 5 to teach at the first college-based medical interpreting courses at the Northern Essex Community College, in Massachusetts, in 1994. Therefore, I searched for OHT 5's whereabouts by contacting resettlement agencies where OHT 5 was supposed to work.

I searched for interviewees from associations other than MMIA and IMIA. I contacted OHT 21, president of NATI, on April 30, 2010, by joining her mission group to visit the offices of senators representing the state of Nebraska. To recruit some interviewees from CHIA, I contacted one of my colleagues in San Francisco and was introduced to OHT 6, then CHIA's vice president. OHT 6 hosted me during the field research and introduced me to OHTs 8 and 28. OHT 19 introduced me to OHT 23, who had visited Japan in 2007, and I conducted a preliminary interview with OHT 23 who hosted me while I conducted interviews with OHTs in the state of Massachusetts from 2007 to 2010. I met OHTs 7, 10, 15, 16, 17, 18, 19, 21, 22, 24, and 25 at events organized by professional associations during the period between 2006 and 2013. I

spoke with OHT 11 at 'Iryo Tsuyaku Kokusai Shinposiumu' [the International Symposium of Medical Interpreting] organized by Multi-Language Information Center Kanagawa (known as 'MIC Kanagawa', a non-profit organization) on December 2, 2006, in Kanagawa, Japan. I met OHT 14, director of the interpreting section, when I conducted field research, and I was introduced to OHT 1 by OHT 14 there. I read a newsletter which featured OHT 29, whom I contacted on August 31, 2013, through the introduction of a manager of the interpreting department of the hospital which had posted this newsletter on its website. I contacted OHT 27 on September 13, 2013, through the introduction of a manager of the hospital where I had conducted field research in 2008. I contacted a manager of a university-based course, well recognized for court and medical interpreting in the Navajo language, and I was introduced to OHT 9 on August 31, 2013. I have conducted interview(s) with each of them.

3-4-3. Ethical Considerations

I thoroughly followed the "Best Practices for Oral History" established by the Oral History Association (OHA). Regarding exclusion from the Institutional Review Board (IRB), OHA stated officially in 2004 (Ritchie & Shopes, January 8, the Oral History Association, 2004 [Footnote No. 7 of the website titled, "Oral History, Human Subjects, and Institutional Review Boards"]):

"[O]ral history interviewing activities, in general, are not designed to contribute to generalizable knowledge and therefore do not involve research as defined by Department of Health and Human Services (HHS) regulations at 45 CFR 46.102(d) and do not need to be reviewed by an institutional review board (IRB). OHRP[the Office of Human Research Protections under HHS] has tried consistently to confirm

this concurrence whenever it received inquiries about this matter from representatives of IRBs or other institutional officials.”

Researchers have been following OHA’s position (e.g., Ritchie, 2003; Yow, 2005; Janesick, 2010). I also followed this position and I did not apply for IRB review. Regarding the names of interviewees, the “Best Practices for Oral History” states, “Because of the importance of context and identity in shaping the content of an oral history narrative, it is the practice in oral history for narrators to be identified by name” (The Oral History Association, Principle and Best Practice. see <http://www.oralhistory.org/about/principles-and-practices/>). However, I left this decision (i.e. whether their real name or a pseudonym would be used) to each OHT in an effort to respect their autonomy. I prepared the consent form (See INFORMED CONSENT FORM at the end of this Chapter) with a column where each OHT would write which name they wanted to use (i.e., real name, initial, pseudonym or other name) and they filled in the column and signed the written consent. In case they chose not to use their real names (i.e., with their initials or any other), I deleted any information which might lead readers to identify them. I explained that they would retain the right, even after the interviews, to cancel their participation or request me to delete their recorded interviews in whole or in part. When three interviewees said they did not want their oral histories to be written, I deleted all the materials (i.e., interview records, transcripts and relevant mails exchanged with them). I sent transcripts of the interviews and results (i.e., written oral histories) to them at least one time so they would be able to read, edit, correct, or add to the results in any way they desired. They allowed me to send them questions arising from transcription and analysis.

The frequency of contact prior to the interviews varied in accordance with whether I had previously known them. I contacted those with whom I had a close relationship by mail or telephone, and with their agreement, I explained the details of the research project. In contrast, with OHTs 3, 5, 9, 27, and 29, with whom I had no prior contact, I took a more cautious stance because of ethical concerns. I approached them first by explaining the study verbally or in writing, and communicated with them many times on the phone or by mail to carefully explain the details. I also engaged in a period of questions and answers regarding the ethical issues until they agreed to the interviews. I explained that disclosing the information they provided, especially their names, would let others identify them. After receiving their verbal or written agreement, I handed or sent them a consent form (see INFORMED CONSENT FORM attached at the end of this Chapter), which, unless they had further questions, they signed and sent back to me.

Out of 32 interviewees, three canceled after the interviews. Therefore, I deleted all the materials relating to them, including the recorded materials. Apart from interviews, I continued to be in contact with each one for several reasons: to obtain further materials, to ask questions arising from analysis, and to ask them to read the draft and edit it. With some of the OHTs, I exchanged over 150 emails and spoke with them multiple times.

3-4-4. Conducting Interviews

Between 2006 and 2013, I conducted interviews in English either face to face or

on the phone. Each interview lasted between 60 to 150 minutes. I had several interviews with some of the OHTs. To maintain consistency, I conducted all interviews in English, even with those whom I usually spoke to in Spanish or Japanese. I followed the definition of oral history interviewing by Janesick, who writes, "Interviewing is a meeting of two persons to exchange information and ideas through questions and responses, resulting in communication and joint construction of meaning about a particular topic" (Janesick, 2010, p.46). Portelli says, "The final result of the interview is the product of both the narrator and the researcher" (Portelli, 1998, p. 71). Frisch took the issue of authorship, saying "we need to understand the way in which authorship is shared, what does this mean for understanding how interviews can actually be a source of "H"istory, as distinct from historical data or raw material" (Frisch, 1990, p. xx[Introduction]). I have kept what Frisch called "authorship" in mind, because the interviewees and I share similar experiences based on the profession we have both engaged in. Hence, regardless whether I tried or not, we tended to find joint meaning on incidents narrated by interviewees. I tried not to mention my opinion, however, I can't deny the possibility that my facial expression or even body language made them understand that I felt similar to how they felt when remembering incidents at work. I recorded all the interviews and immediately started to transcribe them except for that of OHT 19, whose transcription was scheduled for the end of the analytical period because of my recognition of bias due to our intimate relationship working for the same professional organization for a long time. As I described in the Field Note of OHT 19, to deal with my bias, I needed sufficient time to shift my perspective from that of a colleague to one of a researcher.

3-4-5. Transcription and Analysis

I transcribed the recorded interviews verbatim. I listened to them repeatedly and carefully to analyze the voice, tone, and expression of each interviewee and also of myself to assess any bias I might have. I described my relationship with each one in the Field Notes of oral history to recognize any bias at the time of analysis. I was cautious because oral history has been criticized by scholars concerning the reliability and validity of the interviews. In this regard, I followed the steps indicated by Hoffman, who writes:

“[T]he consistency with which an individual will tell the same story about the same events on a number of different occasions. Validity refers to the degree of conformity between the reports of the event and the event itself as recorded by the primary resource material such as documents, photographs, diaries, and letters” (Hoffman, 1996, p. 89).

To achieve validity, I sent transcripts to the interviewees so they would help me if I had difficulty catching their words. I compared the accounts and clarified any discrepancies by speaking to them. I asked similar questions about some specific events several OHTs had attended, and to make sure what they said at the time, who they spoke with, and what impact these events had on the subsequent development of medical interpreting. Materials, including MMIA newsletters, personal letters addressed by key stakeholders, conference brochures, attendants' lists, and even drafts of speeches, were analyzed. I thoroughly reviewed the transcripts and classified their accounts by type of activity (e.g., advocacy, networking, etc.). I identified when each OHT started to work as a medical interpreter and gave them numbers from 1 to 29 in

chronological order (See Table. 1). In an effort to find meaning myself, I searched the literature to identify each one's background (e.g., historical, social, cultural, ethnic, etc.) and incorporated my findings into the results for "joint construction of meaning about a particular topic" (Janesick, 2010, p.46). I remembered "authorship" as presented by Frisch (Frisch, 1990, p. xx). Finally I wrote the oral histories and sent a draft to each one for further editing in case they needed to do so.

Given that an exclusive analysis on medical interpreters associations and/or groups has not been conducted yet, I decided to do it as part of the analysis, and I focused on MMIA to figure out how the world's oldest professional interpreters association had been established and developed. For that purpose, I analyzed the transcripts of the five initial group members (OHTs 1,2,3,4, and 13) and three general members (OHTs 5, 12, and 17) to find themes for pioneering medical interpreters in the early stage of development (Takesako & Nakamura, 2013). I conducted a thematic analysis by following Boyatzis's encoding method (Boyatzis, 1998).

INFORMED CONSENT FORM

This informed consent is for the medical interpreters and/or stakeholders who are working in the United States who are invited to participate in a research titled “Development of Medical Interpreting in the United States” (Tentative title).

1. INFORMATION OF THE RESEARCHER

1-1 Name: Kazumi Takesako (MS)

1-2 Affiliation: Graduate School of Osaka University, Japan

2. INTRODUCTION

This research is for the doctoral dissertation of Ms. Kazumi Takesako, Ph.D candidate with Osaka University, JAPAN. You are invited to take part in this research. Details of the research are described as follows:

2-1 Purpose: To understand how medical interpreters have gained professional status in the United States, by working closely with stakeholders.

2-2 Type of the Research: This research will involve you in an interview with the researcher who records and transcribes it for your reading. The questions are primarily related to your personal history, your efforts to be professional in the State of () and your perspectives in working as a medical interpreter or as a stakeholder.

3. PARTICIPANT SELECTION

This research introduces oral history taking method. You are one of the professionals in the context of development of medical interpreting in the United States especially in the State of () to share your personal and professional perspectives, observations or opinions, etc.

4. VOLUNTARY PARTICIPATION

Your participation in this research is entirely voluntary. It is your choice whether to participate in or not. You may change your mind after decision of participation and you can stop participation at any time before, during and even after the interview.

5. PROCEDURE

After you accept participation, I will ask you to have an interview and allow me to record it so later it will be transcribed and read by you before my analysis. During the analysis or transcription process, you might be asked some questions or additional information through mails.

6. RISKS AND DISCOMFORTS

There is a risk that you may share some personal or confidential information by chance. If this happen to you in your judgment, you are able to correct or delete it during your reading of transcribed texts.

7. CONFIDENTIALITY

This research basically requires your name remains in the data and the research paper. With this in mind, I would like to make sure of your choice.

☐ You will authorize me to leave your name as ().

☐ You won't authorize me to leave your name and just leave as anonymous.

☐ Other preference, if any ().

8. BENEFITS

There might be no immediate benefit to you, but your generous participation will help us understand who and why medical interpreters and stakeholders in the United States have been making efforts and advancing the profession and careers in the society. I expect that my findings of this research will be used for future progress of the profession in Japan and other nations as well. Your observations and comments will provide me of hands-on lessons from which we will learn to improve the situation.

9. WHO TO CONTACT

If you have any question about this research, please call Ms. Kazumi Takesako at (E-mail address and phone number).

If you have any question or concern about your rights as a research participant, please call (The supervising professor's E-mail address and phone number).

10. CONSENT STATEMENT

I have read all the information provided above. I have been given the opportunity to ask questions and all the questions have been answered to my satisfaction. I agree to participate in this research.

Print Name of Participant

Print Name of Researcher

Signature of Participant

Signature of Researcher

Date

Date

CHAPTER FOUR:

RESULTS

4- 1. Outlines of OHTs

4-1-1. General Information about OHTs

A total of 29 OHTs were recruited during the period from 2006 to 2013. Their oral histories are listed in chronological order from the year they started to work as a professional medical interpreter (See Table 1. and APPENDIX: Oral Histories and Profiles of 29 OHTs). They have come from or were born in 20 countries and they speak 25 languages, including rare languages such as Hmong, Khmer, Tibetan, Nepali and Navajo (the most commonly spoken Native American language). There are 14 immigrants, five refugees, and one resettler. A total of seven are spouses of citizens of the United States, while six immigrated to the United States to study and found a profession after graduating from university. Eight OHTs were the first staff interpreters at their hospitals. Out of the 29, 10 OHTs have worked as a coordinator or director of an interpreting section. Their work experience as a medical interpreter varies from five months to 34 years.

Their employment status has also varied, running the gamut from full-time workers to per-diem, part-time, freelance and weekend interpreters. Their working style has ranged from on-site (face to face) interpreters, phone interpreters, interpreters dispatched by agencies, and on-call interpreters, reflecting the diversity of the industry. I recruited interviewees who have been members of MMIA, IMIA, CHIA, NCIHC, NATI, the American Translators Association (ATA), and other professional interpreters or interpreting associations.

4-1-2. Outline of Each OHT's Oral History

For each OHT's oral history, see APPENDIX: Oral Histories of 29 OHTs. OHT 1, one of the founders of MMIA, is considered one of the earliest interpreters employed by a hospital in the United States. She developed the world's first Code of Ethics for medical interpreters and also worked on the Standards of Practice. She recalled her first instance of culture shock at the age of six while her family lived in France. She became interested in learning languages from childhood, influenced by her father, who was fluent in several languages. She became interested in communicating with people as an interpreter due to her mother, who had been involved in human networking. She first worked as a resettlement worker, but liked to work in medical settings, and took a newly created post as a staff interpreter at the Beth Israel Hospital in 1979. As a pioneer, she learned to work by trial and error. Along with OHTs 2 and 3 and (R), a co-founder and the first president of MMIA[(R) passed away in 1995], she formed the initial group of MMIA which met to share work experiences and discuss common issues. The Standards of Practice were the fruit of heated interactions among the group's members because of a diversity of opinion on what medical interpreting was and how to practice it.

OHT 2, a co-founder and the third president of MMIA, has been advocating for refugees and immigrants since 1979. He speaks English, French, Spanish, Portuguese, and Haitian Creole. After working for a resettlement agency, he became a social worker at the Boston City Hospital in 1984, and (R), the director of the interpreting service section at the hospital, sought to recruit him. OHT 2 referred to (R) as a

network builder with other stakeholders and advocate for medical interpreters and LEP patients. OHT 2 secured grants from stakeholders to offer free training courses to MMIA members, and took the helm of MMIA when the group helped enact the Massachusetts state law on medical interpreting (ERIL) in 2000.

OHT 3 was also a co-founder of MMIA. Born in Mexico, she worked as a conference and court interpreter in Spanish, English, French, Portuguese, and Italian. She became the first coordinator of the interpreting section at the Massachusetts General Hospital in 1987. She considered the profession as her vocation, despite facing challenges such as a lack of understanding of medical interpreting by physicians, a lack of manpower, and a hectic work schedule that required frequent overtime. By sharing such difficulties at work, the initial group of MMIA members supported each other. OHT 3 trained bilingual staff and volunteers, and also worked as a professional instructor for aspiring medical interpreters. She worked with a group of lawyers to help pass the state's medical interpreting law (ERIL). As a core member of the committee of the Standards of Practice, she recalled how they had developed the document. She remembered how MMIA connected with other professional associations within the United States and in other countries by referring to some specific individuals who contributed to the development of the profession.

OHT 4, an original group member of MMIA, was born in Portugal, and was significantly influenced by her father, a physician educated in the United States. Since 2000, she has been working as a director at the University of Massachusetts. Despite a lack of training, she started to work as a medical interpreter in the late 1980s. She

detailed how MMIA was formed and how the training videos, the Bilingual Medical Interview, Parts 1 & II, was developed by (G), a physician, (R) and a team at the Boston City Hospital in 1987. She recalled how the state's guidance in 1989 (the Determination of Need Program, DoN) had urged hospitals to create a coordinator's position. Coordinators also formed a group to discuss common issues (See p.109-110*3).. She continued to work as a medical interpreter to share hands-on experiences with trainees, especially difficult cases. The state government invited her, OHT 2, and others from MMIA to develop a document, Best Practice Recommendations for Hospital-Based Interpreter Services.

OHT 5, a refugee from Cambodia, faced anxiety because of language barriers, culture shock, and discrimination in the United States. These memories inspired her to make the utmost effort to learn English and help people in similar circumstances by working as a medical interpreter first for resettlement agencies and then for hospitals. She thought that just becoming a medical interpreter was not enough to help people suffering from trauma and mental health problems. That is why she decided to obtain a master's degree as a social worker through a grant. She worked as a Khmer instructor for the first university-based training course, at the Northern Essex Community School, in 1994 with OHTs 1 and 3 and Informant (M), a researcher who secured a grant from the federal government for the program. OHT 5 was one of the minority-language-speaking participants on the committee that developed the Standards of Practice. OHT 5 is currently working for the state government as a coordinator of interpreting services. OHT 5 has been advocating for the people from Cambodia by becoming a core member of ethnic advocacy associations.

OHT 6 is an immigrant from Guatemala who came to the United States in 1983. She has been motivated to help people in need ever since she took care of her grandfather, who passed away without having access to a hospital. Her experience with language barriers she faced at entering the United States also motivated her to become an interpreter. She initially worked as a laundry worker at a hospital, but by chance served as a medical interpreter for a patient who was going to have his legs amputated. The encounter didn't traumatize her, but inspired her to learn English and medical terminology at community schools in order to become a professionally trained medical interpreter, and then a professional trainer of interpreters. Eventually, she became the vice president of CHIA. OHT 6 said she believes the professional status of medical interpreters has improved partly due to the initiative taken by the state of California to enact relevant laws. She recalled CHIA providing training courses and taking part in advocacy activities.

OHT 7, a nurse born in Panama, is married to an American. She took English courses at a community school and obtained a nursing license in the United States. She worked in a dual role as a nurse and interpreter until Executive Order 13166 was issued by President Bill Clinton in 2000, and the hospital changed its policy and approved her request to work only as an interpreter. She remembered a lack of funding as the main reason why she had to work as the only staff interpreter for a long time. Regarding motivation, the loss of her prematurely born twin babies while living in Germany has encouraged her to help patients, but sometimes she has to deal with her own trauma when seeing patients under similar stressful situations. To deal with

the lack of support from physicians in calling for staff interpreters, she has been educating professionals in various ways, such as by speaking with them about the importance of cultural intervention for patients.

OHT 8 is a Taiwanese nurse who immigrated to the United States in 1977. She recalled how difficult it was for foreign students to pass professional exams, and that it took her two tries before she could become a nurse. She first worked at a local community hospital, but was often asked to interpret for LEP patients. After becoming a mother, she quit nursing to stay at home, but continued to study medicine on her own and took a training course for medical interpreting at the Mount San Antonio Community College, where she had been working as a language coach. She underscored the importance of internship programs at hospitals as a requirement to finish training courses. Lately, she has also been working as a phone interpreter while helping her husband in his business. She stressed the importance of financial contributions made by grant providers, including the state of California and foundations, for the development of medical interpreting. As a freelancer, she has been participating in CHIA conferences to expand her professional network and acquire new technical skills.

OHT 9 is a Navajo born on a Navajo reservation in the state of New Mexico. She became the first federally-certified Navajo court interpreter. She has been working as a medical interpreter as well, instructing a training course since 1993. She co-authored a book titled, "The Navajo people and Uranium Mining"(Brudde, Yazzie-Lewis, 2006). She recounted that Navajo people lived so isolated from the rest

of the country that they faced language barriers at school. She worked on behalf of her community, recalling that physicians didn't understand the culture of Navajo people, so she had to serve as a cultural broker. Despite an increase in the number of medical professionals of Navajo origin, they need medical interpreters in the Navajo language because they have been losing their traditional way of life and native language due to westernization. She acknowledged that the civil rights movement by Native Americans, called the American Indian Movement, learned from the African-American civil rights movement of the 1960s.

OHT 10 immigrated to the United States from Lebanon. Her family entered the United States in 1983 because of political turmoil in her country. She had to help her LEP family as a child interpreter. At first, she did it out of a sense of obligation, but she found herself automatically interpreting for anybody in need of help. She became a court interpreter, but she liked medical interpreting more because it seemed more human. She noticed a change since she started to work in 1994. Medical professionals now care about the quality of interpreting and respect medical interpreters as team members. She attributed these changes to the state law on medical interpreting (ERIL) that was enacted in 2000. OHT 10 stressed the need for cultural competency. She has taken advantage of her cultural background and knowledge, and now works for the federal government, only working as a medical interpreter on weekends.

OHT 11 is an immigrant from India. Her family entered the United States in 1972. She speaks Bengali, Hindi, Nepali, and English. She has been the executive

director of the Cross Cultural Health Care Program (CCHCP) in the state of Washington. She started to work as a public health interpreter and joined a group of physicians caring for refugees at the Pacific Medical Center. She was requested by this group to conduct a survey and interview people in the local communities to determine their needs. The study found language, culture, and a lack of information about health care facilities hampered LEP residents' access to care. She started training courses called "the Bridging the Gap" to educate medical interpreters as well as medical professionals about cross-cultural issues. CCHCP was funded by a grant from the W. K. Kellogg Foundation, which also offered grants to organize a series of conferences which provided opportunities for isolated pioneers in medical interpreting to discuss common issues including roles of medical interpreters. OHTs 1, 2, 3, and 4 and (R) met with the founders of CHIA and NCIHC at those conferences.

OHT 12 is a refugee from Cambodia. He arrived in 1988 after surviving the genocide perpetrated by the Khmer Rouge. He speaks Cambodian, Mandarin, Cantonese, Teochew, Vietnamese, and English. He learned Vietnamese at a refugee camp. His ethnic community in the United States helped him learn English. He volunteered to interpret for a neighbor at the Tufts Medical Center, where he was recruited as a staff interpreter. The hospital is located amid different Asian communities which demanded language services, so more staff interpreters were employed. OHT 12 articulated the importance of politicians' involvement in improving the status of medical interpreters. In 1982, the hospital's interpreting section belonged to the Department of Social Workers and logged 45 interpreted encounters a month. Now, the interpreting service section handles 130 cases a day. He has been serving

there as a cultural broker (i.e., some Asian families don't want patients to be told that they have cancer, and he explains that to physicians).

OHT 13 is an immigrant from Argentina and an initial group member of MMIA. She has worked on behalf of Hispanic communities. Since 1992, she has been leading the interpreting section at the Lawrence General Hospital. She contacted OHTs 1 and 3 and (R) to learn about medical interpreting because there were no training courses. She learned English and medical terminology at the Merrimack Valley Area Health Education Center in 1994. She remembered how physicians were reluctant to rely on her. Her tenacity helped her gain acceptance by medical professionals. She met the demand for interpreting services, despite a lack of funds, by training her own bilingual staff to increase the manpower available. OHTs 1 and 3 educated OHT 13 and her staff. She uses a carrot-and-stick policy. Bilingual staff earn one dollar extra per hour of interpreting, but they also have to attend workshops and pass evaluation tests. She observed how the state law (ERIL) encouraged hospitals to care about the quality of interpreting services.

OHT 14 was born in the U.S. to Jewish immigrants from Russia. She has been the director of the interpreting section at the Beth Israel Deaconess Medical Center since 1992. Under her leadership, the department has grown from 10 staff interpreters to more than 80. Because she lived in a community with Italian and Jewish immigrants, she was interested in foreign languages, and her father encouraged her to learn Spanish. She holds a Bachelor's degree in Spanish and Economics in addition to a master's of business administration (MBA). Her mother and

grandmother helped develop her tenacity and determination in setting career goals. She chose her present position at the hospital based on her language skills and management ability. To her surprise, medical interpreting was not very easy to learn, and she learned it from OHT 1. Her experience as a practitioner in a medical setting helped her understand the complexity and difficulty her interpreters face daily. She has since incorporated a video conference-based medical interpreting system at the medical center.

OHT 15, a physician born in El Salvador, is also a United States-trained public health expert and the coordinator of the Health Care Interpreter Program at the Oregon Health Authority's Office of Equity and Inclusion. He oversees implementation of the state interpreting law. He remembered that the state of Oregon was influenced by the state of Washington, which created its own certification testing system after a series of lawsuits (i.e., OCR investigated in some hospitals for the lack of interpreting services) over a lack of interpreting services. In 1998, a group of citizens lobbied the Oregon legislature to pass a law creating an interpreting system. His duties also include developing technical assistance, evaluating compliance by the health system with requirements for language access for LEPs, and developing a certification system, based on Title VI of the Civil Rights Act of 1964.

OHT 16 is originally from Ireland. He has been working as a professional Finnish interpreter and translator in a variety of settings and as an independent interpreter. He lived in Finland for 15 years, initially working as an architect. But he changed to being an interpreter because he remembered how he liked helping visitors

from the United States as a student volunteer. He does not belong to any medical interpreters associations, but has been making an effort to expand his professional network, taking advantage of learning opportunities like IMIA Conference.

OHT 17 was a nurse in India after going there as a Tibetan refugee in the 1960s. She speaks Tibetan, Nepali, Hindi, Urdu, Panjabi, and English. She resettled in the United States as one of 1,000 displaced Tibetans who were accepted after Congress enacted the Immigration Act of 1990. For the first three months, she was hosted by a volunteer who sponsored her. But she worked hard to be economically self-supporting. She volunteered to take care of patients and learned from a hospital manager about the state-sponsored medical interpreting course. Her experience as a nurse and fluency in several minority languages helped her work as a medical interpreter once she acquired sufficient skill. She has been working on a contract basis at several hospitals. She observed change in the languages needed according to the flow of refugees and immigrants. For example, in 1995, Tibetan and Hindi were needed, but now, Nepali-speaking interpreters are in demand.

OHT 18 is originally from Venezuela. He obtained a master's degree in healthcare management in the United States. He became the director of Guest Support Service at the Boston Medical Center, the former the Boston City Hospital, in 1996 after working as a translator in French and Spanish. He observed how his father, a diplomat, relied on interpreters. Because he has lived in eight countries, he is flexible in adapting himself to new cultures. He was introduced to the medical interpreting profession through a friend, a medical student from Haiti who was working

as an on-call medical interpreter. He joined MMIA and took courses that OHT 2 organized for members. He approached physicians to win their support and also accumulated data to convince hospital administrations to give importance to the provision of medical interpreting services. Because of an influx of refugees from African countries, he had to find interpreters speaking hundreds of dialects. He noted that compared to two decades ago, there are plenty of training courses available now, but that expectations are high in terms of the quality of interpreting services provided.

OHT 19 was the president and now is the executive director of IMIA. OHT 19 is secretary-general of the Federation International des Traducteurs (FIT). As the daughter of a diplomat, she has lived in many countries. But contrary to OHT 18, she has suffered cultural and identity problems. She became interested in languages due to her mother, a translator. After studying in American schools in every country she lived in, she immigrated to study and work in the United States. After volunteering at churches, she worked as a translator. She helped prepare medical evaluations for occupational accidents and started to work at hospitals, but the pay was so low that she was forced to do other kinds of interpreting work. After obtaining a master's degree in education, she returned to medical interpreting with a determination to educate newcomers and improve the job's professional status. She felt a strong need for a certification system and took the initiative in building a testing system at the national level in 2009.

OHT 20 is originally from Taiwan. She lived in Japan before immigrating to the United States, and speaks Taiwanese, Cantonese, Mandarin, Japanese and English.

She works as a staff interpreter at a hospital, after being recruited while working as a hospital volunteer. She stressed her determination to acquire skills. OHT 20 works as a professional trainer and has been taking courses continuously. She said that physicians are more prepared to work with medical interpreters compared with a decade ago, but stressed the need for continuous education of physicians about medical interpreting.

OHT 21 was born in the United States, but studied Spanish and anthropology in Mexico. She served as president of the Nebraska Association of Translators and Interpreters (NATI), and is a staunch advocate for the medical interpreting profession. She is also a state-certified court interpreter. After returning to the United States, she noticed a huge need for language services for LEP residents who worked in factories. After volunteering to help them, she and her Mexican husband established their own language services business. In 1998, she brought together people who shared an interest in issues regarding language access for LEP residents and the lack of professional status for interpreters and translators. A small group of freelancers, language service managers, medical professionals, and community advocates developed into NATI in 2000. The professional association works to provide training to members as well as leads advocacy activities.

OHT 22 was born in Argentina, but studied and found work in the United States. He was the director of the Massachusetts Department of Public Health, and led the “You Have the Right to an Interpreter” campaign in 10 languages. His choice to become a medical interpreter came from his interest in the medical profession. He first

worked as a community interpreter before becoming a medical interpreter. Although he liked the profession, he left it for better paying jobs. As a keynote speaker at IMIA 2010 Conference, he took up the issue of the poor pay for medical interpreting. He encouraged the audience by saying, “Use every opportunity you have to educate patients, colleagues, and providers [physicians] about the work you do and the skills necessary to do it well”.

OHT 23 is originally from Puerto Rico. She has been working as a phone interpreter, per-diem interpreter, and overnight-shift interpreter. She first served as an interpreter for her husband when he was hospitalized in the United States, and was recruited by chance while interpreting at the emergency room. She became a coordinator at the Cambridge Health Alliance Hospital, which sent her to the first course offered by the Cambridge College, with which the hospital had developed the curriculum for a medical interpreting course. After the enactment of a state law on medical interpreting in 2000(ERIL), the media started to actively report about the profession. She was featured by a local media outlet as one of the first 36 graduates of the course. Her hospital conducted the first pilot test to compare the advantages and disadvantages of face-to-face, phone, video, and remote interpreting (also called, Video interpreting). The objective of this research was to find ways to reduce the cost and increase the efficiency of interpreting services.

OHT 24 was born in the United States, and has been serving as the testing and certification director for the National Board of Certification for Medical Interpreters (NBCMI). She started to use her language skills for advocacy activities by helping

foreign participants. She recalled having participated in the civil rights movement and fighting for women's and immigrants' rights. After losing her job with an airline after the September 11 attack, she was introduced to a job as coordinator of interpreting services at a public hospital in Atlanta, Georgia, where a recent influx of immigrants needed interpreting services. To acquire skills and knowledge, she formed a study group, which was joined by a physician educated in Colombia who taught them medical terminology. She convinced the hospital's management of the importance of medical interpreting services by telling them that LEP patients would become income generators because of Medicare and Medicaid.

OHT 25 was born in the United States, but learned Portuguese by speaking with relatives in her father's native county of Brazil. She has been working as a phone interpreter at the Cambridge Health Alliance Hospital, and has been the vice president of IMIA. Initially, she worked in marketing, but was laid off after the September 11 attack. She looked for a new job and decided to take a medical interpreting course. OHT 25 recognized that her language fluency and cultural background would enable her to secure work. She became a pioneering medical interpreter specializing in mental health, predicting the industry would become polarized and that medical interpreters would need to specialize to survive the competition. Her hospital considered phone interpreting to be a way to reduce total cost and secure access to LEP patients.

OHT 26 is Japanese. She recalled the difficulty in adapting to a new way of life in the United States, mainly due to language barriers. After completing her

education and finding work, she married an American medical professional who encouraged her to take medical interpreting courses to learn medical terminology. He then asked her to help at his clinic. She was taught by OHT 20. She also worked as a court interpreter, but preferred working as a medical interpreter because it was more rewarding. The first thing she learned was how to handle difficult cases, the second was how to revalue herself, and the third was to revalue her life. She acknowledged her role as a cultural broker.

OHT 27 was a refugee from Laos. After working as an IT engineer, she decided to change her job. She has been working at a hospital as a staff interpreter for Hmong people since 2005. She recalled that her family had benefitted from a wide range of assistance, including governmental assistance based on the federal Refugee Act of 1980 and the assistance of volunteers from her own ethnic community. OHT 27 is the eldest of four sisters and the only one who can speak Hmong with her parents. She helped her parents as a child interpreter. She had to make every effort to acquire Hmong language and cultural skills good enough to work as a medical interpreter. Her experience taking her mother to the hospital for treatment served as hands-on training for her career. Hmong patients distrust Western medicine, resulting in a particularly low rate of cancer screening that helped her find the present post, where she is expected to serve as a cultural broker.

OHT 28 is a refugee from Cuba who came to the United States in 1970. She has been working as a freelance medical interpreter for agencies. Her relatives and the local Cuban community helped her family settle in the United States. She

remembered some rioting by minority groups in 1965. She first worked as a journalist, but heard from a friend about a course at the Mount San Antonio Community College which she eagerly took as a way to develop a new career. The state-sponsored course aimed to provide a chance for bilingual people to have a second career, as well as to address a lack of language services by increasing the number of qualified interpreters.

OHT 29 was born in Korea. After retiring at the age of 76, he started a new career as a staff interpreter at the Interpreting Service Department of the UC Davis Medical Center in May 2013. He immigrated to the United States in 1983, and after obtaining a teaching credential, he worked as a high school teacher until 2002. He recalled how challenging it was to cope with cultural differences between his country and the United States. He attributed his motivation to become a medical interpreter to his Korean values and his daughter's health issues. He preferred medical interpreting over other types because he felt caring for patients made it more worthwhile.

2. Findings by Themes

4-2-1. Advocacy

Medical interpreters' advocacy activities:

MMIA's late founder and MMIA's first president (R), IMIA's first president OHT19, and NATI's president OHT 21, in particular, took the initiative in advocating for the profession. OHT 21 said, "*We needed to have a voice. We formed NATI because so many people were abusing patients... We have a motto: Educate, Advocate, and Associate for the Good of the Profession*". Similarly, advocates from a minority

group led activities against discrimination. For example, OHT 9, the nation's first federally certified Navajo interpreter, recounted how Navajo miners had been discriminated against by not being informed about life-threatening radiation risks. She co-authored a book titled, "The Navajo People and Uranium Mining" (Brugge et al., 2006) to document such discrimination for advocacy purposes. She said, *"I am an activist working with the environmental justice. I interpreted all the testimonies of people."* She also referred to the American Native Indian movement in the wake of the civil rights movement of African-Americans. OHT 24 is also an activist who has participated in every kind of advocacy activity, including the civil rights movement of African-Americans, the fights for immigrants' rights, women's rights, and against the Vietnam War. She led the lobbying activities of multiple stakeholders' groups aimed at U.S. senators. In April 2010, her group went to Washington D.C. to demand LEP patients' rights to professionally trained medical interpreters and federal reimbursement for language services. OHT 24 recalled *"before the civil rights movement, minorities in the U.S. were relegated to menial work, they were not able to the profession. Without the civil rights movement, many of us wouldn't be able to be medical interpreters or offer language services."*

Most of OHTs remembered having witnessed discriminatory attitudes towards LEP patients, who were denied access to information regarding diagnosis and treatment. OHTs who experienced discrimination on the basis of their color, national origin or foreign accent were motivated to help LEP patients. OHT 5 remembered, *"because my color isn't white and because my speech has a heavy accent, I will never forget insensibility and a lack of compassion of one of my immediate supervisors."*

Others who experienced language barriers when entering the United States or while they were in foreign countries were positive about helping those in need of language assistance. OHT 6 recalled, *“I used to interpret for my grandfather when he went to the bank or where they discriminated (against) him. . . . Nobody interpreted for me on the day we arrived. . . . I thought I would provide the service with dignity and respect.”*

Collaboration with multiple stakeholders:

OHTs 1, 2, 3, 4, 5, 12, 13, and 19 remembered (O), a lawyers’ group leader, had ignited a statewide movement to enact the Emergency Room Interpreter Law (ERIL) by collaborating with multiple stakeholders, including state agencies, MMIA, health care institutions, and ethnic advocacy groups listed in Table 3. (attached at the end of this Chapter). Regarding the same movement, OHT 3 recalled speaking at a Senate hearing because (O) asked her to tell about medical encounters that ended terribly due to a lack of professionally trained medical interpreters. According to OHT 15, a civic group concerned and demanded that the state of Oregon provide medical interpreting services. As a result, the state of Oregon eventually enacted Health Care Law ORS 409 in 2006. OHT 22, while working for the Massachusetts state government, together with the media launched a campaign, *“You have the Right to an Interpreter [Name of the campaign]”* to educate LEP patients that they had the right to demand medical interpreting services at no cost.

4-2-2. Stakeholders

4-2-2-1. Federal and State Governments

Informant (GP)*¹², Senior Health Advisor and Project Officer for the Office of

Minority Health, recalled having assumed the role of an interpreter for his immigrant family in early childhood. He started to work in the field of disabled populations in the 1970s. After coordinating multiple projects for communities, he has been working for The Office of Minority Health since 1994 (Personal communication*¹², . Informant (GP)*¹² and Informant (J) worked together to develop the document, the Culturally and Linguistically Appropriate Services in Health Care (CLAS) Standards (The Department of Health and Human Services, 2001, March [Final report]), which has been recognized nationally as well as internationally for providing guidance for the delivery of culturally competent care for diverse populations.

OHTs 1, 2, 3 and Informants (J), (L), (K), and (P) recalled the participation of OCR's regional managers at a conference in 1998. OCR's objective was to ask for feedback on the January 1 Guidance Memorandum issued by the Office for Civil Rights in 1998 (The Cross Cultural Health Care Program & Society of Medical Interpreters, April 10, 1998, [Cover letter of the Fourth Meeting of the National Working Group on Interpretation in Health Care, Seattle, Washington, May17-19, 1998]).

OHTs agreed about the importance of the Civil Rights Act of 1964 and Executive Order 13166 (EO) by the Clinton administration in 2000. But most OHTs believed that state guidance and state interpreting laws had a greater effect on hospital decisions to establish interpreting services and increase employment for medical interpreters. OHTs 2 and 4 reported how their state government has made efforts to urge hospitals to establish a medical interpreting system and that they took part in those state projects. OHT 4 said guidance issued by the state in 1989, the

Determination of Need Program (DoN), had an immediate effect on the drive by hospitals to employ their first interpreting staff and/or coordinator (See p.10-110 *3).

OHTs 2, 4, 13, 14, 18, and 19, who were managing interpreting sections, agreed on the importance of the state mandate of the Emergency Room Interpreter Law (ERIL) by the state of Massachusetts in 2000. OHTs 6, 10, 12, 14, and 18 indicated that ERIL was more effective than Executive Order 13166 (EO) issued by Clinton. MMIA's newsletters and other materials provided by the founders evidenced how frequently state agencies had participated in MMIA events to disseminate crucial information on ERIL.

OHTs described how their state supported training organized by medical interpreters associations so newcomers could learn skills at a time when training courses were still not available. OHTs 1, 2, 3, 4, 5, 6, 8, and 13 worked on such training courses. OHT 2 described *“at present [in 2000], we are offering two 60-hour Department of Public Health-funded courses ...for the recently passed Emergency Room Interpreter Law [a state mandate by the state of Massachusetts].”* OHT 8 worked with OHT 6 on the California-sponsored course at a community college which aimed to help bilingual people become medical interpreters. The state governments intended to increase the number of qualified medical interpreters to eliminate language barriers.

4-2-2-2. Physicians and Researchers

OHTs 2 and 3 highlighted the importance of specific anthropologists and

physicians who provided cultural insights when medical interpreters discussed their roles. They said that without a theoretical basis, they might not have been able to define the “cultural broker role” of medical interpreters. OHTs 1, 2, 3, 4, 13, 18, and 19 evidenced the presence of specific physicians [i.e., Informant (P), a community-based physician, and a hospital-based physician (G)] as supporters. Informant (J) and OHT 18 remembered having heard (G) always saying, *“I am a doctor and doctors listen to what doctors say.”* OHT 4 remembered (G)’s contribution to producing the videos, the Bilingual Medical Interview, Part I & II, saying, *“(R) [the first president of MMIA] and (G) partnered with our office to develop a tool for medical interpreters and doctors to understand how to work with interpreters.”* According to OHTs, (G)’s presence was vital to convince medical society, which was reluctant to include medical interpreters as team members. Additionally, MMIA’s founders (i.e., OHTs 1, 2, and 3) and Informant (J) referred to Informant (P), who had secured a grant from a major foundation to organize the first nationwide conference in Seattle, WA, in 1994 to enable stakeholders, most of whom were medical interpreters or trainers, to discuss the definition of roles, one of the topics most urgent for them.

Individual physicians helped medical interpreters at work. OHT 24 even called them “Champions” and took advantage of their positive influence upon other physicians who often distrusted medical interpreters due to a lack of understanding of the importance of medical interpreting. Several foreign medical students or researchers worked as medical interpreters or volunteers in the 1970s and 1980s as recalled by OHT 3 and 13. OHTs 3, 13, 18, and 24 obtained a lot of medical knowledge from them.

4-2-2-3. Foundations

OHTs 6, 8, and Informant (L) and (J) recalled major foundations had financed CHIA's activities, including the development of standards (The California Healthcare Interpreting Association, 2002). Informant (L) received a grant to train bilingual medical professionals and medical interpreters for Asian minority languages. Informant (J) received grants from several foundations to organize events to educate stakeholders and to disseminate relevant information on language barriers for advocacy purposes.

Informant (J) said the United States is unique in that foundations serve as financial supporters of medical interpreting. OHTs 1, 2, and 3 recalled being invited for discussions at a series of conferences sponsored by a major foundation. Attendants at those conferences included OHTs 1, 2, and 3, and Informants (J), (L), (P), (K) and (M). They also remembered a grant from the same foundation that was used to sponsor an annual MMIA conference in 1997.

4-2-2-4. Professional Medical Interpreters Associations

OHTs 1, 2, 3, 4, and 13 started to meet in order to recount stressful experiences and to exchange views on how to deal with them. OHT 3 recalled: *"We needed to find somebody to talk to and listen to. That is why we got together!"* OHTs 6, 7, 8, 10, 11, 12, 16, 18, 19, 20, 21, 22, 23, 25, 25, and 26 participated in events organized by professional medical interpreters associations to learn technical skills and expand their professional network. OHTs 1, 2, 3, 4, 5, 13 and Informant (J), (K), (L), (M), and (P)

remembered having discussed common issues such as the standardization of professional requirements.

OHTs 1, 2, 3, 4, 6, 10, 12, 13, 18, 19, 20, 21, 24, 25 and Informant (J), (L), and (P) remembered that associations took the lead in advocacy movements together with other stakeholders such as state agencies and ethnic organizations. MMIA's initial group members were frustrated, with OHT 3 stating: *"We felt everybody got paid for a job in healthcare, but interpreters were expected to be volunteers and not get paid for their work. We needed to get organized to show hospitals that we were contributing an essential component to healthcare."*

Most OHTs found professional medical interpreters associations helped their members learn relevant information on the practice of medical interpreting. OHTs 1, 2, 3, and 5 viewed the training videos, the Bilingual Medical Interview, Part I & Part II, which were deemed to contain the profession's best practices, as early as 1987 because MMIA used these videos for their certification course. The videos show that at the time they interpreted using the 'third person method'*¹³. However, OHT 1, who learned the 'first person method'*¹³ from a colleague with a conference interpreting background, later put the 'first person method'*¹³ into practice. MMIA took the initiative in developing methods based on members' hands-on lessons from day-to-day work, and in disseminating them by establishing the standards for best practice*¹³.

Their strong professionalism was epitomized by OHT 2, MMIA's third president. He insisted on the wording of *"competent medical interpreter"* on the

document titled, “Best Practice Recommendations for Hospital-Based Interpreter Services (The Commonwealth of Massachusetts, Office of Health and Human Services, Massachusetts Department of Public Health). He was frustrated that professionally trained medical interpreters were treated the same way as untrained staff or volunteers employed by hospitals. OHTs 18, 19, 21, 24, and 25, all leaders in the certification project, expressed their frustration over a lack of professional status. OHTs 11, 18, 19, 21, 24, and 25 took the initiative in promoting national certification in 2009. OHT 19, IMIA’s first president, explained the reason why she took the initiative in building NBCMI, a certifying organization, “We are afraid that un-qualified, un-trained interpreters will damage our profession.”

The role of professional associations has been to expand networks. When MMIA organized its first national conference under OHT 2’s leadership in 1997, OHT 4 witnessed how professional associations connected, stating, “*When OHT 3 and I were there, we met (P) and (K) in the MMIA meeting. That group spun off to form the National Council (NCIHC).*” OHTs 1, 2, 3, 4, 5, and 13 recalled how (R), the late founder of MMIA, used to connect the organization with other stakeholders, including state agencies and a lawyers group led by (O), the leader of lawyers’ group, to help enact the state law on medical interpreting(ERIL). OHT 21, a leader of NATI, has been working closely with state agencies and policy makers. OHT 5, 9, 11, 12, 14, 21, 27, and 29 have maintained a close relationship with ethnic communities. OHT 19, a leader of IMIA, has been expanding the professional network beyond national borders by reaching out to international associations such as the Federation International des Traducteurs (FIT), the largest association of translators in the world.

4-2-2-5. Immigrants and Refugees

Both the federal and state governments have supported the learning of English by newcomers to the United States, according to OHTs 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 15, 17, 18, 19, 20, 22, 23, 26, 27, 28, and 29, who were immigrants, refugees or worked on behalf of newcomers. Ethnic communities and churches offered English education as well as language facilitation, said OHTs 1, 2, 3, 4, 5, 12, 13, 17, 18, 19, 20, 21, 27, 28, and 29. Many of them offered their own time and energy to help newcomers as well. However, the accounts of OHTs mirror different factors as well. Their motivations were based on their experiences before becoming medical interpreters. For example, OHTs, 5, 6, 7, and 12 were so motivated that they mastered English despite the many difficult challenges they had to face. OHTs 5 and 12 survived atrocities in Cambodia and were highly motivated to help other refugees.

The role of medical interpreters as cultural brokers has been stressed in various ways. OHT 10, whose origin is Lebanese, shows how cultural aspects can differ between people even though they speak the same Arabic language and live in the same country. She used her knowledge to treat people from Egypt, Iraq, Morocco, Syria, and Lebanon because she had lived with them in her country. She said interpreters should note differences “*from the appearance.*” She added, “*You sometimes see them how they wear. The language is not too hard to learn, it’s a culture [which is really challenging]. Culture is different in countries*”. OHT 12 from Cambodia said “bad news should not be provided to patients, and physicians have to know how to greet people, because the American greeting sounds rude to Asian

patients.” OHTs 6, 10, 23, 27, 29 and Informant (GP) actually interpreted for their LEP family members while young. OHT 11 stressed that the health care system should provide cultural- and language-appropriate services. She conducted a survey for a local community in Seattle and discovered ethnic disparities. LEP populations didn’t know their rights regarding health services. They needed culturally appropriate services, in addition to linguistic ones, to obtain better access to care. OHT 27, from Laos, who has been working as a cultural interface, said she has to explain the reincarnation beliefs of Hmong patients to physicians. OHT 29, a former high school teacher from Korea, learned differences between Korea and the United States. Teachers, for example, are treated like kings in his country, but in the United States, students are disrespectful toward them. Eye contact is regarded as impolite in Korea, but it is different in the United States. Based on these findings, he has been working for Korean patients as a cultural broker.

4-2-3. Perspectives on the Profession

Some common perspectives have been voiced. OHTs found a mission to help patients in need of help. They uniformly said their satisfaction as medical interpreters does not come from the money they make but from the rewarding feeling they get from their day-to-day work. A typical account was given by OHT 26, who repeated “*Never! Never! Never!*” when I asked whether she regretted having chosen this profession. OHT 8, a former nurse, said “*to be an interpreter, you need a heart. It is a hard-working profession. It has a lot of responsibility. Without a passion, you can’t do it.*” OHT 16 shifted from architecture to interpreting. He found his real profession. OHT 3 left conference and court interpreting, which were more lucrative and enjoyed

higher status, to become a medical interpreter. She said, she had found her vocation. OHT 6 found her vocation, too. OHT 29, from South Korea, started to work as a medical interpreter at the age of 76, after working as a teacher. For him, medical interpreting has been just a small part of his entire life of helping people in need in his community. OHT 14 spoke of having rewarding moments, *“I think [it makes you] feel like you have touched another person’s life and helped them at a moment of vulnerability.”* OHT 23 expressed her view *“it is not really about the money, it’s not about the working conditions, because you really want to do and believe in what you are doing.”*

Many OHTs have worked as court interpreters, but OHTs 2, 3, 10, 11, 19, 20, 21, 26, 27, and 29 preferred medical interpreting to court interpreting because of the humanistic nature of helping patients. OHT 20 likes the humanistic nature *“because we all have the same agenda, patients get better and physicians want patients get better, interpreters make sure [their communication for the same goal].”* OHT 10, who was once a court interpreter, explained the reason for her change, *“I help more each other, more humanity. It’s more like I enjoy people in medical interpreting.”*

4-2-4. Motivations

The motivation of medical interpreters varies. OHT 5, a former refugee, experienced discrimination herself at work due to her color, national origin, and foreign accent. OHTs 6, 10, 23, 27, 29, and Informant (GP) actually interpreted for their LEP family members while young. Each OHT’s story is different, however, their stories depict they commonly have tried to find meaning for spending time and energy in order

to help LEP patients in need of help. OHT 7 overcame the traumatic experience of having lost her babies due to stress from the language barrier and has been motivated to help mothers in similar situations. She said: *“I am happy to be able to do what I would have wanted or more than what I could have. I am not a robot, we have feeling. But I am a professional, I do my best to be kind with energy to help those patients in need.”* OHTs who are children or grandchildren of immigrants attested to their ethnicity-based motivations for advocacy. OHTs who are native English speakers, such as OHTs 1, 2, 14, 21, 24, and 25, recalled having been told by older family members about the communication difficulty they faced in daily life after entering the United States. OHT 14, in particular, remembered how difficult it was for her mother and grandmother to start living here.

Table 1. List of the Oral History Tellers

NO.*	Name or Initials**	Country of Origin	Working Languages***
1	Jane (Crandall) Kontrimas	U. S. A.	<u>English</u> , Russian
2	John Nickrosz	U. S. A.	<u>English</u> , <u>French</u> , Spanish, Portuguese, Haitian Creole
3	Margarita Christlieb Battle	Mexico	<u>Spanish</u> , <u>English</u> , French, Italian, Portuguese
4	Lisa Morris	Portugal	<u>Portuguese</u> , <u>English</u>
5	Saly-Pin Riebe	Cambodia	<u>Khmer</u> , French, English
6	Lourdes Cerna	Guatemala	<u>Spanish</u> , <u>Kiche</u> , English
7	I.P	Panama	<u>Spanish</u> , English
8	W.T	Taiwan	<u>Taiwanese</u> , Mandarin, English
9	Esther Yazzie-Lewis	U. S. A.	<u>Navajo</u> , English
10	Randa	Lebanon	<u>Arabic</u> , French, English
11	Ira SenGupta	India	<u>Bengali</u> , <u>Hindi</u> , <u>Nepalese</u> , <u>English</u>
12	Joshua Van Ngo	Cambodia	<u>Cambodian</u> , <u>Mandarin</u> , <u>Cantonese</u> , <u>Teochew</u> , Vietnamese, English
13	Liliana A. Zagaria	Argentina	<u>Spanish</u> , English
14	Shari Gold-Gomez	U. S. A.	<u>English</u> , Spanish
15	David Cardona	El Salvador	<u>Spanish</u> , English
16	Desmond B. O'Rourke	Ireland	<u>English</u> , Finnish
17	Dolkar	Tibet	<u>Tibetan</u> , <u>Nepali</u> , <u>Hindu</u> , Urdu, Panjabi, English
18	Oscar Arohca	Venezuela	<u>Spanish</u> , <u>French</u> , English
19	Izabel Arocha	Australia/Brazil	<u>Portuguese</u> , <u>English</u> , Spanish
20	Y.	Taiwan	<u>Taiwanese</u> , Cantonese, Mandarin, Japanese, English
21	Janet Bonet	U. S. A.	<u>English</u> , Spanish
22	Jordan Javier Coriza	Argentina	<u>Spanish</u> , Portuguese, English
23	Milca Ortiz Rivera	Puerto Rico	<u>Spanish</u> , English
24	Linda Joyce	U. S. A.	<u>English</u> , Spanish

25	Anita Coelho Diabate	U. S. A.	<u>English</u> , Portuguese
26	Midori	Japan	<u>Japanese</u> , English
27	Joah	Laos	<u>Hmong</u> , English
28	Mari Padron	Cuba	<u>Spanish</u> , English
29	Song Que Hahn (韩 成 奎)	South Korea	<u>Korean</u> , English

Note:

* The numbers are in chronological order in accordance with their start of medical interpreting.

**The names are written with the names as authorized by each OHT through a consent form (i.e., Some authorized their real names, others their initials or only first names).

** The native languages are underlined. The names of the languages are described as the OHTs described (e.g., Cambodian and Khmer).

CHAPTER FIVE:

DISCUSSION

5-1. Advocacy Movements

The Civil Rights Act of 1964 is widely considered to be the fundamental federal law in the United States to mandate language interpreting services by providers of medical care. Even official documents published by the federal government refer to the law in the following way. The Policy Guidance document issued by the Department of Justice, for example, is entitled, Enforcement of Title VI of the Civil Rights Act of 1964 (The Department of Justice, Federal Register, 2000, Aug. 16, p.50123). The National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards), which have been widely adopted as the fundamental standards aimed to redress ethnic disparities in health care, are “based on Title VI of the Civil Rights Act of 1964” (The Department of Health and Human Services, 2001, March [Final report]). Every textbook and/or presentation for medical interpreting courses starts with an introduction of this law in the context that medical interpreting services should be provided as the law stipulates (e.g. The Cross Cultural Health Care Program, 1999; Michalczyk, 2007 [Presentation], July; Roat, 2008, June [Presentation]). Even manuals for physicians explain the legal background of Title VI of the Civil Rights of 1964 (e.g., The California Primary Care Association, 2000; the National Health Law Program & the National Council on Interpreting in Health Care, 2006).

The literature, however, shows that the enactment of laws was not the only factor behind the development of medical interpreting. It was the civil rights movement of the 1950s and 1960s that strongly instilled in people the importance of ensuring

equal access to public services, because the nationwide disorder that resulted from the struggle for civil rights forged a new societal value against racial discrimination. People who discriminated against African-Americans or who did not question the discriminatory conduct of others recognized that such behavior would result in serious consequences for the nation, as depicted by the National Advisory Commission on Civil Disorders, 1968 (The National Advisory Commission on Civil Disorders, 1968). Consequently, people started to give importance to equal access to public services. Once that principle became a shared value, it encouraged multiple stakeholders to work for the same goal, whether through the enactment of state laws mandating medical interpreting services, the filing of complaints by civic movements with OCR over the lack of language services, or other advocacy projects on behalf of LEP patients. On the other hand, sociologists have reported that even though most European immigrants who came to the United States before the civil rights movement also suffered from language barriers, they didn't voice their right to language services (e.g., Bodnar, 1985; Chiswick, 2005). However, upon seeing the success of African-Americans in obtaining civil rights, other minority groups started to form their own advocacy movements, which were led by local ethnic communities. Hispanics started to launch similar movements (Rosales, 1997), the Jewish community raised its voice against discrimination in the 1960s (Kazis, 2002), and Asian immigrants demanded their right to public services (Kiang, 1994; Pho, 2007).

It was these movements that changed people's perspectives on whether equal access to health care should be demanded as a civil right. They fostered the emergence of advocacy-oriented people who would take action upon seeing discriminatory conduct,

including the failure of hospitals to provide medical interpreting services to LEP patients. Many such people became stakeholders and worked together to provide medical interpreting services to LEP patients upon recognizing that the provision of such services was indispensable to attaining their common goal. OHT 9, 21, 22, and 24 were epitomized examples. People who experienced discrimination were active in promoting or helping advocacy movement for LEP patients' access to care. Typical examples were OHTs 5 and 12, who as refugees experienced discrimination due to their color, national origin, and foreign accent. OHT 5, in particular, became an advocate for others in similar situations. OHT 2, who was born in the United States, remembered being discriminated against because of his Canadian accent, which motivated him to help LEP patients. Those who experienced language barriers at the time of entry into the United States or while they were in foreign countries were active in helping those in need of language assistance, according to most OHTs.

Another reason for the collaboration of multiple stakeholders in pursuit of common goals for advocacy was the involvement of native English speakers who were born in the United States. Because of the huge number of European immigrants and refugees who had helped build the nation since the 1950s (Bodnar, 1985), they would have been told by grandparents or other relatives how language barriers had crippled their access to social services. If these stakeholders happened to be assigned to some projects for medical interpreting, they might have recalled those family talks in their youth. I contend that these types of stories narrated by one's own family members could have instilled passion into them for pursuing these projects. OHTs' accounts and Informant (L)'s comment support my point. OHTs 1, 2, 14, 21, 24, and 25 remembered

being told stories by older relatives. OHT 14, in particular, recalled how difficult it was for her mother and grandmother to start living here. OHT 10's relatives recounted their difficult life at entry at the family party I was invited for. OHT 10 helped her LEP family as a child interpreter, but she felt it was a kind of duty at a young age. Additionally, Informant (L), who has been working since 1981 at an Oakland based health center where I conducted field research in 2010, described how she had witnessed the hardships of her family (Personal communication, August 14, 2012). Informant (L) stated:

Growing up I witnessed my Issei [the first generation immigrant] grandparents often having to choose between what the family believed to be less than quality health care and (the) Japanese-speaking skills of the clinician. Always, the language skills of the physician won out.

She explained her motivation to work as an advocate:

I recognize discrimination and racism that Asian immigrants face. As a Sansei [the third generation], working on language access issues was an opportunity to help address an injustice that prior generations had experienced but not had the resources nor civil rights tools to address (Personal communication, August 14, 2012).

OHTs' narratives depicted how they had witnessed or taken part in advocacy activities: OHT 9 recalled that the American Native Indian movement began in the wake of the civil rights movement by African-Americans. She said, "*I am an activist working with the environmental justices. I interpreted all the testimonies of [Navajo] people.*" OHT24 was at a civil rights rally in the 1960s. She said "many people do not

realize that our being able to offer interpreting services comes from tremendous struggle and is built on the back of the thousands of people who participated”. She organized an advocacy activity to visit senators and representatives offices on Capitol Hill (Washington D.C.) demanding LEP patients’ rights to professionally trained medical interpreters and federal reimbursement for language services on April 30, 2010. OHTs 10, 16, 19, 21, and 24 took part in this lobbying activity as did I. OHT 21 accepted on behalf of NATI the Martin Luther King, Jr. Humanitarian Award in 2010 for advocacy efforts on behalf of minority populations in Nebraska. She helped stakeholders establish NATI. During her visit to the senators’ offices, I observed that she voiced her strong commitment to advocacy based on Title VI of the Civil Rights Act of 1964.

The provision of language services is mandatory based on Title VI (e.g., Chang & Fortier^{*1}, 1998; Chen et al., 2007; Federal Register, 2000) and equal access to care has to be secured. However, OHT 11, who conducted a survey for communities in Seattle, revealed a different picture. LEP populations didn’t even know about their right to health services. She stressed that the health care system should provide cultural and language appropriate services. Most OHTs recalled having witnessed the discriminatory attitudes held by some people towards LEP patients, who were denied access to information regarding diagnosis and treatment. OHT 22, who was working for the Massachusetts state government, launched a campaign, “You Have the Right to an Interpreter” (The Commonwealth of Massachusetts, Executive Office of Health and Human Services, Department of Public Health, 2010), to educate LEP patients to recognize their right to demand medical interpreting services at no cost to them.

Official documents have urged hospitals to provide language services to LEP patients (e.g., Federal Register, 2000; the Commonwealth of Massachusetts Department of Public Health, Office of Health Equity, 2008). However, what motivated hospitals wasn't the simple enactment of laws, but the efforts by stakeholders to guarantee linguistically- and culturally-appropriate medical interpreting to LEP patients at the state level. OHTs 1, 2, 3, 12, 15, and 21 clarified who had teamed up to help enact the state laws and/or built the state certification system in the initial stage of the development process and how they did it. OHT 3 regarded (R) as a prime mover who had collaborated with every stakeholder. OHTs who had worked with (R) attributed her networking skills with stakeholders as the key to subsequent collaborations. Proof of her importance was shown by how (R) was missed by multiple stakeholders when she passed away in 1995 (e.g., The Cross Cultural Health Care Program, 1995 Letter for (R)'s funeral ceremony]; the University of Minnesota, 1995 [Letter for (R)'s funeral ceremony]).

The literature indicates that this type of cohesive effort for advocacy by stakeholders remains unchanged. For example, major pharmacy chains were sued in New York for failing to provide language services to LEP customers. A lawyers' group filed a civil rights complaint against them (New York Lawyers for The Public Interest, Inc. [Document] 2002/ 2003/ 2008), and experts in the legislative sphere issued reports based on Title VI of the Civil Rights Act (The National Health Law Program, 2008). Researchers authored articles on this issue (Bailey et al., 2011; Weiss, et. al, 2007), and the media brought the matter to public attention (Anne Barnard, 2007, New York

Times). The entire process was shared with the world on Dec. 11, 2009, through a Webinar presentation (Wong, 2009 [Webinar presentation though DiversityRx]). Finally, the mayor signed a law requiring pharmacies to provide language services for those who needed them (New York City Government, 2009 [Online released news]). Informant (E), IMIA's New York Chapter Chair, has spearheaded as an instrumental figure of these multiple stakeholders movement for advocacy.

These civil rights movements led the country to enact the Civil Rights Act of 1964, whose provisions were reinforced when Executive Order 13166 was issued in 2000. Together they made the federal government responsible for securing meaningful access to health care for everyone (Federal Register, 2000, Aug. 16, p.501239). However, according to legal experts, even federal agencies, including OCR, didn't recognize the importance of the federal legal mandates and they had to be educated about them. Perkins, for example, advised the director of the OCR by saying "the Guidance should expressly include managed care organizations ... and their contractors and subcontractors" (Perkins & Wong, 1999, [Letter posted on website]). The accounts of OHTs and the literature demonstrated that because of the legal complexities involved the simple enactment of laws and issuance of guidance have not been effective in forcing state governments and hospitals to deal with the language issue. The involvement of legal experts such as those from the National Health Law Program was also vital because it was their words and explanations that provided a basis for stakeholders to take action (The National Health Law Program & the Access Project 2004, 2004; the National Health Law Program & the National Council on Interpreting in Health Care, 2006).

Despite the huge difference in measures adopted by states, as highlighted by legal experts (e.g., Perkins & Vera, 1998; Youdelman & Perkins, 2002), states have generally complied with federal laws. OHTs described how states such as Massachusetts and California urged medical institutions to provide interpreting services to LEP patients. However, access issues have not sufficiently improved. In their accounts, OHTs revealed that LEP patients are still not being fully informed of their right to a medical interpreter. Massachusetts has been considered one of the most advanced states regarding medical interpreting services (e.g. Fortier*¹, 1998; Perkins & Vera, 1998). But even there, it took until 2010 for the state government to initiate a media campaign to directly inform LEP patients of their right to an interpreter. The campaign, “You Have the Right to an Interpreter,” led by OHT 22, was broadcast on the radio, so newcomers to the country could understand what rights they had. A government website also provides the relevant information in 10 languages (The Commonwealth of Massachusetts, Executive Office of Health and Human Services, Department of Public Health, 2010). Due to the diversity of language needs, even the state of Massachusetts still has to take additional measures for advocacy purpose. Given the constant influx of refugees and immigrants from many countries, states should make further efforts to act in tandem with ethnic organizations in communities where these newcomers live. OHTs 1, 2, and 5 worked for Voluntary Resettlement Agencies (VOLAGs*¹⁴). OHTs 5, 10, 12, 17, 27, 28 and 29 remembered having been assisted by community volunteers.

5-2. Stakeholders of Medical Interpreting

I will discuss the roles of stakeholders in the following order: Federal and State Governments, Physicians and Researchers, Foundations, Professional Medical Interpreters Associations, and Immigrants and Refugees.

5-2-1. Roles of the Federal and State Governments

The federal government has enacted a series of laws (See Table 2.) aimed at securing equal access to public services for refugees and immigrants, who now come from every corner of the globe, especially since the immigration law, the Immigration and Nationality Act, was amended in 1965. As previously mentioned, the most important role played by the federal government has been through legislation and administrative guidance, enacting the Civil Rights Act of 1964 (Title VI) and issuing Executive Order 13166, followed by the Policy Guidance issued by the Department of Justice (Federal Register, 2000, Aug. 16). Based on this legal framework, states have implemented measures at their discretion (Yudelman & Perkins, 2002).

Regarding cross-cultural issues, the federal government has reviewed academic studies (e.g., Geronimus et. al., 1996; Kaufert^{*8} et al., 1990; Putsch^{*9}, 1985). It consequently identified disparities in health outcomes (The Council of Economic Advisers for the President's Initiative on Race). To secure equal access to health care for the entire population, the federal government established two major agencies -- The Office of Minority Health (OMH) for cross-cultural issues and the Office for Civil Rights (OCR) for civil rights issues.

The federal government's ultimate goal has been to help newcomers become

economically self-sufficient as soon as possible. To achieve that, it enacted the laws listed in Table 2. The federal government passed the Refugee Act of 1980 to help refugees, who need greater assistance than immigrants. “This, the Refugee Act of 1980, meant federal reimbursement to states and localities for support of refugees, where needed, for three years, and for special help for instruction in English, job training, and other programs” (Jenkins, 1988, p. 12).

These laws appropriated funding for states so they could pay for language services provided by Mutual Assistance Associations (MAAs*¹⁴) and Voluntary Resettlement Agencies*¹⁴ (VOLAGs) which worked to help refugees from entry into the country till they started working. As many of OHTs recalled, the refugee policy created jobs for medical interpreters with refugee origins, who started to work for these associations or agencies by using their cultural and linguistic skills.

OMH was founded in 1989 based on the document, “Report of the Secretary’s Task Force on Black & Minority Health” (The United States Department of Health and Human Services, 1984). Heckler, then the Secretary of Health and Human Services sent the annual report on health status which disclosed that “there was a continuing disparity in the burden of death an illness experienced by Blacks and other minority Americans as compared with our nation’s population as a whole. … I felt —passionately—that it was time to decipher the message inherent in that disparity [the underline as original]” (Heckler, 1984 [the letter attached to the “Report of the Secretary’s Task Force on Black & Minority Health]). Since then, under the policy of equal access, OMH took the initiative in developing the CLAS Standards, which aim to

secure equal access to health care for the entire population. It has also provided concrete ideas about how to apply the CLAS Standards to relevant stakeholders (The United States Department of Health and Human Services, the Office of Public Health Services, the Office of Minority Health, 2001, March). The CLAS Standards have served as a benchmark document for practitioners, including medical institutions, private practitioners, policy makers and accreditation organizations. The dissemination of this document convinced hospitals to prioritize culturally- and linguistically-appropriate interpreting services (Putsch^{*9} et al., 2003). Informants (GP)^{*12} and (J)^{*1} described how they collaborated to develop the CLAS Standards. As a result, native speakers or those who had acquired cultural knowledge were required for specific ethnic groups, and refugees and immigrants who acquired English skills started to work as medical interpreters in medical settings, according to most of OHTs, because MAAs^{*14} and VOLAGs^{*14} employed them.

As a result, professional opportunities increased steadily for most of the languages needed, including for speakers of less common ones. The Joint Commission, an influential accreditation organization, referred to the CLAS Standards in regard to providing culturally-competent services (Wilson-Stronks et al., 2008), so hospitals were pressured to rely on culturally-competent interpreters to be accredited by the organization. OCR has been investigating cases to enforce Title VI. It has repeatedly issued policy guidance similar to the one in 1957 (See Table 2.), but hospitals often failed to comply. OCR issued policy guidance at the same time as EO 13166 in 2000 to make the strongest possible impact (Jellinek & Isaacs, 2008). “It was intended as a wake-up call to the providers of federally funded services, and it certainly did get the

attention of the health care establishment” (Jellinek & Isaacs, 2008, p.11). OHTs noticed their employment opportunities increased dramatically and employers respected them more than before. Experts reported a ripple effect from OCR’s enforcement policy from one state to another, but they highlighted the slow nature of enforcement and the limited number of cases involved (Fortier^{*1}, 1998; Perkins & Vera, 1998). This implies that the federal enforcement policy has been toothless to some extent and suggests there should be other ways to encourage physicians and hospitals to provide medical interpreting services. I will discuss these factors in more detail in the section on the roles of stakeholders. On the other hand, OMH has been working on culturally and linguistically appropriate services, which require medical interpreting. Informant (GP)^{*12} described his achievement in the resume: “Developed the OMH’s Center for Linguistic and Cultural Competence in Health Care...Since launching of the Center in 1995, I successfully acquired an annual budget appropriation of \$1.6 million for the Center.”

State governments have played the role of implementing federal law on medical interpreting (Fortier^{*1}, 1998; Perkins & Vera, 1998). As I described previously, most OHTs agree on the effect of state laws. Several OHTs stated that the issuance of the Determination of Need (DoN) guidance issued in 1989 (See Table. 3 ^{*3}) in the state of Massachusetts created jobs for them in the late 1980s because DoN required that hospitals establish interpreting sections in order for the state to approve purchases of new equipment. The subsequent enactment of the Emergency Room Interpreter Law (ERIL) definitively mandated the provision of interpreting services by hospitals in 2000 . State agencies also made efforts to educate hospital administrators to comply with the

mandate by working closely with other stakeholders. Some state agencies, for example, made presentations at seminars given by professional medical associations, and also provided money for training new medical interpreters, as OHTs 1, 2, 4, 6 and 8 described. Thus, state governments played an implementing role in different ways.

As Table 3. shows, many ethnic advocacy organizations have emerged in the state of Massachusetts since the 1980s. The state's policy toward accepting refugees has been to outsource assistance activities for them to Mutual Assistance Associations (MAAs^{*14}) and Voluntary Resettlement Agencies (VOLAGs^{*14}). Despite slight differences, other states' policies are similar and a huge number of MAAs^{*14} and VOLAGs^{*14} work on behalf of refugees (Jenkins, 1988). Jenkins quotes one study which "identified more than five hundred Mutual Assistance Associations (MAAS[MAAs]^{*14}) created by the Indo-chinese[as original] refugee community in the United States from 1975 to 1980" (Jenkins, 1988, p. 11). As I mentioned earlier, these groups provided job opportunities for medical interpreters, as recalled by OHTs 1, 2, and 5. The federal legal framework (See Table 2.) provided grants to states, which, in turn, provided funds to MAAs^{*14} and VOLAGs^{*14} (See Table 3.^{*1/2}), which employed interpreters, most of who were former refugees or immigrants, throughout the entire refugee adaptation period, from receiving them at airports to taking them for health checkups. In this way, they gained experience in medical settings through this work, and some of them found the job so meaningful that they chose to become professional medical interpreters.

Differences in state language policies among states that have been documented

(e.g., Ladenheim & Groman, 2006; Perkins & Youdelman, 2002; Perkins & Youdelman, 2008; Perot & Youdelman, 2001) strongly imply that the development of medical interpreting has varied in terms of the extent and coverage of minority populations. Despite a lack of data on the difference in quality of medical interpreting among states, it seems apparent that the quality of medical interpreting has varied and that the federal and state governments had to narrow these gaps to ensure equal access to health care for all. Limitations on the efficacy of federal and state government action partly stem from the failure to fund interpreting costs, which weakens the incentive for hospitals to comply with government guidance.

5-2-2. Roles of Physicians and Researchers

As I previously mentioned, another factor likely influenced physicians. To examine this point, I reviewed the literature to determine why physicians have become concerned about language issues and found one of the reasons is related to the concept of informed consent. Doing research through PubMed, I input as keywords, “1975/ malpractice/ California,” and found 12 articles as of January 20, 2010, including a special article entitled, “A Crisis in Medicine” (Butler, 1975). Most of the papers report on malpractice lawsuits. According to Faden & Beauchamp, the co-authors of “History and Theory of Informed Consent,” the advent of informed consent was between the 1950s and 1960s. “Physicians’ responses in this earlier period foreshadowed some modern view of the role of consent-seeking and communication with patients, in an attempt at discouraging suits” (Faden & Beauchamp, 1986, p. 82). The Joint Commission included informed consent in its Accreditation Manual in 1970, and the American Hospital Associations issued a statement to encourage informed consent

(Faden & Beauchamp, 1986). Lawsuits since 1975 discouraged medical students from entering the field of gynecology and obstetrics, and physicians refused to accept cases in which there was a possibility of a risky delivery (Whitelaw, 1990). The introduction of informed consent as a required practice in combination with a surge in the number of LEP patients in the 1970s drove medical society to grow concerned over language issues. Another factor was the new physician perspective on LEP patients as clients, partly because of the consumer rights movement. For them, LEP patients could be a source of both income and financial loss if they sued over a lack of medical interpreting services. OHT 18 depicted how worried hospital administrators were about potential lawsuits, and they moved to increase the number of qualified staff interpreters or expand the budget for training courses for them.

One of the roles of researchers has been to provide evidence-based data covering a wide spectrum of themes. Medical anthropologists have provided their insights (e.g., Kaufert^{*8}, 1990, Kaufert^{*8} & Koolage, 1984; Kaufert^{*8} et al., 1990), and physicians have conducted research on the challenges of cross-cultural communication, writing a huge number of papers that were later used by stakeholders to prove why medical interpreting services are necessary (e.g., Jacob et al., 2001; Putsch^{*9}, 1985) . The issues of language and culture caught the attention of stakeholders who read such data. Among stakeholders, some foundations that aimed to reduce social and cultural barriers to health care learned the importance of medical interpreting and decided to make large grants to such programs (Wielawski, 2010). The federal and state governments also decided on their policies toward medical interpreting based on such data (e.g., The Commonwealth of Massachusetts. Executive Office and Health and

Human Services, Department of Public Health, 2010; the United States Department of Health and Human Services, the Office of Public Health Services, Office of Minority Health, 2001, March).

Physicians and researchers have provided theoretical frameworks enabling medical interpreters and stakeholders to deal with cultural challenges (e.g., Kaufert*⁸ & Koolage, 1984; Kaufert*⁸ et al., 1999; Putsch*⁹, 1985). In the 1970s, when newcomers to the United States rushed to hospitals and physicians and medical anthropologists started to conduct research on cross-cultural medicine, there were few academic papers available (e.g., Kaufert*⁸ & Koolage, 1984; Putsch*⁹, 1985; Sluzski, 1978). OHTs read some theoretical frameworks for cultural intervention and tripartite encounters (between physician, patient and medical interpreter) when they discussed matters with other interpreters. OHT 3 authored a textbook herself (Battle, 1994), saying, “I was using these materials [Kaufert*⁸ & Koolage, 1984; Sluszska, 1978]” to train volunteers, interpreters, and physicians.

Cultural beliefs often seriously affect communication in medical settings by preventing medical professionals from understanding what patients really mean, because the two sides are from different ethnic groups and cultures (e.g. Fadiman, 1997; Haffner, 1992; Kaufert*⁸ et al., 1984; Keiv, 1968; Putsch*⁹, 1985/1988). With this in mind, pioneering medical interpreters who developed the profession’s standards relied on the theoretical framework derived by researchers to include “cultural broker” among the four roles they play. Some OHTs said, “Without their theoretical support, medical interpreters couldn’t have included the role of cultural broker in their work”. On the

other hand, cultural competency was encouraged by OMH (The United States Department of Health and Human Services, the Office of Public Health Services, Office of Minority Health, 2001, March), and case studies documented by physicians demonstrated why medical interpreters, adept at cultural issues, should intervene in patient-physician communication (e.g., Putsch^{*9}, 1985/1988). Physicians who opposed the use of medical interpreters learned to respect them as professional team members because they could help with difficult cases stemming from patients' cultural beliefs, as described by many OHTs.

A huge influx of immigrants and refugees and the introduction of informed consent to avoid malpractice lawsuits drove physicians to rely on medical interpreters when they encountered LEP patients. Based on these experiences, some physicians started to clarify technical issues such as the advantages and disadvantages of medical interpreting. The literature has indicated that the most documented topic has been cultural and linguistic barriers (e.g., Jacob et al., 2001/2007; Woloshin et al., 1995/1997). Several physicians with ethnic backgrounds have been very active in writing articles suggesting that medical interpreting is essential for communication with LEP patients (e.g., Flores, 2004; Jacob et al., 2001; Morales et al., 1999). In contrast, there were many physicians who wrote one or two articles on language issues but many more on their own medical specialty. Through discourse analysis, some physicians documented the strong possibility of committing errors (e.g., Flores et al., 2003/2012; Gany, et al., 2007; Pham, et al, 2008). A limited number have reported cases of malpractice which resulted in damage payments from lawsuits stemming from cases of actual misinterpretation (Harsham, 1984). Many have argued that medical interpreting by

professionally trained interpreters is vital for communication, especially due to the requirements of the informed consent process (e. g., Hunt et al., 2007).

Looking at physicians' roles in the workplace, it is clear that they have played an important role in support of medical interpreters as allies, promoters of interpreting by trained interpreters, and teachers of medical terminology at hospitals, according to many OHTs. OHT 24 teamed up with them, recalling "when we started, we found people and providers who supported language access and we called them 'Champions' ...". Several physicians have worked closely as members of professional associations, conducted research to convince state legislators to pass medical interpreting laws, and made significant efforts to advocate the importance of relying on professionally trained medical interpreters. Informants (P) and (G) are the physicians mentioned the most by OHTs. This study finds that physicians, who are considered powerful opinion leaders at hospitals, have generally accepted medical interpreters as members of the health care team. Consequently, the status of staff interpreters was secured at hospitals.

5-2-3. Roles of Foundations

Foundations with an interest in health care gradually found their mission was to redress ethnic disparities, based on reports and papers which revealed how seriously access to care and outcomes were endangered due to a lack of language services (e.g., Wielawski, 2010). While the federal government has not been actively involved in the health care field as some have criticized (Fortier^{*1}, 1998; Perkins & Yolanda, 1998), foundations have played an important role, especially in the early period of

development of medical interpreting, by donating a large amount of money to multiple projects (e.g., The California Endowment, 2003). For example, the Robert Wood Johnson Foundation and the Henry J. Kaiser Family Foundation, two large foundations interested in the health care field, jointly supported “a \$5.5 million program [\$1.5 million from the Henry J. Kaiser Family Foundation, and \$4 million from the Robert Wood Johnson Foundation], called Opening Doors: Reducing Socio-Cultural Barriers to Health Care[Name of the project]” (Wielawski, 2010, p. 238; See also the Robert Wood Johnson Foundation, 1998). They worked closely with professional medical interpreters associations and supported their activities, too (e.g. The California Healthcare Interpreting Association, 2002). They also worked with advocacy organizations that disseminated information relevant to medical interpreting for LEP patients (Wielawski, 2010).

A significant number of reports, large-scale surveys, and demonstration projects to develop medical interpreting have been financially supported by foundations. Some OHTs and Informant (L) recalled major foundations had financed CHIA's activities, including the development of standards (The California Healthcare Interpreting Association, 2002). Informant (L) received a grant to train bilingual medical professionals and Asian-language interpreters, while Informant (J) received grants from several foundations to organize conferences and/or other activities. Informant (J) worked to organize the first national level conference to address language barriers in 1995, which brought together hospital administrators. The major sponsor for this event was the Henry J. Kaiser Family Foundation. The presenters' articles were then published (The Journal of Health Care for the Poor and Underserved, Volume 9,

Supplemental 1998).

A major foundation motivated to redress unequal access to health care by LEP patients financed efforts by ethnic advocacy organizations to form a coalition to educate stakeholders. Different ethnic advocacy organizations formed a coalition with the help of founding organizations to educate medical professionals on language rights and responsibilities through seminars and workshops (California Pan-Ethnic Health Network (CPEHN), [Slide posted on website], Language Access Advisory Project California 2004). They also published policy announcements for the general public (CPEHN, A Blueprint for Success: Bringing Language Access to Millions of Californians).

Major foundations, including the W. K. Kellogg Foundation and the Henry J. Kaiser Family Foundation, played an important role in enabling the stakeholders who had started to organize or take local initiatives to meet at conferences by funding specific events. Such attendees included OHTs 1, 2, 3, 4 and Informants (J), (L), (P), (K) and (M) (The National Working Group on on Interpretation in Health Care, June 10-11, 1994/ May 17-19, 1998,[Attendance list]). By attending these conferences, the initial members of MMIA expanded their professional network beyond state and even national borders. Major foundations, including the Robert Wood Johnson Foundation (Isaacs & Colby, 2012) and the Commonwealth Fund (Youdelman & Perkins, 2002), helped stakeholders publicize the status of medical interpreting services at major hospitals nationwide, interpreting courses available, and the laws in each state (e.g., The National Health Law Program, 2006) by funding large-scale field research at an

early stage. Based on this work, stakeholders could craft strategic plans to improve the situation. From this type of fundamental data, stakeholders, who were previously isolated from each other, could initiate mutual contact and expand their network from the local to the national level. At a time when the Internet was not as developed as it is today, this type of information helped aspiring interpreters find courses that were available and employment as well.

Recently, foundations seem to be at a crossroads as stakeholders. While they remain interested in language issues and support medical interpreting, once they start to focus on another issue, they change the recipients of their grants. The recent downturn in the financial environment has also affected grants, according to Informant (J). CHIA had been funded by the California Endowment since its establishment in 1994, but such financial aid has recently been stopped because the California Endowment has moved its focus to other health care issues (Personal communication*¹⁵, October 2012/ January 17, 2013).

Another example is that the National Conference on Quality Health Care for Culturally Diverse Populations, organized by the Resources for Cross Cultural Health Care (RCCHC, now DiversityRx) since 1998, expects to receive support from fewer foundations in the future for similar reasons (Personal communications*¹⁶, December 5, 2013).

5-3. Roles of Professional Medical Interpreters Associations

Sociologists have provided some insights into the development of various professional associations. According to them, a group of people practicing skill-oriented services based on specific trainings developed into a professional association. It sets a minimum fee or salary and establishes a professional code of ethics and minimum qualifications to distinguish those who qualified with those who are not qualified and advocates for higher status (e.g., Carr-Saunders & Wilson, 1933). OHTs accounts support these sociologists' insights. Professional medical interpreters associations have emerged under similar circumstances, have established professional standards, and have taken the initiative in advocating the profession.

Medical interpreters developed a strong sense of professionalism after facing frustration over their lack of professional status. First, while the federal law has been consistent in ensuring "meaningful access to [medical interpreters] by LEP persons" (Federal Register/Vol.76, No.74 (2011, Monday, April 18)/Notices, p.21758), it does not support professional status for medical interpreters for a lack of federal certification testing system. For example, the Policy Guidance issued on April 18, 2011 states, "Competency to interpret, however, does not necessarily mean formal certification as an interpreter, although certification is helpful" (p.21762). The driving force for achieving professional status was the professional associations composed of medical interpreters themselves, who were determined to have their professionalism properly recognized. To achieve this, they turned to advocacy as recalled by several OHTs especially those who had established these associations.

Second, medical interpreters knew other interpreting professions had been recognized. Sign language interpreters, for example, with whom they worked as colleagues at the same hospitals, had been certified through national certification testing and earned more than medical interpreters, leading medical interpreters to question why their status was lower than others doing the same work at the same hospitals.

On the other hand, the professional status of court interpreters had been secured by the Massachusetts state government in 1986 [as Ernest Winsor, Esq., from Massachusetts Law Reform Institute described “the bill went [requiring professional interpreting services in the trial courts] went through in one year and was signed by Governor Dukakis as Chapter 267 of the Acts of 1986” (The Massachusetts Medical Interpreters Association, 2002 [Newsletter], p.2; See also Section 2 of General Laws Chapter 221C^{*17}). In addition, at the federal level, court interpreters have been federally certified since 1978 with the enactment of the Court Interpreter Act, Public Law 95-539 (González et al., 1992). The difference in status with these two other interpreting occupations (i.e., sign language and court interpreting) was likely considered a type of discrimination and the frustration of medical interpreters increased. Their demands intensified after the state law on court interpreting bill was signed in 1986 (The Massachusetts Medical Interpreters Association, 2002 [Newsletter], p.2) and they observed how court interpreters gained better working conditions and more job opportunities. There is no evidence that (R), the first president who passed away in 1995, was inspired by the state court interpreting law to call on the group’s

other original members to start meeting, but it may be meaningful that MMIA was founded in 1986, the same year as the court interpreting bill was signed.

According to OHTs 1, 2, and 3, the same advocacy group which had helped enact the state court interpreting law approached (R). From that group, they learned how to achieve critical mass in order to take action and how to use legal language. This study shows that, regardless of the time and place of formation, professional medical interpreters associations collaborated with members or groups expert in the legal field. The medical interpreters' role was to provide detailed cases of language and cultural barriers to these legal experts for use in convincing policy makers of the importance of medical interpreting as recited by OHT 3. Their strong sense of professionalism has been expressed by OHTs. They were frustrated that professionally trained medical interpreters were treated the same as untrained staff or volunteers by hospitals. Regardless of which association they headed, the leaders all expressed their frustration over a lack of professional status. Their comments represent their intention to distinguish professionally trained and competent medical interpreters from untrained and incompetent ones. OHT 19 argued that without an official and uniform definition of competency "professional medical interpreters could be concerned over the possibility of seeing unskillful interpreters damage the professional image". To medical interpreters duly trained and currently practicing, the difference (i.e., between trained and certified interpreters and un-trained and u-ncertified ones) in technique, ethics, and skill seems to be quite clear, although it might not be so to outsiders.

It is worth noting that certification testing systems have been set up as a result of the bottom-up approach by professional medical interpreters associations and groups. In 2002, 12 representatives from three organizations met to plan for pilot testing of certification as reported by MMIA (See also, The National Council on Interpreting in Health Care^{*3}, History).

“EXCESS OF GOOD, LACK OF ACCESS, BRING AXIS MEMBERS TOGETHER
[Captial letters as original title]

In what will surely come to be considered a milestone in the history of health care interpreting, on the weekend of February 2nd and 3rd, 2002, MMIA, the California Healthcare Interpreters Association (CHIA), and the National Council on Interpreting in Health Care (NCIHC) met in Boston for the express purpose of pushing forward the issue of certification for medical interpreters” (The Massachusetts Medical Interpreters Association [Newsletter], 2002, Front page).

Although it took time before they were ready to build a testing system in 2009, the approach in the United States seems very mature compared with other countries such as Norway. Norway set up a certification testing system, but skipped fundamental steps such as providing education in interpreting skills, developing a curriculum of specific knowledge, and training experts to evaluate aspiring interpreters. This led to “the enormous rate of failure on the NICE [the Norwegian Interpreter Certification Examination] (85%) as well as the high costs of arranging the exam, many critics have argued” (The University of Oslo, Department of Linguistics, Interpreter Certification Project [Report], 2001, December, p.5). In contrast, in the United States, there are two certifying bodies (i.e., the National Board of Certification for Medical

Interpreters, NBCMI, and the Certification Commission for Healthcare Interpreters (CCHI)]. NBCMI has already certified over 800 interpreters since 2009 and is still increasing the number of applicants and the number of languages tested (Arocha, 2013, March [Presentation]).

Professional medical interpreters associations have been involved in the development of standards and rules required for competent medical interpreting. Who other than practitioners could have done so from scratch and how could this have been done without forming a sizable group to exchange perspectives stemming from different professional careers, cultural, social strata, and educational attainment, among other factors? Professional medical interpreters associations and/or groups have taken the initiative to improve the technical levels of their members. For example, the training video (the Bilingual Medical Interview, 1987) was developed by a team composed of the Boston City Hospital, the Boston University, the Department of Health and Hospitals, Boston, and the Boston Area Health Education Center. On this video, (G) and (R) played a role of a monolingual physician and an interpreter respectively. This video clearly shows that the best practices in 1987 were different from what is taught today. On this video, medical interpreters didn't use "the first person^{*13}" in speaking and didn't encourage direct communication between physician and patient. According to the accounts of OHT 1, "the first person^{*13}" usage was added later. These technical changes have been made based on the knowledge of the founders as well as other pioneering interpreters who formed professional associations in the early days.

Another role for professional associations was providing opportunities for networking. At a time when online networking was limited, organizing events was an effective way to bring together stakeholders with similar interests (Takesako & Nakamura, 2013). Just by mentioning a key phrase, such as equal opportunity for LEP patients while attending these events, they could discuss with the state agencies working on behalf of refugees and immigrants. Association conferences and events attracted stakeholders working for medical interpreting or concerning about it for discussions on how to develop the profession. Although the motivation to promote medical interpreting varied among stakeholders, such events served as starting points for future strategic discussions (e.g., Chang & Fortier*¹, 1998; the Massachusetts Medical Interpreters Association, 1996/2000/ 2002,/2003/2004,/2005/ 2006 [News letter]).

Professional medical interpreters associations organized annual conferences and mutually invited and made presentations at national and even international conferences in order to be visible at the national and international level (The Massachusetts Medical Interpreters Association, 1997-2013 [News letter]). Leading figures from professional associations and the medical interpreting industry, including OHTs 1, 2, and 3, and Informants (J), (K), (L), (M), and (P) met at a series of conferences sponsored by the W. K. Kellogg Foundation between 1994 and 1999. These meetings were co-organized jointly by the Cross Culture Health Care Program (CCHCP), a Seattle based non-profit training course, and the Society of Medical Interpreters (SOMI) under the leadership of (P) to enable key players to meet and discuss common issues to advance the profession (The Cross Cultural Health Care Project, 1994).

Among technical issues, the most critical one was the definition of roles [specific roles: conduit, clarifier, cultural broker, advocate, See Bridging the Gap, A Basic Training for Medical Interpreters, 40 Hours for Multilingual Interpreter Groups, Interpreter's Handbook, Third Edition, January 1999, p.18-22, the Cross Cultural Health Care Program). It took six years for the discussions to end after starting in 1994 (Avery*¹⁰, 2001). Interpreting style, positioning, models, modes, and technical and ethical rules sometimes seem like things that should have been developed through a simple procedure. Now established, they are taken for granted by today's medical interpreters, including myself, when they are taught during training courses. However, the accounts by OHTs have changed my assumption totally. Most of the standards we now benefit from are the legacy of a long and tough process taken by several professionals who represented different associations. Without the involvement of such professional associations, medical interpreters' roles could have not been properly defined. As these OHTs and Informants (M) and (P) recalled, opinions on role definitions were clearly divided among the attendants of these conferences. But without such opportunities to meet, role definitions could have been narrowly drawn or ineffective for practical use.

5-4. Roles of Immigrants and Refugees

Except for those already fluent in English, immigrants and refugees generally started their new lives as recipients of medical interpreting services. Soon after entering the United States, some of them started to help their LEP family as a child interpreter or help newcomers as a volunteer in ethnic communities, according to

OHTs 6, 10, and 27. Upon acquiring a minimum knowledge of English, some started to work for Mutual Assistance Associations (MAAs^{*14}) or Voluntary Resettlement Agencies (VOLAGs^{*14}). For example, the Catholic Charities, a large VOLAG^{*14}, established its interpreting pool in 1986 (See Table 3.), and some OHTs worked as community interpreters before working as medical interpreters for MAAs^{*14} or VOLAGs^{*14}, as recalled by OHTs 1, 2, and 5. In this way, a few of them eventually chose medical interpreting as a profession. In other words, they were on the patients' side at first, and later learned, little by little, the challenges and rewarding nature of interpreting through formal or informal work. When they found it meaningful or worthwhile, they shifted their stance to becoming a kind of cultural interface between patient and physician, according to OHTs 7, 10, 12, 13, 18, 19, 25, 27, 28, and 29.

They had several possibilities regarding work after achieving some degree of command of English. They could have chosen other jobs, but some decided to work as interpreters. From the two types of interpreting professions most in demand by society, medical interpreters chose the one they thought more human than being a court interpreter. As found previously in Section 4-2-3., Perspectives on the Profession, many OHTs spoke about the humanity of the profession in comparison with court interpreting. OHT 3 clearly differentiated them, saying "in court cases, everybody fights the other party, there is a conflictive kind of relationship, whereas in medical sessions, there is a completely different atmosphere, everybody is working for the same goal: helping the patients." OHTs 8, 10, 20, 21 and 26 shared the same view. And for people new to the country, a job that respected their ethnicity would have been attractive. As many OHTs said, they would be thanked by both patients and

physicians. Although they had to take courses to become medical interpreters, they could feel positive about spending money, time and energy to acquire the skills and knowledge to become medical interpreters.

Since the 1970s, a huge influx of immigrants and refugees to the United States has caused problems in local communities. In Los Angeles, around 1983, the media reported, “Just absorbing hundreds of thousands of immigrants, all at once, would be a tough enough task for the overburdened overlapping local governments. (For example, of L.A.’s 550,000 schoolchildren, 117,000 speak one of 104 languages better than they do English—including 35 kids fluent only in Gujarati, a language of western India.)” (Kurt, 1983, June 13, p.20). Physicians demanded information on how to deal with these patients and the Western Journal of Medicine, which covers 14 states, released special issues in 1983 (The Western Journal of Medicine, 1983) and 1992 (The Western Journal of Medicine, 1992) exclusively focused on how to deal with LEP patients. Some articles referred to “curanderismo”, a diverse folk healing system (Maduro, 1983). Others referred to the preferred way of Ethiopian patients to disclose terminal illness, saying, “Being sensitive to patients’ worldviews may reduce the frustration and conflict experienced by both refugees and American physicians” (Beyene, 1992, p. 328). Just reading these articles was not enough to diagnose these patients. Unless it was explained to physicians how these patients see diseases and their causes, and how they described their symptoms, the doctor would have found it difficult to diagnose them. As candidates for being a cultural interface between physicians and patients, immigrants and refugees were the best choice for interpreting in cross-cultural interviews.

Immigrants and refugees find their cultural knowledge and language skills helpful both in starting a new life on their own and assisting others in need by serving as a cultural broker. They are expected to be more efficient than those without such specific ethnic origin. They work to help medical professionals understand cultural complexities and help patients understand Western medicine. As described by several OHTs, they interpret the cultural meaning of what patients describe or do not describe.

In this way, their participation in the development process of medical interpreting has diversified linguistic and cultural coverage in the United States. The total of 29 OHTs cited in this study speak 25 languages and come from 20 different countries. Their experiences as refugees have provided additional knowledge on mental health interpreting. A typical example of their value is the participation by OHTs with immigrant and refugee backgrounds on the committee of the Standards of Practice (The Massachusetts Medical Interpreters Association & Education Development Center, Inc., 1996/2007). OHTs recalled how former refugees from Asian countries shared experiences of atrocities in their home countries, and their voices enabled the document to incorporate ideas from different perspectives. Their knowledge on mental health has been passed from them to others. For example, in ten years, OHT 25 who used to work in marketing learned the knowledge upon layoff after the September 11 attack, and became a pioneering medical interpreting specialized in in mental health by taking advantage of her family's cultural diversity. They have also added flexibility to technical rules, preventing the standards from becoming too rigid and allowing exceptions by paying attention to the diversity in perspectives on health care beliefs.

5-5. Perspectives on the Profession

During the interviews, many OHTs voiced their preference for the medical interpreting profession by comparing it with other interpreting professions. With a general objective in mind, this study does not focus on the perspective of individual medical interpreters, just outlines their comments, and refers to visibility. Angelleli concluded, “Medical interpreters perceived themselves as being more visible than court or conference interpreters” (Angelleli, 2003, p.26). In this study, OHTs acknowledged their visibility in medical settings. They felt happy when they were thanked by patients because OHTs considered patients’ gratitude as a token of their contribution. OHT 8 described, “*The patients are really grateful and appreciate that medical interpreters can be there for their services. And they are not nervous.*” These rewarding moments have kept them working as medical interpreters as several OHTs recalled. They have not shifted to other interpreting professions. OHT 27 from Laos exemplified, “*Medical interpreting is more human. Sometimes, computer responds and corrects, but Hmong people, humans give happy responds or angry responds, you have to feel the emotions, you feel mad, except really not, they are really there, the doctors and nurses are really mad, you can feel their anger or frustration, yeah, it’s difficult but also rewarding.*” For example, compared to conference interpreters, who are within the booth without a direct contact with the audience, medical interpreters have direct encounters with two parties (i.e., physicians and patients). OHTs perceived their intervention as positive assistance for two parties. MMIA’s logo with three squares vividly represented their three-party perspectives as recalled by MMIA’s founders.

With their comments in mind, professional bifurcation should hinge on whether candidates for interpreting professions like human nature, what many OHTs described, or in other words, visibility, or whether they don't like it. This study found OHTs felt stress and dilemma in terms of interpersonal relationship between two parties, however, those who have kept working should have felt positive in obtaining better outcomes by making themselves visible through their interventions. OHTs recalled how they had been serving as patients' cultural brokers and/or patients' voices. OHTs compared their profession with court interpreting and most of them described that medical interpreting was more human than others and that was why they preferred this profession. Medical interpreters can see their results immediately from changes on facial expressions of patients. These moments have kept them feeling their visibility. For example, LEP patients thank for intervention by medical interpreters just because patients feel grateful for their assistance as recognized by most OHTs. They liked to help patients in need of language services and considered their work indispensable and rewarding as team members of healthcare. Some considered it as their vocation. Many believed that medical interpreters work toward the same goal as other medical professionals, in clear contrast to their perspectives on court interpreting. Some OHTs worked as court interpreters, but disliked the conflict of court settings. Other OHTs worked not for money but for the satisfaction of helping people in need.

5-6. Motivations

The oral history method allows researchers to determine people's motivations by encouraging targets to recall and speak about unforgettable moments in their life, family relationships and relevant memories, and even feelings (Yow, 2005). Since the

general objective of this study is to figure out the development of medical interpreting in the United States, the motivation of individual interpreters does not seem to be directly relevant. But the findings are worth paying attention to because the oral history method encouraged them to voice personal episodes that would otherwise remain hidden. With this in mind, I would like to share some of the findings (For detail, see APPENDIX: Oral Histories and Profiles of 29 OHTs). This study found OHTs were motivated so strongly that they chose to work as medical interpreters despite the possibility of working in another interpreting profession. A typical example is a comment made by OHT 8 when I asked why she didn't return to her former profession of nursing. She answered without hesitation that "because if you will work only to make money it would be hard, but if you think those people need help, we help them". Their motivations were varied. For example, OHT 5, a refugee from Cambodia, was motivated to help other refugees, while OHT 6, an immigrant from Guatemala, was motivated to provide interpreting services to others with dignity and respect, and OHT 7, an immigrant from Panama, was motivated to provide language services to pregnant women because of her own traumatic experience. In contrast, OHTs 15, 24, 25, and 27 wanted to change their previous jobs and found medical interpreting as an avocation or vocation. Although this study does not focus on their motivations, their oral history accounts commonly showed the strong possibility that their individual motivation kept them working hard despite challenging issues arising from time to time and a lack of professional status compared with other interpreting professions.

5-7. Limitations

This study has several limitations. First, the targets are limited to medical interpreters who currently work or used to work at hospitals. Further study has to be conducted with a focus on freelancers and those who work at other medical institutions. Second, among stakeholders, most of those that were analyzed were physicians who work at hospitals. Further study should focus on private practitioners and other medical professionals (e.g., nurses) who have been working in medical settings. Third, qualitative research should focus on stakeholders other than medical interpreters to broaden the scope of analysis, because this study has only collected the perspectives of medical interpreters.

Table 2. Federal and State Legislations regarding Immigrants and Refugees

Year	Federal laws
1946	The Hill Burton Health-Facility
1957	The Civil Right Act of 1957
1964	The Civil Rights Act (Title VI)
1965	The Immigration and Nationality Act The Voting Rights Act of 1965
1968	The Fair Housing Act of 1968
1973	The Comprehensive Employment and Training Law The Rehabilitation of 1973
1974	Supreme Court, in <i>Lau v. Nichols</i> , 414 U.S. 563(1974)
1978	The Court Interpreters Act
1979	The Gateway Cities Assistance Act
1980	The Refugee Act of 1980
1985	The Fish/Wilson Amendment to the Refugee Act
1990	The Minority Health Improvement Act The Americans with Disabilities Act of 1990
1994	The Civil Rights Commission Amendments Acts of 1994
1995	The Immigration Act
1996	The Illegal Immigrant Reform and Immigration Responsibility Act
1998	The Guidance Memorandum issued by OCR*
2000	Executive Order 13166 The Policy Guidance

Note:* The Guidance Memorandum was issued by the Office for Civil Rights on January 1, 1998.

Table3. The Massachusetts State Legislation and Emergence of Voluntary Resettlement Agency (VOLAG^{*14}), Mutual Assistance Association (MAA^{*14}), and other advocacy organizations

Year	State Laws and Guidelines	Ethnic Organizations and Advocacy Organization
1903		-The Catholic Charities ^{*1}
1915		-The Jewish Family Services ^{*1}
1918		-The International Institute of Lowell ^{*1}
1963		-Greater Boston Chinese Cultural Association ^{*2}
1970		-The Massachusetts Alliance of Portuguese Speakers (MAPS)
1973		-La Alianza Hispana -The Lawyers' Committee for Civil Rights -The Barbell [I] Coalition
1979		-The Cambodian Community of Massachusetts ^{*2}
1984	Executive Order No.229 by Gov. Dukakis	-The Vietnamese American Civic Association ^{*2} (VACA) -The Cambodian Mutual Assistance of Greater Lowell
1986	The Court Interpreter Law ^{*17}	-The Massachusetts Medical Interpreters Association (MMIA) -The Catholic Charities' Medical Interpreting Service -The Ethiopian Community Mutual Assistance Association ^{*2}
1987		-The Barbell (II) Coalition -The Massachusetts Immigrant and Refugee Advocacy Coalition (MIRA)
1989	The Determination of Need (DoN) program for medical interpreting system planning ^{*3}	-The Barbell (III) Coalition -Haitian American Public Health Initiative(HAPHI)
1991		-The Russian Community Association of Massachusetts (RCAM) -Chinese American Christian Community

		Services, Inc.
1992		-Bosnia Community Center for Resource* ² Development (BCCRD) -Tibetan Association of Boston* ²
1993		-Somali Women and Children's Association* ² -African Initiative for Community Development, Inc.
1995		-Somali Development Center* ²
1996	Acute Hospital Request for Application (RFA) process Welfare Law on Immigrants	
1998		-Universal Human Rights International
2000	Emergency Room Interpreter Law (ERIL)	-African Assistance Center (AAC)* ²

Note:

*1: Voluntary Resettlement Agency (VOLAG), voluntary agencies who resettle refugees and provide for their basic needs during the first month after arrival in the U.S. For detail, see (p.11)

<http://nnaac.org/wp-content/uploads/2011/09/refugee-case-management-manual-Mass.pdf>

*2: These organizations are officially called Mutual Assistance Association (MAA), a non-profit community –based organization, and the Office of Refugees and Immigrants of the Massachusetts government provide grants to support their work including translation and interpreting to help resettlement. For detail, see <http://www.mass.gov/eohhs/gov/departments/ori/ori-programs-/maa.html>.

*3: The first DoN was established by the legislature in 1971, but in this study refers to the DoN issued in because it relates to interpreting services. For detail, see <http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/ohp/don/>

CHAPTER SIX:

CONCLUSIONS

This study highlights the coincidence of the influx of immigrants in the 1970s and the introduction of informed consent as a standard practice due to a series of malpractice cases across the country. Together, these two factors caused physicians and medical professionals in general to give importance to medical interpreting.

State governments have varied in their language policies, and they all implemented measures at their discretion. OHTs recounted that the enactment of laws created jobs for them and led society to recognize their professional status to a considerable extent. However, the legal status of medical interpreters has not been secure enough in that the laws stipulate that LEP patients must be able to secure meaningful access to health care, however, it does not state they should be provided with professional interpreters. United States' policy allows hospitals to use not only professional medical interpreters but also bilingual staff, volunteers or anyone if they are competent to interpret.

Physicians played an important role in conducting studies that encouraged policy makers, government agencies, and foundations to promote medical interpreting. OHTs referred to specific physicians who worked closely with professional medical associations to help enact state laws regarding medical interpreting, who helped medical interpreters isolated in the early 1990s discuss common issues through a grant from foundations, or who supported medical interpreters at work. The positive stance of

physicians helped medical interpreters secure status as members of the health care team. Some foundations which questioned ethnic disparities in health care outcomes played an important role in funding demonstration projects of medical interpreting and large-scale surveys or research. The development of medical interpreting in the United States is characterized by the positive involvement of foundations as financial supporters.

Professional medical interpreters associations played an important role as advocates for the profession. For the lack of federal certification system, they created own certification testing system. Their bottom-up approach deserves particular attention. They have taken the initiative in overcoming technical issues by gathering hands-on knowledge from practitioners. They have served as clearinghouses to disseminate crucial information for newcomers to the profession. They have developed standards such as the code of ethics and standards of practice to ensure good practice. All the technical groundwork was established by them.

This study discusses several factors behind the development of medical interpreting services: Legislative framework, civil empowerment, medical interpreting associations' initiative in publishing standards, advocacy movements, and collaboration with multiple stakeholders. This multiplicity of factors has produced the synergy needed to promote the social status of medical interpreters in the United States. This study provides a new perspective by analyzing chronologically the stories of 29 medical interpreters, covering the time from the inception of the profession to the present day. Their subjective accounts identify not only stakeholders who promoted the development

process, but also the challenges that medical interpreters have faced at work. This study expects to serve as a lesson for many countries searching for ways to establish a system of medical interpreting as well as for Japan, where people are just starting to call for building a system that takes into account the many and diverse issues that interpreters face.

NOTES:

- ¹ In addition to the literature review, relevant information has been obtained through interviews with Ms. Julia Puebla Fortier, Executive Director, DiversityRx(former Resources for Cross Cultural Health Care), on January 1, April 11-12, June 12, November 15, 2012, December 5, 2013, and February 3, 2014.
- ² In addition to the literature review, relevant information has been obtained during the presentations: One was titled, Interpreter Certification: Minimum proficiency or Sign of Mastery, co-presented by Ms. Cynthia E. Roat, MPH at the 10th Annual National Conference on Medical Interpreting on November 11 and 12, 2006, organized by the Massachusetts Medical Interpreters Association at Massachusetts, USA. The other was presented by her at Osaka University, Osaka, Japan, on June 18, 2008.
- ³ The National Council on Interpreting in Health Care*¹ (NCIHC; see <http://www.ncihc.org/history>) does not have the word, 'Association' on its name, however, I consider it as a professional association for the following reasons:
 - 1) See page 95, "Sociologists have provided some insights into the development of various professional associations. According to them, a group of people practicing skill-oriented services based on specific trainings developed into a professional association. It sets a minimum fee or salary and establishes a professional code of ethics and minimum qualifications to distinguish those who qualified with those who are not qualified and advocates for higher status (e.g., Carr-Saunders & Wilson, 1933)." I follow this definition in this study because NCIHC has established the standards, and has been working, for example, to distinguish qualified and un-qualified interpreting practices and/or interpreters and has been advocating for the profession by stating political statements as well as by reporting for the purpose.
 - 2) In my study, OHT 4, who was NCIHC's treasurer, recalled its initiation, "*That group spun off to form the National Council (NCIHC). It is like a policy making think tank. It's a group of people who want to create a policy and standards.*" Other OHTs also recalled how this group has collaborated with other medical interpreters associations to promote medical interpreting. In addition, my literature review indicates several of NCIHC, especially the founding members, belong to other associations.
 - 3) Given that the objective of my study is to analyze the development of medical interpreting, I include, in this study, NCHC as one of the key professional associations which have shaped development of medical interpreting in the United States based on my finding from OHTs' oral histories.

- ⁴ Nikkeijin, “refers to descendants of Japanese who emigrated abroad. In the context of the issue of foreign workers in Japan, however, the term Nikkijin especially indicates South American-Japanese descendants up to the third generation and their spouses. Such Nikkeijin are mainly those from Brazil, Argentina and Peru” (Sellek, 2001, p.230).
- ⁵ Relevant information also has been obtained in communication with Dr. Hans Verrept, Intercultural Mediation & Policy Support Unit., FPS Health, Food Chain Safety and Environment, Belgium, during the conferences such as IMIA 2008(October 10-12, 2008, Boston, MA, USA), on the Critical Link 6(on July 26-39, 2010, Birmingham, UK), and IMIA 2013(January 18-20, 2013, Miami, FL, USA).
- ⁶ The same information was also obtained during the the field research at a Taiwan’s NPO for community interpreting, named 台北市賽珍珠[Pearl Buck]基金会 on April 11, 2012. The information on the Fu Jen Catholic University’s new initiatives has been obtained directly from Dr. Chen-shu Yang, Professor, Director, Graduate Institute of Cross-Cultural Studies since I visited her in 2012.
- ⁷ The information obtained from Dr. Diane Levin-Zamir, then the National Director, Department of Health Education & Promotion, Israel, upon speaking with her at the WHO’s conference, 2010 in Taipei, Taiwan (the 55th HPH Newsletter was drafted by the Vienna WHO-CC for Health Promotion in Hospitals and Health Care international conference on health promotion in April, 2012).
- ⁸ In addition to the literature review, the information and relevant papers were obtained from Dr. Joseph Kaufert, Professor, Department of Community Health Sciences Manitoba First Nations Centre for Aboriginal Health Research, Faculty of Medicine, Adjunct Professor, Dep. Anthropology, University of Manitoba, Canada, Unit, Faculty of Medicine, University of Manitoba, Canada. He accepted interviews by phone on February 13, 2013, and have sent mails to me since then (on March 7, 8, 26,27, April 8, 9, June 28, 29, and July 9, 2013).
- ⁹ In addition to the literature review, the information and relevant materilas were obtained from Dr. Robert W. Putsch who accepted interviews by phone on March 16, 2013, and have sent mails to me with attachements since then (on March, 19, 23, 24, 25, 29, April, 4, 5, 19, 23, May 6, 15, June 3, and 4, 2013). These materials served me as crucial information to trace back to the inception of medical interpreting in the United States as well as Canada and Belgium.
- ¹⁰ In addition to the literature review, the information and relevant materials were obtained from Dr. Maria-Paz Beltran Avery whom first I met in 2008 in Boston, USA. She accepted an interview by phone and exchanged mails with me (on August,

25/28/31 and October 7, 2012). In addition, she lent the videos “the Bilingual Medical Interview, Part I & Part II” to John Nickrosz who made a copy and provided it to me when I had an interview.

- ¹¹ When I started this study in 2006, I missed one of the four founders of MMIA, Raquel Cashman, because she had already passed away in 1995. Another founder (OHT 3), who had been missing since 1998, was localized with a help of another founder (OHT 1) and I could glean valuable witness accounts from OHT 3 as one of the participants in the legislative movement to enact the first state law of medical interpreting in 2000, the Emergency Room Interpreters Law (ERIL) in the state of Massachusetts, which motivated other states to craft similar state laws. Another interviewee (OHT 2) whom I conducted the first interviews in 2010 retired in 2013 and I have lost his trace. Another individual (O), a lawyers’ group leader for the enactment of ERIL, I finally searched for his whereabouts thanks to OHT 1, however, (O) could not accept my interview for poor health. Under these circumstances, this study provides valuable resource for future studies.
- ¹² I contacted Mr. Gudalupe Pacheco, M.S.W., Senior Health Advisor to the Director, Office of Minority Health, Office of Assistant Secretary for Minority Health, U. S. Department of Health and Human Services while IMIA 2013 Conference, Florida, USA, and had an interview with him on February 7, 2013. He sent me his resume. He provided crucial information also on his family and ethnic background.
- ¹³ For example, the ‘third person method’ is when the doctor says something, the interpreter interprets, “The doctor asks you[the patient] when did you feel the pain.”, by saying the third person subject of the sentence [the doctor]. With contrast, the ‘first person method’ is just to say , “Did you feel the pain?” For today’s best practice the first person method is used.
- ¹⁴ See the definition and acronym of Mutual Assistance Association (MAA) : “Ethnic-based associations that galvanize ethnic community support for resettlement and provide services to refugees”. Voluntary Resettlement Agency (Volag[VOLAG]): National voluntary resettlement agency that has entered into a grant, contract, or cooperative agreement with the Department of State or other appropriate federal agency to provide for the reception, initial placement and resettlement processing of refugees in the United States” (see Glossary and Definitions of Health and Human Services, <http://www.mass.gov/eohhs/gov/departments/ori/glossary.htm>).
- ¹⁵ The information was obtained from Ms. Rosanna Balistreri, the Board President of CHIA in 2010 and 2011 when I met her at IMIA annual conferences in Boston and Florida, USA.

- ¹⁶ The information was obtained from Ms. Julia Puebla Fortier, the Executive Director of Resources for Cross Cultural Health Care (RCCHC), also known as DiversityRx, when she gave a lecture at Osaka University, Osaka, Japan in 2013.
- ¹⁷ Section 2 of General Laws Chapter 221C, states, “A non-English speaker, throughout a legal proceeding, shall have a right to the assistance of a qualified interpreter who shall be appointed by the judge...” Retrieved from: <https://malegislature.gov/Laws/GeneralLaws/PartIII/TitleI/Chapter221C/Section2>.

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APPENDIX:
Oral Histories and Profiles of 29 OHTs

I now introduce oral history one by one. Before presenting them, I explain format structure of oral histories. Each OHT's number is described in the upper right, followed by the name, country of origin and languages. A mother tongue or native language is underlined. Next, profile, then oral history goes. At the end, Field Note complements the story by adding some information on my relationship with each OHT and annotations which deserve specific mention from perspectives not directly related to the objectives. Within the quotes, some names have been referred to, but all the names of other than OHTs are withheld and described with an alphabet followed by relevant explanation. In order to respect their speech (i.e., conversational tone or proper style), their expressions have been kept untouched as much as possible once they finally edited the draft although some quoted sentences might not seem grammatically correct.

Oral History Teller, No. 1

Name: Jane (Crandall) Kontrimas

Country of Origin: U.S.A.

Language: English, Russian

Profile

Jane (Crandall) Kontrimas was one of the 4 founders of MMIA. She has been recognized as one of the earliest staff interpreters by the medical interpreting industry and also respected as an instrumental figure in developing important documents such as MMIA Code of Ethics, the first of its kind in the world (Crandall & Nielson, 1987). She chaired the committee of the Standards of Practice for Medical Interpreters which was published in 1996 (The Massachusetts Medical Interpreters Association & Education Development Center, Inc., 1996/2007). She led the committee of certification until December 2007. She has been working as a medical interpreter in Russian language at the Beth Israel Hospital since 1979. Her current titles are Russian interpreter, Interpreting Training Coordinator and Interpreter Ethics Liaison.

Oral history

Her father was a Professor of Mechanical Engineering of the Massachusetts Institute of Technology and spoke French, Spanish and Russian. Her earliest exposure to other cultures was in France at the age of six when her father took a sabbatical semester.

I have a memory of going to school and at recess on the first day, they stood around me in a circle.... I couldn't say anything to them. [They were] looking at me, and I couldn't be sure whether they would be friendly or not. I was wondering... and they were looking...And the longer we stood there, the more un-comfortable...And then suddenly it occurred to me to sing a song! And I sang a song, a nursery song. "This old man, he played one, he played nick knack on my drum." Immediately I felt a difference...but I had certainly had in my real life experiences where the people around me did not speak my language; they spoke a language I couldn't speak.

Psychologists have researched children's developmental process and found mothers' attitudes influenced children's positive attitudes (Pomerantz et al., 2005). What she

learned from her mother was to develop a human network as she phrased “learned with my mother’s milk.”

I saw my mother organizing many events at the kitchen table as I was growing up ...without even realizing I was learning a “life skill”....She [my mother] was interested in people, and I am sure that somehow some of my interest in how people communicate as an interpreter comes from her.

Her father took her to Moscow when he attended an international conference. After her return, she chose to work for a resettlement agency for immigrants from Russia. At the federal level, the Refugee Act of 1980 was enacted and masses of newcomers arrived in the nation (Waters & Ueda, 2007).

Older people cannot learn a new language in three months (maybe no one can) but older people had to see a doctor more often, and the hospital was faced with a lot of people, --but they couldn’t take care of them without communicating.

Jane recollected memories with her colleagues at the resettlement agency.

*When I worked at the Jewish Family and Children’s Service [a volunteer resettlement agency, VOLAG*¹⁴], three of us were hired as interpreters. We had just graduated from college and had majored in Russian. We worked full time and supported ourselves on our earnings. I found out when I submitted my taxes that year that I was considered below the poverty line! I suppose they saw it was paid volunteering. Actually one of them may have done it as a true volunteer.*

Jane liked most the assignments in medical settings among varieties of resettlement interactions. Thus she explored the possibility of working for healthcare sphere. In 1979, she was hired by the Beth Israel Hospital as the first staff interpreter. However, a new career was not easy at all.

Oh, it was very hard!! [with an accent on her voice] It was very hard to know, because first of all, I didn’t really know what to do, and nobody knew it. So, there was nobody who taught me or told me or showed me the way, so, I was learning as I went along. All of the things you have to learn...at the beginning, to use the 1st

person for example,... I didn't use the 1st person at first..., it didn't occur to me. It was later someone [a Spanish conference interpreter] told me about that and I began to use it. And I found it was much better that way.

She reported on how other hospitals established interpreting services in the state of Massachusetts.

There were several hospitals in the greater Boston area: Each had its own language specialty, based partly on the prevalence of patients who spoke a particular language in the geographic area, and partly on where the interpreters were. For example, in 1979 & 1980 the Beth Israel Hospital had a Russian interpreter on staff (me), while two blocks away the Brigham & Woman's Hospital had a Spanish-speaking interpreter on staff. Not surprisingly, the Russian-speaking patients usually came to the Beth Israel Medical Center and the Spanish-speaking patients usually went to the Brigham & Woman's Hospital.

In the late 1970s, newly arrived Jewish refugees were supported for the first several months in studying English, taking vocational training, and job hunting by resettlement agencies outsourced by the federal government and by volunteers from the ethnic communities. These volunteers used their own skills to help newcomers. Physicians provided free medical services, and English as a Second Language (ESL) teacher volunteered to teach English to older immigrants. In 1979, the Council of Jewish Federations (CIF) and the federal government established a fund providing a system through which the Comprehensive Education and Training Program (CETA) assisted refugees' study and vocational trainings (Kazis, 2002). Under these circumstances, Jane thought of training a pool of volunteers from CETA program to help patients (Gold-Gomez, 2003).

Despite volunteers' help, the workload was so great that she had to find a way to cope with stress at work.

People don't think the interpreters deal with complicated emotional situations, but THE FACT IS YES, YES, YES[Capital letters are as written by OHT 1]! But when I

began,... probably I didn't have much life-time experience either being just out of college...so meeting for supervision with a social worker a few times was very helpful.

While Jane worked, she always questioned what was appropriate behavior in interpreting situations. To answer to these ethical questions, Jane co-authored MMIA Code of Ethics for Medical Interpreters with (I), the first ethical code in medical interpreting field (Crandall & Nielson, 1987). After developing MMIA's Code of Ethics, she started to work on other standards, too.

I got interested in the Standards of Practice because when I started working I would go to an appointment, and I would do something, but if it didn't work, I would think "what would have been a better way to handle a situation like that?", and ...so I was doing something, but I was not sure it was right and I would think...what I can do better?

Asked about her perspective on medical interpreting, Jane explained.

I can't say anything about the courts setting, but I believe the interpreter role is quite limited. In medical setting, we could do as much or as little as we wanted (at first) as no one knew what we should or should not to. Physicians would ask us for advice, sometimes appropriately sometimes inappropriately. We had to figure out as we went along what was appropriate. Speaking as an interpreter, one of the things in common is we are all here for good healthcare for the patients.

Jane traced back to the first encounter with (R), one of the 4 founders of MMIA during a two-day training course for medical and mental health interpreter training programs organized in 1987 with a grant from the Massachusetts Department of Public Health and the Massachusetts Department of Mental Health.

(R) began working as a community organizer. I got a call from her. She had been thinking of gathering interpreters together, that was an idea I had been thinking about it too, but I hadn't done anything yet. She contacted the other people, I got the room and set up the agenda, and we met with a group of people,...that was the

very first meeting, of what later on turned to be MMIA.

Around ten participants gathered to exchange information and worked to organize some training courses. Gradually differences in opinion surfaced.

Some of us were frustrated at not being officially recognized, but we were more interested in getting interpreters for our patients, and training them to do a good job, and training ourselves too, and having agreement on interpreter role.

She talked about initial group members.

Each person had own focus of interest or action. Some were more interest in teaching and training interpreters, some were interested in focusing on patient access to health care. I was perhaps most interest in working out what the scope and boundaries of the interpreter role should be ideally.

For a certain period, the initial group members met informally and they shared experiences as she reproduced their typical interactions as follows:

“This is what happened to me” “Let me tell you what happened where I work” “How do you handle this?” “I had something similar”, “Let me tell you what happened where I work, and “but what’s the right approach to that?”

Their discussion was often troubled because members’ opinions were so diversified. The goal of creating the Standards of Practice (The Massachusetts Medical Interpreters Association & Education Development Center, Inc., 1996/2007) was achieved after (M), an expert researcher from Education Development Center, Inc. (EDC), joined the committee to put the committee on the right track.

(M) had some grants to work on starting the college program, and her project was somewhat parallel to what we were doing so, she created time, her own personal time for the Standards of Practice. We got together, we started to discuss and almost argue, although we had seemed to argue different points of view throughout the previous meeting, she combined it all into statements we could all agreed with.

The Standards of Practice (The Massachusetts Medical Interpreters Association & Education Development Center, Inc., 1996/2007) were the fruit of heated interactions, as recalled.

We were all passionate, so if we disagreed, it was never personal. It was like discussion of ideas, so we might disagree completely. But it was then we were all understanding all together.

MMIA promoted the Standards of Practice (The Massachusetts Medical Interpreters Association & Education Development Center, Inc., 1996/2007).

The MMIA presented some workshops on it, and several hospitals with teaching/training programs to acquaint staff, freelancers and per-diem working interpreters with the Standards of Practice.

In the mid-1990s, professional identity was not established, as she recalled a discussion at the first international conference of community interpreting in Canada, the Critical Link held in Canada, in 1995.

When they said community interpreters, they meant medical interpreters. In fact I think there may have been a discussion when some interpreter from the USA said “I’m not a community interpreter, I am a profession medical interpreter.”, and the other person said, “Well yes, that is what a community interpreter is, although it can also be a court interpreter, it is any interpreter who interprets for the non-dominant-language community.”

Field Note

I was first introduced to Jane (Crandall) Kontrimas by OHT 14, the Director of the Interpreter Services Program who introduced me by saying, “I am pleased to introduce you to our pioneering interpreter in 2006. She taught me to work as medical interpreter here”. OHT 20, personally introduced me to her and I asked for her participation in this study during IMIA Conference 2011. Since the interview in October, 2011, we have exchanged over 150 mails. She helped me tracing back to the inception of MMIA by finding OHT 3. In addition, she did her best to localize the leader (O) of the Barbel

Coalition I, II and III who didn't accept my interview for health reason. She helped me find documents and materials to support as evidence of MMIA's activities.

Oral History Teller, No. 2

Name: John Nickrosz

Country of Origin: U.S.A.

Language: English, French, Spanish, Portuguese, Haiti creole

Profile

John Nickrosz was one of the 4 founders of MMIA. When medical interpreting courses were scarce, MMIA's free courses were organized under his leadership. He collaborated with other members to produce video tapes to show real-life interactions in medical settings to aspiring members. He was instrumental in securing grants to organize conferences, training courses and events for MMIA's members' skill up and knowledge learning. He led MMIA in supporting legislative movement to enact a bill for interpreting service. He is a certified court interpreter and advocated for a myriad of refugees and immigrants since 1979. He was a member of the Massachusetts Department of Public Health's Refugee and Immigrant Health Advisory Committee. He has worked as a Coordinator or Director of medical interpreting services at the Boston City Hospital, now the Boston Medical Center, the Cambridge Hospital, the former New England Deaconess Hospital, the Tufts Medical Center, and others.

Oral History

John Nickrosz was born in 1938 in Lowell, a manufacturing city surrounding the Merrimack River in the state of Massachusetts. Lowell is situated thirty three miles from Boston, and known as the Mill City for its textile industries. He describes how he grew up in a multi-ethnic and linguistic family.

My family on my mother's side is French-speaking, my grandmother was from Canada, and my grandfather was born in Belgium. My father's parents were from Lithuania. My father was born in Waterbury, Connecticut and my mother in the Lowell.

The Franco-American community nurtured his sensibility to culture and language.

There was a sort of scorn for the way Canadians spoke French. People looked down on the Canadian French. I was affected by that. I've always wanted to speak standard French, that's why maybe I decided to study to become a French professor. I was twenty one when I went to France in 1961.

His enthusiasm for community work continued.

I spent a year in South America practicing Spanish. I was at the French Embassy

in Asuncion, Paraguay. I was tutoring the children of the French diplomats. After that I spent six months in Peru and did voluntary work while working on my Spanish. After that I spent three months in Venezuela and also did volunteer work there.

Looking back then, John voiced his feeling about previous job.

The sad thing is that I was not able to continue teaching literature which I enjoyed a great deal but I had wonderful experience in my new field [medical interpreting].

John found another position at a community based resettlement agency where immigrants from Colombia worked in Lowell which is known as a mill city which needed cheap labors.

I created a program in the Catholic Church in Lowell. I called the program the Multilingual Resource Center. We did immigration work, divorces and also provided interpretation. Most of the clients were from Colombia because there had been a great influx of Colombian weavers and mechanics to work in the textile mills.

John moved to Boston in 1984 to work as a social worker for the Department of Access at the Boston City Hospital.

(R), the founder of MMIA started to have a new interpreting department in Portuguese and then offered a new job of the Manager of on-calls, because we just had 8 hours before extended to 24 hours. And also there was another pilot program, where the interpreters company, doctors, medical professionals, she would ask me at times to interpret for Portuguese-speaking patients. There was an influx of Brazilian immigrants. I had married a Brazilian woman in Paris and learned Portuguese. Later she(R) asked me to become the manager of the on-call pool of interpreters that worked after hours.

John recalled how (R) gathered a group within the Boston City Hospital.

(R) collaborated with a medical doctor (G) in creating awareness among the young medical residents being trained at the Boston City Hospital. With (G), she worked on the famous videos [the Bilingual Medical Interview, Part I & Part II] which were conceived to educate health care providers to learn how to work with them effectively.

John saw her efforts to advocate for better payment of medical interpreters.

(R) advocated for and I think she was instrumental in getting the pay rate of freelance interpreters in healthcare institutions citywide, if I remember correctly, at the time, from \$10 to \$15 dollars per hour with a 2-hour minimum. As we know, the pay rate for medical interpreters continue to be woefully inadequate in comparison with that of court interpreters who are about to receive a significant pay upgrade here in Massachusetts.

John witnessed (R)'s negotiation with the management people.

(R) worked hard to get the pay rate of her own staff interpreters raised. Interpreters at the former Boston City Hospital belonged to the hospital worker union and were classified as clerical staff at the very lowest level.

Major hospitals with acute service departments had to provide interpreting services to those LEP patients because the Massachusetts State Department of Public Health issued guidance named Determination of Need process (DoN) in 1989 to deal with a huge influx of refugees.

There were a lot of Haitians, Haitians cape Verdeans, Latino people, a lot of Afro Americans, while there were a lot Russians immigration.

John compared the work as a medical interpreter with that of a court interpreter.

I like both, a lot people don't like court interpreting, but I think people who are involved in courts are often depressed because of the situations they are facing, so, there is something you can help people. You can help people, in the courts as well, because people are depressed because of the situations.

John described another episode in which he interacted more with a patient in need of help.

We went from the room to the procedure room, she [the pregnant woman] said to me, "I am so sad!", so, I had a chance and I told the team...so they interviewed her and that was the husband lost his job and then he stopped talking to her and then he was so depressed, And so, the team called her husband, and he got some help or something and so he started to come again, so and so, so moving. May be you can do something, you know? My job is to work as a part of the team, you know, if you see something, that you can pick and help the situation, you do it.

John traced back to the inception of MMIA.

(R) created a hospital-wide program, and that was giving courses and also started meeting with people and MMIA started to meet getting people together from different hospitals to talk about medical interpreting, to organize trainings and things like that. So she was very inspirational.

(R) asked him to be a secretary of MMIA and he prepared a document of incorporation to sign with other 3 founders, including (R), OHT 3 and 1. After (R) passed away in 1995, (K) became the second President, and, he became the third President of MMIA. By working for many courses, he developed training courses for MMIA's members. According to him, the three squares of MMIA's logo mark represented three parties; medical professionals, patients and medical interpreters.

John recalled (R) as a network builder.

(R) got involved in all areas that could affect the future of medical interpreting. As a member of the Massachusetts Department of Refugees and Immigrant Advisory Board, she was able to advocate the creation of hospital-based professional medical interpreter programs. As a result, the Massachusetts Department of Public Health thorough the DoN process started to compelling hospitals across the state to create professional medical interpreter programs....She also regularly gave trainings for the Massachusetts Department of Public Health and Department of Mental Health, a Bachelor-level medical interpreter curriculum, including schools like the University of Massachusetts, Boston and the Northeastern University.

John referred to some specific individuals who helped form MMIA's initial group.

Again, we got the support of a few non-interpreters, particularly (M) and also one doctor (G) from the former Boston City Hospital.

MMIA's initial members worked for a common goal.

I know the inspiration from (R) but any people did that to help not shine for ourselves but for others in need of help.

When Cross-Cultural Communication System [one of the interpreting companies located in Boston] asked him about the Standards of Practice, he answered.

The Standards were developed by (R) and the active committee members, people like OHT 1, 3, (M), (K), and (H) with an input from a group of experienced interpreters. We have to get organized politically, not only when we had a dynamic

leader and sponsor in (B) [a Senator with Hispanic origin who passionately endorsed the enactment of ERIL] and a very extensive coalition with representatives from many sectors that they were able to get something done. (Cross-Cultural Communication System) [I rewrote initials of the names on their article within ()].

John highlighted the importance of grants for activities.

In recent years, the MMIA has been fortunate in securing grants from the Massachusetts Department of Public Health to offer interpreters learning opportunities. For example, at present, we are offering two 60-hour Department of Public Health-funded courses on interpreting in the Emergency Room and in acute mental health settings to help interpreters prepare for the recently passed Emergency Room Interpreter Law[ERIL]. Last year our organization became licensed by the Cross Cultural Health Care Program of Seattle, Washington to offer the nationally recognized Bridging the Gap Interpreter Training Program.

MMIA News, Fall 1997, Volume 3 showcased programs organized by multiple stakeholders including the Northeastern University's American Sign Language (ASL) programs, the Northern Essex Community College, the Education Development Center (EDC), Lawrence General Hospital, the Massachusetts Immigrant & Refugee Advocacy Coalition (MIRA), an advocate organization for immigrants, the Office for Civil Rights, the Social Medicine at Harvard Medical School, the Health Care for All, and the Massachusetts Law Reform Institute (The Massachusetts Medical Interpreters Association, 1997[News letter]).

According to him, annual conferences were important.

At one point we got a grant from the Cross Cultural Health Care Program where (P) [a cross-cultural expert and community based physician mainly practicing in the state of Washington] was a director. He gave us a grant to host a meeting of people involved in medical interpreting across the country. Because there were going to be so many experts on medical interpreting in Boston, I organized a conference for medical interpreters and made it a yearly event which continues to this day. We invited very knowledgeable people to come in and talk to our interpreters. (P) was very very instrumental in moving medical interpreting forward, you know? He worked with us.

He represented MMIA and voiced how important to have competent medical interpreters and to address the quality issues at a meeting convened by the Commonwealth of Massachusetts Executive Office of Health and Human Services Massachusetts Department of Public Health, *Interpreter Services in Massachusetts Acute Care Hospitals* (The Common Wealth of Massachusetts, 2008). He listed important individuals and described how they collaborated toward the enactment of the state law (ERIL) in 2000.

The author of the bill (O) is encouraging us all to contact our local state senator to ask him/her to call state senator (Q), chairperson of the (W) and (MM) Committee, to get the bill proposal out of committee and have it presented for vote in the senate. The MMIA owe its origin to this very bill which has been pending for the state legislature for ten years. This law would mandate the use of interpreters in hospital emergency room, etc. Ten years ago when the bill was first submitted to the legislature, (R) called a group of colleagues to gather to lobby for the bill and it was this group that formed the original MMIA. (The Massachusetts Medical Interpreters Association, 1998 [News letter]).

Field Note

I was introduced to John Nickrosz by OHT 20. He invited me twice to have an interview at his house. He offered me a box of hard copy materials, including MMIA News letters, several training text books he wrote, in addition to six video tapes in which MMIA's seasoned members acted as interpreters and patients, including John Nickrosz himself. While he drove me back, he talked to his neighbor's son. He said, his neighborhood lacked for communication among residents compared to Lowell.

Oral History Teller, No. 3

Name: Margarita Christlieb Battle

Country of Origin: Mexico

Language: Spanish, English, French, Portuguese, Italian

Profile

Margarita Christlieb Battle was one of the 4 founders of MMIA. She was born in Mexico in 1944. Her mother, a daughter of a diplomat, spoke all the time in English to her. She studied to be a professional conference interpreter and studied French in Mexico. At the age of twenty four, she went to France and studied psychology and anthropology. She married to an American. She continued to study psychology in Brazil. She arrived in Boston in 1976. She became the first staff interpreter and the Coordinator of Interpreters at The Massachusetts General Hospital (MGH) in 1987. She retired in 1998.

Oral History

Margarita understood how foreign patients feel when they face drastic changes in life and confront cultural barriers during illness.

Going from Mexico to Paris was a total culture shock. My most difficult transition was from Brazil to the United States. I felt alone and without support. I had my first baby only 3 months old and I arrived in the snow. I had never lived in a city where dealing with snow was a part of everyday life. I had never experienced that. It was very difficult for me, as you can imagine.

In the 1980s, a lawyers' group, self-called, Babel II Coalition, worked with some politicians to demand professional interpreting services in court settings. This advocacy movement culminated in Chapter 627 of the Acts of 1986 [a state law of court interpreting] signed by Governor Dukakis (The Massachusetts Medical Interpreters Association, 2001; Winsor, 2002 [Newsletter]). She worked first as a court interpreter.

In the role of court interpreter I could see their very difficult situation. I worked with French speaking Haitians and with many Spanish and Portuguese speaking people from Latin America. I had a difficult time with the opposing roles of defense attorneys and state attorneys.

Margarita used to feel something was missing as a professional conference interpreter.

The point was that I didn't want to just translate and represent what the speaker said without having a personal voice.

Her soul-searching journey ended when she started to work as a medical interpreter in 1987.

I had found my vocation. Because, finally in my life I would be able to make an important contribution using my professional skills and life experience. I felt very motivated. I think as a human being, we all want to leave something behind us and for me this was my opportunity.

In the late 1980s, the medical interpreting profession was quite young. Few hospitals employed staff interpreters. Margarita was one of such interpreters.

For the first year, we had 15 to 20 language requests on a daily basis. Every 5 minutes somebody would call and say: "I need an interpreter." I was basically the only professional interpreter. I felt I was like a general without an army!! It was SO stressful. I felt as if I was in the middle of a war zone, with so many suffering people and not enough resources to help them.

According to the materials provided by Margarita, the Massachusetts state government enacted "An ACT TO CREATE A BUREAU OF INTERPRETING SERVICES WITHIN THE EXECUTIVE OFFICE [capital letters used as the original document]" in 1989, the same year this state issued DoN (The Commonwealth of Massachusetts, No.2498, 1989, January). This evidences that the state was taking the initiative in promoting interpreting services to LEP residents. To comply with it, hospitals relied on practically any resource available on the spot. At her hospital, foreign researchers volunteered to interpret in 65 languages including some from Japan.

There were many international scientists working on various kinds of research[at MGH]. When people were hired, the administration would ask them if they would be willing to be called upon as volunteer interpreters.

In addition, many volunteers came to help her.

There were medical students, the elderly people, retired people, and those who came aspiring to be medical interpreters, high school students who wanted a summer volunteer job.

Hospitals used any bilingual staff, too.

They would mistranslate basic words, for example using the word 'liver' instead of 'kidney'. Also, they were so afraid of the doctors that they would never acknowledge

when they didn't understand. Instead, they would just make up things. I would say to myself, "I didn't want to see someone die, while I was sitting at my desk in my office having one of those unqualified people helping out!"

Interpreting cost was an extra burden, hospitals lacked for a budget to employ new staff interpreter. The first staff interpreters had to work alone for many years. Consequently, Margarita decided to educate volunteers.

I started to develop a list of vocabulary, including the most basic vocabulary we could require all volunteer interpreters to know.

Margarita authored a text book entitled, "Working with Interpreters~ The Dynamics of the Patient-Interpreter-Clinician Triad", in 1994 (Battle, 1994).

I was using these materials (this 'model') as part of the training I gave to the volunteers, interpreters and also to the physicians. It is based on the article "The Patient-Provider-Translator Triad: A Note for Providers" (Sluzski, 1978).

Margarita remembered adversity at work as follows:

At times, doctors would tell us that working with interpreters took too much time so they refused to see non-English speaking patients. Some of the secretaries would feel uncomfortable when they heard a conversation they could not understand. They did not consider that in order to provide the same level of care to ALL[capital letters as written by OHT 3] patients, without discrimination, qualified medical interpreters are necessary for non-English speaking patients.

Finally, her tenacity and dedication spoke for herself at work.

It took many years. But eventually people could trust that I was doing something good.

Margarita articulated her perspective of roles of medical interpreters.

I wanted [patients] to "have a voice", because as a medical interpreter, my role is part of the healing process, I am part of the medical team, not just going to say words. We disagreed a little bit because I wanted to extend the roles of interpreters more, but (g) [one of the initial group members] wanted interpreters to do just translating accurately without any other responsibilities. The position of the interpreter is so important, because in the dynamics of the interview between the patient and the provider, the interpreter has a very unique role, you know.

As one of the four founders of MMIA, Margarita recalled how they had established the professional association. When she was desperate to find ways to cope with difficult situations, she received calls from (R).

At the beginning (R) was not successful because we were all extremely busy and did not have time to attend any meeting outside of the hospital. After her many calls and intelligent networking abilities, I went to the meetings. (R) was such an excellent listener. (R) had a gift for networking, coordinating, strategic thinking and inspiring people.

The initial group members shared difficult cases and supported each other.

All we could do was to talk about all the problems we had, and tell each other all the cases we had been through, horrible, just horrible cases. We needed to find somebody to talk to and listen to. That is why we got together.

The group's direction changed toward advocacy.

We felt we were not respected as professionals with a fair payment. We felt everybody got paid for a job in healthcare but interpreters were expected to be volunteers and not get paid for their work. Interpreters have a very important job which was not acknowledged or appreciated by the hospitals. We needed to get organized to show hospitals that we were contributing an essential component to healthcare.

They took the issue of Civil Rights seriously.

A very important issue in our pursuit for professional, accurate medical interpretation is Civil Rights. We discussed the responsibility of the medical interpreters regarding patient's rights to communicate with health care providers.

The Babel III Coalition, the group of lawyers which successfully helped enact the court interpreting state law in 1986, approached MMIA and other stakeholders to enact medical interpreting state law (The Massachusetts Interpreter Services Coalition, December 12, 1994[Meeting agenda]; the Babel III Coalition, 1998, March 3; 2000, April 20, 2000). Margarita worked very closely with the Babel III Coalition and spoke at the hearing to the Senators.

The leader (O) of this group was aware that to implement the Civil Rights Laws, medical interpreters who were reliable communicators, were needed. I worked

closely with him (O) and my role was to reveal to (O) all those cases of miscommunication, including many “horror stories” of patients whose civil rights were not respected.

They felt a need for standardizing minimum roles as requirement for professional medical interpreting, however, diversities of opinions avoided them from standardization. Margarita stated that it was (M) who enabled them to develop the Standards of Practice. She depicted how the Standards of Practice (The Massachusetts Medical Interpreters Association & Education Development Center, Inc. ,1996/2007) was developed through a process called DACUM.

We started to explain what we each thought the job of the interpreter was from the beginning to the end. (M) recorded everything that was said on the white board, and then, at the end, we reviewed the list. We started to assign categories to each item.

Margarita worked as a professional trainer for many courses including the first community college based training course (Lara, 1993, August 18 [Newspaper]; Sessler, 1993, October 10 [Newspaper]).

I must say that many of those courses were organized because, through the MMIA, people began to notice us, and we were successful in convincing hospital administrators and doctors that it was essential to train their interpreters. I was active very active in branching out and promoting the medical interpreting profession. The MMIA was the launching pad.

Margarita regarded (R) as the mover and shaker who connected with everyone. (The Cross Cultural Health Care Program in August in 1995; the University of Minnesota, October 24, 1995). She highlighted some of them as follows:

The other important person that (R) connected with was (P), in Seattle. And also another very important person there, his name is (K). He is an anthropologist. He wrote a very important paper that I always studied so carefully, you know, he describes the conflict of the cultural brokers.

Margarita quoted (R)'s words to explain how MMIA became a critical mass in the society.

(R) used to say: "The MMIA is like a snow ball. It starts with a little bit of snow in your hands and when you begin to roll it, it grows and grows until it takes on a life

of its own". These trainings and conferences represent how we were rolling our snow ball.

Margarita spent time and energy for conferences at national and international levels.

Conferences are important for all participants to learn about what other people are doing, networking with people and becoming motivated to continue the work with increased focus and motivation and more contacts.

Margarita remembered having presented at the Critical Link 1, the first community interpreting conference originated in Canada in 1995.

It is true that the preferred term was "Community Interpreter" at the Critical Link Nobody used the terms. We coined at the MMIA: Medical Interpreter [Capital letters placed by OHT 3].

Margarita explained her perceptions of medical interpreting compared with court interpreting.

In court cases, everybody fights the other party, there is a conflictive kind of relationship, whereas in medical sessions, there is completely different atmosphere, everybody is working for the same goal; helping the patient. You are part of a team because you know you are working for the common goal, to help the patient.

In retrospect, her experiences helped her life.

At the end of 2000, my oldest son, age 23 was diagnosed with colorectal cancer. I can only tell you as difficult and painful as it was, the previous experience at the Massachusetts Hospital [MGH] had prepared me to stay strong and accompany my son every day for all those years, giving him the most loving care that was possible!

Field Notes

Since I knew her name as a member of the MMIA Subcommittee on Standards of Practice, almost seven years have passed. Everybody knew her name, but nobody knew her whereabouts since she had left Boston in 1998. It was OHT 1 who did her best to find Margarita Christlieb Battle's current address in Mexico. After our first phone interview, she started to dig her files out of the basement, and scanned 65 pages of materials, including a picture of (R) [with Informant (M), OHT 3 and another attendant], the only picture of (R) I could collect despite my utmost efforts during the whole research period, the attendant, booklets of the conferences, flyers of events, news paper

articles and even copies of personal letters addressed to Margatita. The number of our mails exceeded 150. Several phone calls strengthened our relationships not as an interviewee and a researcher, but those who share common life challenges as a mother, a wife and a professional medical interpreter. For many professional medical interpreters across the country, she has been a missing person, however, she is an individual who provided me of missing written materials out of her archives as she stated:

I know people these days often throw away papers.... I probably have an inclination for protecting history. I have saved many documents that at the time were contributing to my personal and professional experience and that remind me of the implications and consequences of those huge and important efforts of so many people!

Oral History Teller, No. 4

Name: Lisa Morris

Country of Origin: Portugal

Language: Portuguese, English

Profile

Lisa Morris was born in 1963 in Portugal. Her father studied medicine in the United States and met her mother who is an American. She lived and studied in the United States and Portugal. She took a Junior Year Abroad Program for one year in Switzerland and as a Bachelor degree in Romance Language and a master's degree of Science-Training & Development. She joined MMIA in the late 1980s and was one of the initial group members. Since 2000 she has been working as Director, Cross Cultural Initiatives, Division of Family Medicine and Community Health, Medical School of the University of Massachusetts. She prepares and monitors a budget for the delivery of the Medical Interpreting Training, Translation Project and Cross Cultural Programs. She was a secretary of MMIA, is a treasurer of NCIHC and is a member of IMIA.

Oral History

Lisa Morris never experienced language barriers because she acquired languages naturally while her family frequently moved between two countries. It was through her jobs between 1989 and 1991 that she witnessed how LEP workers suffered from difficulties due to their poor language skills. In those days, many work related accidents occurred because they didn't accurately speak and read. She recognized such kinds of infringements of LEP patients' rights.

That was in Rehabilitation facility that I worked in. They got injured and sent to a state facility for rehabilitation of physical therapy, occupational therapy or counseling. I found that those of the patients, kind of dangerous. LEP patients got trampled at the door, to get them least of the respect in assistance, they don't know their rights.

After several job experiences, she became a medical interpreter in the late 1980s.

I love medicine, because I would be in my Dad's office many times, and he had asked a little thing about patients. I departed to go into the languages[linguistic studies]. And when I graduated, I actually used my languages through every career I have, but I gravitated back into another career. I started to work first at a hospital.

The profession was not recognized in general. Lisa recalled the state of Massachusetts' issuance of guidance (DoN:the Determination of Need Program) in 1989 made her career (See p.109-110*3).

I really see my career started when I went to a hospital. At the very first time, they interacted me, and I was hired because hospitals in Massachusetts begun to hire someone to oversee whatever the services. Many hospitals began to introduce cardiac catheter, and the Department of Public Health issued "Documents of Need(DON)". In order to be able to function as a cardiac catheterization laboratory [by the Department of Public Health], they had to have 24 hour interpreter services.

The DoN guidance drove hospitals to provide medical interpreting services and to employ coordinators and/or medical interpreting staff. This guidance lacked for specific instructions on how to establish these services, so hospitals implemented them at their own discretion.

So, basically that was how my job became. So, it wasn't just me, other people in [the state of] MA, too. It was a funny story, no one knew where to belong. I actually belonged to Educational Department of the hospital, but one of my colleagues was in Social Services, other colleagues of mine [belonged to] Patients' Relations, because I know you talked with OHT 3. She was in the Patients' Advocate Department, Patients' Relations. My Department was actually [called] the Education Department, they actually were training department for the doctors and nurses.

At first, she didn't know how to work as a medical interpreter.

I had no particular training. There was no training then. I learned from a colleague who had been already working. I went to watch them to train and I started doing it.

Medical professionals in the late 1980s were not yet ready to accept medical interpreters. She faced opposition from the staff, especially from physicians.

When I talk about my first experience, that I got there, when I was on the floor, I came in and said, "Hi, Doctor, I am asked to come here to interpret for you." And he said, "Oh, what do you do?" And I said, "To interpret for you patients." "I have never used you before!" "I don't need you. Why would I need you? Before I never did, why would I need you?", "I came here, there is a need here, then if you won't me, here I was gonna to do what you want to do." I said. Basically, I stayed and the

patient mumbled anything. Actually I was expected to interpret for the patient and the doctor, so, I made friends with him. Every time, he would go to the floor and see Portuguese patients, he called me, and said, "Can you come?" So, little by little, I turned enemies into friends. Sometimes, I showed up and nurses said, "I don't need you, get out of here." But it was funny, a year later, they were saying, "How do I do this without you."

Between 1991 and 1995, Lisa worked as a coordinator of interpreting services and was in charge of multiple assignments as shown below.

When I was a coordinator, there were a few coordinators. Coordinators were also interpreters. We not only did manage, but also we scheduled who was interpreting where, I also was interpreting at the hospital for very long time.

Compared with the early 1990s, job descriptions of coordinators became more specific in the late 1990s.

As the things progressed, when I moved into particularly to a HMO [Health Maintenance Organization], there my position became much more coordinating with still some interpreting.

Coordinators were important to ensure the quality of interpreters and finally to meet the patients' needs. She encouraged newcomers to acquire linguistic skills.

I think the key importance is maintaining quality. Because who's gonna be hired and how are they practicing, because what was noticing here in the US...a lot of programs of training, but the quality of the person who come depends on the quality of the training they received, and trainer standardize the field of the delivery of the training. Nobody, no matter how you train, so comments [from newly employed staff] are, "I didn't learn in that way." And we say, "Oh, well.", you don't say [to newcomers], "You are wrong." "Let me share something new [way] with you, and you can try." "This might feel better and this might work better." Because you don't say, "You don't take a lot of training." either. You have to be cautious about how we handle, I think the coordinators are mechanics of day to day tasks of managing, but at the same time, maintaining a quality and showing to the doctors and nurses what they need as well as the patients, because the bottom lines are the patients' needs.

Lisa recalled that coordinators also formed a group to share common issues and

information through their networks.

When I went to Medical school a few years later, a group was formulated, [and they were] called the Form of Coordinators of Interpreters Services (FOCIS). That was a kind of social format formed for coordinators to discuss issues with their institutions and to implement the interpreting services, or [discussed] how they handle the interpreters. I think FOCIS was formulated in late 1990 or 2000.

Lisa underscored her commitment to continuous learning as a trainer.

The reason why I liked to stay interpreting because my master in training ended in 1995, but I started to do a lot more training. If I couldn't be an interpreter simultaneously as a trainer, I couldn't share bad story in the class room. As you know, in the interpreter career field, they need a continuous education. There are changes, always new terms, new things, and new stories, so unless you involve in the field, you become no good as a trainer.

Asked why she chose to work as a medical interpreter, she replied as follows.

Why medical? Yeah, first of all, I found in medical settings... something in my heart ...my passion in American environment. And few times I went to a court, it was a very intimidating environment, I also felt the cold environment. There is no room for passion. There is in medical room for something you need to explain. There is a room for advocacy.

Lisa traced back to the beginning of MMIA.

I involved in MMIA, I believe, may be 1986 or 7. (R) was the one who introduced a concept of medical interpreting at one of the city's largest hospitals here in Boston [the Boston City Hospital]. She and I went to many meetings. The meeting was very small, and it was (R), OTH 3, OHT1, myself, (I) who was the vice president, just say, no more than a dozen on a regular basis. We actually met in Boston on a monthly basis at the various hospitals in Boston. Everybody took a turn.

At first, the initial group members just gathered informally without the name or logo.

I didn't even know the log, and I do know that was a name and the log came years after, and the name and everything was decided by (R), OHT 1 and 2, when they went to file with the State [to be an NPO].

In the 1980s, there was a sharp increase in the number of LEP populations in the city of

Boston. The Boston City Hospital had serious communication problems with LEP patients with diversified cultural backgrounds as it was a public hospital. In 1987, a medical team of this hospital produced the videos, the Bilingual Medical Interview, Part I & Part II, and used them for MMIA's trainings, too.

The videos were produced because an education center for medical professionals [the Area Health Education Center], (R) and (G) partnered with our office to develop a tool for medical interpreters and doctors to understand how to work with interpreters.

When MMIA organized its first national conference under OHT 2' leadership in 1997, she served as a secretary. Lisa remembered some attendants from the state of Washington and saw that NCIHC was formed.

When OHT 3 and I were there, we met (P)[a community based physican in the state of Washington] and (K) [an anthropologist and sociologist from Canada] in the MMIA meeting. That group spun off to form the National Council (NCIHC). It is like a policy making think tank. It's a group of people who want to create a policy and standards ... it is a very valuable organization.

Lisa was a member of the state program, in which from MMIA, several members including her and OHT 2, (A), (G) and (I) attended. This project was organized by the Commonwealth of Massachusetts Executive Office of Health and Human Services Massachusetts Department of Public Health with an aim to develop a document, Best Practice Recommendations for Hospital-Based Interpreter Services (The Commonwealth of Massachusetts, Department of Public Health, Office of Equity, 2008).

It was such a long time ago, but I remember, we met on a monthly basis until we finally agreed on a document. I think at least a year, yes. To give hospitals and managements how they should be directing the efforts with respect to medical interpreting initiatives in hospital settings.

Field Note

When I contacted Lisa Morris, she remembered seeing me for the first time back in 2006 when I was introduced to NCHCI members' breakfast meeting at the hotel, which was also a venue for MMIA Annual Conference. Her face was familiar because we had seen at IMIA conferences, too. I remembered her name rather than her face because Lisa had presented several projects at academic societies. OHT 20 introduced me to her and I asked for an interview.

Oral History Teller, No. 5

Name: Saly Pin-Riebe

Country of Origin: Cambodia

Language: Khmer, French, English

Profile

Saly Pin-Riebe's resume highlights professional affiliations as the Board of the Directors of major immigrants' advocacy organizations including the Advisory Board member of the Cambodian Mutual Assistance Association, MAA^{*14}. She also worked with an organization of the United Nations between 1992 and 1993. She is a winner of multiple awards including the big one "Unsung Hero" from the State Government and other ethnic organizations. She works with the State Government as a coordinator of interpreting service since 2004.

Oral History

Saly Pin-Riebe worked as a high school teacher until 1975. In 1979 the genocide of Khmer Rouge of the "Killing Fields" [Quotation marks and capital letters as placed as originally described by OHT 5] swept through Cambodia. She fled and stayed in The United Nation's High Commissioner for Refugees (UNHCR)'s camps and a refugee camp in nearby country and worked as a volunteer with the International Rescue Committee. Her husband and family were killed. She wrote an essay about the genocidal tragedy.

The fear of a possible war between the ousted Khmer Rouge of the "Killing Fields" swept through the country. I didn't want to see my child die like so many others, with one arm in the crab hole and another hung over the dam in the rice field. I arrived in Boston in June 1981 after moving from camp to camp in Thailand and Indonesia (Pin-Riebe, 1994).

In 1981 the resettlement services were not ready yet, and Saly couldn't find her interpreters.

*I didn't have any family members, no friends with me, and just came as a so called "Free Case" through a program of the Resettlement Agency^{*14}. The Refugee Service was still ill prepared for the people from Cambodia and Asian people. The language was the main problem for refugees.*

Saly was taken by resettlement workers to a nearby hospital. This experience molded in her mind to help people in similar situations.

They finally found an interpreter of my language. So, they could explain the

situations that they needed to separate my daughter from me. I didn't know what was going on with my life. I came without any family member and I got sick, but that was a breaking point in my life to see what the difficulty was, if without help of communicating when I need the most to know about my daughter's safety.

Refugees' difficulties were not only language barriers, but also cultural barrier.

I remember how one of my first American friends tried to help me find a job. "Can you do the job?", the interviewer asked me. "Maybe and let's wait and see", I replied with hesitation. Unfortunately, I did miss the boat. My friend said I wasn't assertive enough to say, "Yes, I can do it." I didn't know how to sell myself. God knows, for Cambodians, this answer is perfectly fine and acceptable. We hesitate because we want to show humility. Our success will speak for itself later and somebody will talk about it for us. But does it work that way here? (Pin-Riebe, 1994).

Saly reminisced about how intolerable her new life was.

Being an immigrant in this country I have faced prejudice, discrimination, and mistrust. Because my color isn't white, and because my speech has a heavy accent, I have sometimes had uncomfortable experiences. ...I will never be able to forget insensitivity and lack of compassion of one of my immediate supervisors ...I decided to quit and swore I would never work there again, even though the company president offered me a good raise (Pin-Riebe, 1994).

Saly had three classes a day wherever possible; at community school, at Christian churches, and at classes organized by resettlement organizations^{*14}.

My English was not perfect at that time. Finally they called me "interpreter". Like this, I started interpreting in 1982 and 83 as a volunteer, as a case worker and as a resettlement worker. Later on, I got hired either by interpreter charity or resettlement worker at the airport.

Saly decided to live in the ethnic community where the Khmer Buddhist Temple was constructed. She devoted herself to community activities to help people suffered from similar plights in the community.

I use my experiences as examples to show that a lack of knowledge and understanding leads to gaps in the system. Later, when I became involved in the field of refugee services, I remembered my own experiences and used them to help

improve the program that existed. ...I am with people who try to learn and who always advocate for refugees and immigrants (Pin-Riebe, 1994).

The state government outsourced their health screening services for refugees to resettlement agencies^{*14} which employed minority interpreters who were former refugees themselves. Thus, she started to work as a medical interpreter and as a resettlement worker as well. She was quoted by a local newspaper.

"I am so excited about this," said Sali[Saly]-Pin Riebe, 37, herself a Cambodian refugee [...] who works with [her colleague] in the same section of the Massachusetts Department of Mental Health, had left her mother, eight sisters and a brother behind when she came to this country with her daughter" (Cannaday, 1986 [Newspaper]).

Saly thought that becoming just a medical interpreter was not enough to help those people with trauma and mental health problems, therefore, she decided to be a social worker. In the late 1980s, in view of such huge social needs, bicultural case workers were educated with grant funds.

I went to the Boston University School of Social Work. I got a grant even for my master degree. The need at that time was so huge, I could be a social worker, I could be an interpreter, a case manager, a mental health worker. I went to the training to the Boston City Hospital. I took the class on medical interpreters training given by (R). I also had training for bilingual and bicultural case workers.

Saly and her daughter took part in a project, *Other Colors: Stories of Women Immigrants, A Teachers' Guide*. Their vignettes depict how they differ in values.

We do things, we sacrifice things in the name of the family, which is different from the American individualism. ▼Saly Pin-Riebe

She doesn't understand sometimes the need for my own freedom... ▼Rantana Ty-Riebe (Pin-Riebe S., n.d.)

Field Note

During my interview with OTH 3, she referred to Saly-Pin Riebe in various ways, first as one of the 13 participants who developed the Standards of Practice, and second as one of the instructors to teach the medical interpreting course at the Northern Essex Community School, known as the first university-based course for Spanish and Khmer in 1994. I looked for her current contact and called her at work without being

introduced appropriately by some in the industry. My sudden phone call should have been so unexpected or at least so troublesome that she could have rejected it immediately because she was on a hectic schedule. However, her reaction was compassionate when I talked about foreign patients in need of help in Japan. When the interview was conducted, her first words were:

It is OK to me. In fact, I don't even know how much, how good I can help you, but I always try my best for everything I like to do in life especially when it comes to the important needs of people in the world around me. That is one of the reasons I still stay working at the Massachusetts State until now.

Oral History Teller, No. 6

Name: Lourdes Cerna

Country of Origin: Guatemala

Language: Spanish, Kiche, English

Profile

Lourdes Cerna was born in a village, Guatemala, in 1960 and immigrated to the United States in 1983. She started to work as a laundry worker at a hospital and as a dual role interpreter. She now works as a staff interpreter and an instructor for training courses. She was the vice president of the California Healthcare Interpreting Association (CHIA) when I interviewed her in 2010.

Oral History

In the 1960s, Guatemala underwent a long civil war. People suffered in the uncertainty and social turmoil reached rural areas, and people didn't have a hope for the future (Payaras, 2011). Although her family was not a victim of the military atrocities, her father didn't find anything to do except drinking. She grew up during the civil war when indigenous civilians suffered from direct loss of beloved ones. They lost their dignity. She was raised by her grandparents who taught her to maintain respect and dignity. She learned how valuable to help others.

Though we were very poor, I have the best memory with my grandfather. He was very generous man. He would take off his shoes. He would not eat, but he gives, gives, gives, gives. I would like to do the same because he was very amazing.

Lourdes found her vocation at the age of nine

My grandfather was sick and I was taking care of him. And I really loved taking care of him. And he has a cancer I used to lead practically everything, doing IV [intravenous injection]. After he died I really wanted to do more for people, and I wanted to be in a medical field, because my grandfather had never had opportunity to be treated at a hospital. Because we had no money so he was cared by us at home. So we came to the United States, I wanted to work in the hospital, and I helped just like I helped my grandfather. I became a medical interpreter.

Lourdes used to be a natural interpreter for her family who spoke only Kiche, a dialect. Her brother, who she said, lacked for patience to deal with language barriers.

I leaned to speak both languages and I used to interpret for my grandfather when he went to the bank or wherever they discriminated him so I interpreted for long

time for my uncle and others.

Her experience upon immigration urged her to be an interpreter for people in need.

When I came to the United States, I didn't speak English. Nobody interpreted for me on the first day when we arrived. ...I thought I would provide the service with dignity and respect. I became an interpreter to help people and to help people bridge the gap of communication.

During the period, the 1960s and 1980s, uncountable immigrants rushed to the United States to get out of poverty because of the civil war and a devastating earthquake in 1976 (Gerstenzang & McDonnel, 1999, May 20). While many immigrants worked as agricultural workers, her mother sought to make ends meet by working as a housekeeper for ten years in the United States. She saved enough money to bring her four children to the United States.

My mother said "in the United States things are better. I don't want you to come without your paper [documents for immigration]. Each one was three thousand dollars, but she got all the money for all of us."

Researchers have documented that immigrants tend to live in their ethnic communities and their children don't learn the mainstream language due to speaking their native tongue (e.g., Chiswick, 2005; Davis, 1990; Portes & Bach, 1985). Her case, however, was different because her mother who knew learning English was essential to get a job chose to live in a place far from Hispanic communities in Los Angeles.

My mother brought us where there was very little Spanish so that we had to learn and we went to school where very little Spanish was spoken.

In California, a media reported, "of L.A.'s 550,000 school children, 117,000 speak one of 104 languages better than they do English" (Kurt, 1983). All these children were supposed to find ways to live in a new country. She also struggled to find a job.

When I started to work, I spoke a little English. I worked at a factory of seam over-raaping machine, and you put like buttons, you know, so they pay you four cents for each button. My paycheck was forty a week. That was what I was qualified for.

Lourdes looked for better job. She had been thinking about becoming a nurse since she took care of her grandfather.

I found a job at a nursery home, as a nursing attendant. It was a very rewarding job,

because we took care of people who were elderly and feeding and it was like a total care. I liked it because, we take care of people in need, the elderly sometimes, very depending on care, they couldn't feed themselves because they reminded me of my grandfather. I felt like I was taking care of my grandfather.

Lourdes landed in a job at a hospital despite her poor English.

A friend when I came to the United State said, "Even if you don't know, you have to say, "Yes, I know." So, I remember, when I went to the interview, the lady was [speaking], "LJLJLJLJL." I didn't know what she said, but I said, "Yes, I know." I understand a little bit, but not everything. And she stood up and said, "You have a job." And I said, "Yes, I know." Without knowing what was about. It was in the laundry, and I was in a huge place in the basement, it was for like three thousand patients, you know. It was a lot of work, but it was OK. They paid me good.

Because of a huge need, the California state enacted Kopp Act of 1983 [Health & Safety Code §1259(1990)] which mandated all the hospitals with acute care services should provide language services to LEP patients with equal to or more than five percent of the populations or the patients. In 1983, The Western Journal of Medicine, which covered medical associations in 13 states including California, released a special issue titled, Cross-Cultural Medicine, to help private practitioners in dealing with diversified patients from across the world. Los Angeles was one of the cities with the highest number of immigrants (The Western Journal of Medicine, 1983). In particular, Spanish speaking populations increased by 61% during the period between 1970 and 80s (The United States Bureau of the Census, 1984, See also Bean & Tienda, 1987, p.56-59). However, an assessment of foreign language needs in California found 33% of nurses and 17% of physicians interpreted. It said "any one in the clinic with the slightest knowledge of Spanish or Indochinese languages was asked to interpret." (Rader, 1988, p. 46).

I learned more English, so one day, the lady called me and said, "You speak Spanish. You come with me." It was a third floor, an orthopedic floor, and he was going to have his legs be amputated. That's was how I became an interpreter.

Lourdes's first experience did not traumatize her, on the contrary, this encounter set her life as a professional medical interpreter as she recalled.

I was very scared because I didn't know the proper terminology for "glandules." I cried. I felt so responsible because of the patient's trust. I thought, I have to train

myself so that I can do a better job. I decided to look for dictionary and to go to school to learn more English because after they got me, they called me almost every day. I was interpreting of half of my day.

Once she decided, she studied English at a community college and enrolled in the class on medical terminology. Her enthusiasm motivated her to be a professional trainer.

I took the training course, Bridging the Gap [Training course by the Cross Cultural Health Care Program], and L.A. Health Care Plan [Local Initiative Health Authority of Los Angeles County] training for forty hours, and I took a course called, Training the Trainers, then I went to the Mt. San Antonio College, I took one year training, and then I started to go to San Diego to take the teaching credentials, so I can teach medical interpreters to get the teaching credential. I went to Seattle, Washington, to get the training. Everything was paid out of my pocket including the plane fare, hotels and the training fee for about five thousand dollars. I wanted to train on myself.

In the late 1990s, professional medical interpreters formed an organization, CHIA to play an important role for professionalization and took the initiative in advocacy. She joined CHIA, but never thought that she would be the vice president in 10 years.

The person who supported was President of the CHIA, (V), and she came to my hospital to give an in-service medical interpreting. (V) invited me to join CHIA, and she has always provided me resources information and encouraged me.

When she worked as a nurse and an interpreter, she had to address many challenges. She learned how to deal with it through training courses. To help new interpreters cope with similar challenges, CHIA developed the Standards of Practice (Angelleli et al., 2007).

I think all the interpreters should come with certain ethical things. I think in the hospital setting, there is always very fine line between being an interpreter and doing your job.

Lourdes recalled how the profession has developed during 27 years:

When I started to work, the medical interpreting was not so recognized. But now, they recognize that the interpreting is a profession like nurses and doctors. In the United States, the professional interpreter is the very new profession, so when I first became an interpreter about in 1982, there was no training programs. We

didn't have a concept of what medical interpreting was. Everybody totally spoke any little language, worked as an interpreter. So, I started to work without formal training.

Training opportunities have increased with time.

I guess my first formal training, back in 1989, when I came upon this book [she showed the text book to me] where it was telling me more less how to interpret and so the first formal training back in 1995 about fifteen years ago, it was to learn interpreting in the first person and the in 1997, I went the Mt. San Antonio College where I teach now.

The state of California is the highest in the number of state laws regarding interpreting services (Perkins & Youdelman, 2008). CHIA has been taking the initiatives in appealing to the state government, for example, CHIA called for actions against the governor's veto of the medical interpreting state law, A.B.2739 (The California Healthcare Interpreting Association, Action Alert on A.B. 154, 2003, February 25). She acknowledged that the state laws and the federal law changed minds of hospital administrators..

I think the Senator Bills because the hospitals comply with it no matter what it takes, and another [law which changed minds of people was] the Civil Rights Act of 1964, Title VI.

Lourdes valued what medical interpreters could do for people in need of help.

It was privileged to serve like a bridge, so I always told all the people, to train themselves to be interpreters or for really serving as interpreters or as volunteers that they are doing the best thing a human can do, bridging communication, the Gods noticed, we are doing a great service and I encourage you to train yourself as much as you can so that you can do the best service. We have to serve with dignity and respect.

Lourdes believes training courses require certain points.

We have to prepare the program long enough to be certificated, so I would recommend Japan would develop a curriculum for at least for two semesters of program what includes internship after the study in class room.

In April in 2010, I did my field research in Los Angeles by staying with Lourdes' family for 12 days. I shadowed her at her hospital, participated in the classes and the final exam of the interpreting courses at the Mount San Antonio Community College where she was working as the chief instructor. I interviewed directors of medical interpreting services of L.A. Care Health Plan and the Rancho de los Amigos [the biggest national rehabilitation center in the United States], took part in the workshop organized by the California Pan-Ethnic Health Network (CPEHN), a major advocacy organization based in California, and attended her family parties. In such parties, her relatives frequently worried about her overworking, and said "she gives and gives, but does not think how tired she must be." Her husband said to me "my wife welcomes everybody to stay with us, and the living room has served as the bed-room for anyone. Now you are here." She was so busy with regular work, medical interpreting course, and above all the household that I could only have an interview with her on the night before my departure at 23:30.

Oral History Teller, No. 7

Name: I. P.

Country of Origin: Panama

Language: Spanish, English

Profile

I.P. was born in Panama and she graduated as a licensed practical nurse. She married an American husband who works for the military. They lived in Germany. After returning to the United States, she started to work as a nurse at a hospital in Wisconsin. Because of her Spanish proficiency, she was asked to work as a dual role interpreter for the first 13 years. After negotiating for a long time with the administration people who were reluctant to open an interpreting service section, she finally could take a formal interpreting course paid by the hospital and became the first staff interpreter of the total of 30 interpreters and has been working at the same job for 12 years.

Oral History

I.P. said she really learned the importance of interpreting for LEP patients from own experiences as she recalled her ordeals while living in Germany.

My husband doesn't speak a word of Spanish, and I couldn't speak English well, then I got pregnant where none spoke Spanish. I had all kinds of communication problems for any day-to-day shopping at grocery stores. I had to deal with everything alone. I felt lonely, and stressed. The first twin babies were born prematurely and passed away in 20 weeks. You can imagine, I was a newlywed wife, living far from my family in Panama, with language barriers and then I faced all these unfortunate happenings. I felt lost. Later I became pregnant again and I had twins, too. One baby survived but one baby passed away in 26 weeks. I felt lost as if my eyes were covered with bandage. I couldn't see what was going to happen, better or worse to my babies. It was a total anxiety. I couldn't even ask medical providers just because of the [poor] language proficiency.

These experiences energized her so much that she was decided to study English.

After I finish traveling with my husband, I settled in Milwaukee, his home state, I took English course at a community school. I took nursing course and passed the requirement to work as a nurse to apply for a position at the hospital in six months later.

Since the 75 percent of the patients of her hospital are the Latinos, mainly from Central

America, she was asked to interpret.

I had dual roles to work as a nurse with my patients, but I had to rush to medical settings of any department. I returned home late and was exhausted but I had to take care of my child. I got tired. I went to supervisors and the administration and said, "You have to choose one of two, a nurse job, or interpreting job for me!" However, they didn't understand the importance of interpreting. They refused to pay attention to me by telling that they didn't have enough human resource, budget, or whatever reasons.

It was Executive Order 13166 in 2000 (by President Clinton) which mandated hospitals to provide medical interpreting services that changed their minds totally. She noticed such a change.

Both the administration and supervisor considered the services as requirement and they allowed me to take a formal training course. I took forty hours of the Bridging the Gap training course and became capable of training. I shifted from nurse to the first staff interpreter. I gladly can say that it was the best transition I ever did.

Although the awareness was raised, not all the change was convenient to her.

I was in trouble with my pager beeping all the time, because all the patients and medical professionals demanded me to work for them. I was overwhelmed alone. More importantly, I worried about LEP patients, especially about pregnant women. My hospital has many pregnant women with high risks such as diabetes and deliveries by Caesarean section, which required a long period of care and cautions. I had to work average of eighteen cases per day. Most of them were difficult cases, including patients in emergency room.

I. P. made utmost efforts to convince the administration. Compared with the time when she started to work as a nurse some 30 years ago, the federal law, CLAS standard (The United States Department of Health and Human Services, the Office of Public Health Services, Office of Minority Health, 2001, March), and the Joint Commission (a major accrediting organization)'s standards motivated the administration to make decision to employ more interpreters in line with the number of LEP patients and their diversity. In addition to the laws, the studies gave evidence, for example, the use of trained interpreters increase patients' satisfaction by ensuring accurate communication and by reducing unnecessary exams and patients' return to the hospital for a lack of understanding (e.g., Baker et al., 1998; Hornbenger et al., 1997; Karliner et al., 2007;

Woloshin et al., 1997).

It took a lot of work to finally have administration to see the need of professional interpreters here. Formerly many patients would return because they didn't understand how to take medication. Many were told to bring the own interpreters, family member, or any none who knew a little bit of Spanish would serve as an interpreter . [Now] We had 4 major hospital including the one I work at and more than 75 clinics where our staff interpreters had reach 33 full time.

The biggest challenge for the administration was a lack of budget.

The challenges for administration is how to get reimbursement. We started 13 years ago with a budget of \$ 250.000 and today our budget is about 4 million and growing.

Another challenge was to cope with growing diversity of patients coming mainly as refugees, and the solution was to rely on outsourced telephone interpreting services.

We cover over 100 language. Most of our interpreters are Spanish speaking because we have a very large population of Spanish speaking here but we also have Serbians, Russians and Hmong. We also use Cyacom, a telephone company, for many other language we are looking to implement video conference.

The challenge for interpreters has been medical professionals' lack of interest in using medical interpreters and a lack of patience to wait until medical interpreters reach them. She knows from her experience the serious risk of providers' poor language proficiency as reported by Harsham (e.g. Harsham, 1984).

The staff still refuse to use interpreters and use family member or ask patients to bring their own interpreter or force patient to sign waver form. Many medical professionals speak little Spanish and communicate with their patients without calling us. It a matter of just three seconds to call interpreters, and we don't understand why, but still they do speak without care for the risks of poor communication. I really worry about it.

To cope with the aforementioned issues, she tried to educate professionals in various ways.

After the sessions, I speak with physicians on how cultural knowledge is important for accurate diagnosis. Culture matters. For example, compared with the US patients who speak and complain against physicians, patients in Panama, for us,

physicians are respected so much that we don't reject what physicians say. Sometimes, we organize for the staff seminars on how to work efficiently with medical interpreters, and what positive outcomes they can expect from us.

I. P. also screens language proficiency of the staff.

We also assess bilingual employees and they need to pass the assessment to be able to individually work without an interpreter and a third party does this test.

I. P. mentors newcomers and trains staff in working as medical interpreters.

Now they have formal training, but after employment, I take around and introduce them to every department.

Since I. P. worked alone for a long time, she tried to connect herself with professional medical interpreters associations and studied the literature.

I am a member of the CHIA, NCHCI, and IMIA. I attend conferences, and I participate in webinar presentations for example, the IMIA offers free participation in webinar to the members. I learn a lot in this way.

I. P. reasoned why she seriously worries about the lack of communication between healthcare staff and patients.

Although I am a trained professional, when I see babies in ICU [Intensive Care Unit] accompanied by their mothers with anxiety on the face, I remember how I was under similar situations in Germany. I was so traumatized that I remember those experiences. I feel pains. Few times, I ask my colleagues to replace when I get affected. At first, I hesitated to write to the parents what was happening to their babies, but looking back how I desperately needed such information, I write a memo and give it to the parents.

Her traumatic experiences gave her a mission to help those in need of help.

I am happy to be able to do what I would have wanted or more than what I could have. I am not a robot, we have feeling. I feel pain. But I am a professional, I do my best to be kind with energy to help those patients in need.

I. P. acknowledged a change by looking back on her 30 years of experience.

We, medical interpreters are more respected by the staff and patients[now]. It was hard for me as the first interpreter, but people appreciate my expertise and

experiences.

One of her colleagues, a medical interpreter in Hmong language, has been working to publish a dictionary of medical terminology.

Field Note

I talked a lot with I. P. during a bus ride on the way from IMIA conference. We exchange experiences while sitting. Since then, we occasionally have been exchanging mails. She offered some news on the industry and provided data on her services.

Oral History Teller, No.8

Name: W.T.

Country of Origin: Taiwan

Language: Taiwanese, Mandarin, and English

Profile

W.T. worked as a registered nurse in Taiwan. She came to the United States in 1977. She worked at a hospital as a nurse, simultaneously as a dual role interpreter. After marriage, she dedicated her time to rearing children and helped her husband's work. She has been working as a freelancer and phone medical interpreter for seven years. She served as a language trainer for the Mount Saint Antonio Community College Medical Interpreting Course for three years. She is an actual member of CHIA.

Oral History

There are three waves of Taiwanese immigrants to the United States for several reasons including for uncertainty regarding relation with the Republic of China. The first wave was seen after World War II to 1965 and the second was seen during the period from 1965 to 1979. The social economic situation in Taiwan didn't provide appropriate job opportunities to professionally trained work force. It caused "brain drain" and those educated in the United States remained in the United States (Ng, 1998, p.18). "A large percentage of the Taiwanese immigrants were educated at a higher level and were Christians even before they moved to America. [...] In Taiwanese church activities, women play an important role." (Ng, 1998, p.91/92/94). W. T. was one of such Taiwanese immigrants.

I worked in Taiwan for four year after graduating from a nursing college. So I thought I needed to go out and then at least to see what's going on outside Taiwan and so I wanted to explore.

W.T. was not a LEP person.

My English was from College and to speak English fluently was a challenge to me. I thought going to school for two years is a good way to sharpen and get into the system of healthcare assistance.

According to a report, Asian physicians accounted for 70.6 percent of the total number of physicians and surgeons who immigrated to the United States, however, their professional credentials obtained in home countries were not valid in the United States and several couldn't work as physicians (Sillas, 1975). W.T. stated how she could deal

with this challenge.

I applied to attend the nursing program in U.S. that is designed for the registered nurses to get their BSN [RN, registered nurse, with a Bachelor of Science] degree. So, since I was a foreign student for that kind of program, I was required to pass the RN exam in United States within one year in order to continue.

It was her determination that made her dream come true.

I used to tell myself to keep trying and work hard until I pass the exam and finish the BSN program. Otherwise, I had no tomorrow. With the student Visa, I was unable to work and unable to make a living. The law forbids foreign student to work. Only when the student graduates from the school program then he or she can apply for working Visa status and then transfer to permanent residency status.

W.T. reminisced about how difficult the exams were.

It could be difficult not only because of the language barrier for the newcomer, but also the professional knowledge proficiency. Trust me, the exam itself is a lot more than just the English proficiency test or US citizenship test. So, I took the exam and after the second try, I passed. And I finished the program on time (the program was for one year and nine months). So, after I graduated from that program, I could practice nursing.

W.T. worked in a local community hospital as a nurse but she was forced to work as a dual role interpreter until she retired in 1996.

I sometimes encountered Mandarin speaking patients, and I would automatically be called to do the interpreting for my doctor. At that time, I was a nurse.

Her life changed to be a wife helping husband's business and a mother of two children, however, she was career-oriented.

Since I quit the jobs, I still continued to keep my professional nursing knowledge. I always checking what the current trends and what the information I need. I read the medical newsletter. Then when I heard this medical interpreter training, I thought that would be good and I just took the course, and I had a training.

W.T. had a formal training and an internship as part of the course.

I had a medical interpreting training at Mt. San Antonio College (thirty four hours with eight hours a week in internship). So, either forty or forty eight hours, I was in

internship.

A national survey indicated Californian hospitals offered twice as much incentive as hospitals in other states and have more strict policy of requirement for quality services than others (Huang et al., 2009). They are probably the reasons why interns were not so welcomed. Besides this, California is known as the state with the highest number of the language relevant laws (Perkins & Youdelman, 2008). She has witnessed how the medical society has changed when it comes to the status of professional medical interpreters after the enactment of the state laws.

When I went for the internship, I saw the resistance. They used own nurses, physical therapists, but at least nowadays either because the legislation requires them to have language services or hospitals are more acceptable of trainees than when I did internship . I see that physicians in the medical colleges, they have trained to use the interpreters, so, it's more widely accepted. The medical colleges teach the physicians that they should use the language personnel. For example, the CHIA does not just have an annual conference, but they have periodical educational seminars. It's gradually like, people are more aware of that. Because of the legislation, they were required to recognize the need of medical interpreters.

W.T. informed me of internship system.

A bigger institution has own interpretation service department. Institutions have medical interpreters so we can share that with either Spanish, Mandarin or different interpreters, so all the students in internship were shadowed by the staff interpreter. Whether interns are allowed to interpret or not depends on the policy of that institution.

After her completing the course, she became a professionally trained medical interpreter and at the same time she became a language coach who helped the chief instructor understand Mandarin speaking students' practices during their role play scenarios.

The training had the students who speak Mandarin, because the instructors might speak English or Spanish, but, at that time, there was nobody who spoke Mandarin. When they practice, the labs already have some scenarios, when practicing medical interpreting, so they need somebody who knows both languages.

I asked her why she challenged a new profession despite a possibility of returning to

nursing profession. She answered without hesitation.

I think because if you will work only to make money it would be hard, but if you think those people who need help, when they are in need of your help, we help them, you hope them, and you can get sick too, and then somebody can help us. It's like taking and receiving. And we don't just work for we do but, I think you need a heart. Without a heart, it's going to be difficult to do it. ...To be an interpreter, you need a heart. It is a hard working profession. It has a lot of responsibility so I think you need a passion, a lot of passion. Without a passion you can't do it.

Her former career as a nurse wasn't always good for her training of medical interpreting because it was difficult for her to switch from nurse's mindset to that of a medical interpreter.

I think the hardest part was the training to be a medical interpreter. We don't say, "This is right." Or "This isn't right." Then both sides can decide on what was wrong and it is up to them, -- we are asked to be just a voice. We are just interpreting. Whatever the patients say, we say, whatever the physicians say, we say, that is our role, we are just a voice. We are trained to be in that way. Our role is to be just a voice.

W. T. first pointed out the importance of the professional association, CHIA.

When you go to an annual conference, you have all kinds of different speakers from fields, and you can build a network with people. They support. Since I am a freelancer, if I don't go, I don't know anything. I am not a hospital interpreter. At those events, I connected with all my students and colleagues. Once you graduate from a program, it's not student and teacher anymore. We are all coworkers, once you finish the program. We are all coworkers.

W. T. underscored the importance of the financial contribution by foundations and by the state for medical interpreting training courses such as the Mount San Antonio Community College.

Some grants, like the California Endowment to form a program was important. They allocate the budget. I think for community or community organizations, or community efforts, they see the need of it [development of medical interpreting service] they can come up with some fund to help resolve the problem.

W. T. described what it meant.

The patients are really grateful and appreciate that medical interpreters can be there for their services. And they are not nervous with us. This is an emerging field and also the necessary link of the medical health delivery system and I just wish the government acknowledge the need and help this profession to be recognized and acknowledge and get a popular and reimbursement for the efforts, and this is beneficial for hospitals and it's going to be for the better of the human kind. Going to the training is good because every field has their way and their professionalism.

Field Note

I met W.T. at the final exam at the Mount San Antonio Community College. OHT 6 introduced me to her. I had an interview at a community center in April, 2010. She took me to Sunday mass and introduced me to her friends and relatives at the church. She had been teaching a Bible class for three years and had been in charge of Woman's fellowship at her church. I participated in her class and the lunch party. She invited me to her house where I spoke with her husband and daughter.

Oral History Teller, No. 9

Name: Esther Yazzie-Lewis

Country of Origin: U.S. A.

Language: Navajo, English

Profile

Esther Yazzie-Lewis was the first federally certified Navajo Court interpreter and the first Navajo staff interpreter at the Federal District Court in Albuquerque, NM. She also works as a medical interpreter. For the Navajo Interpreting Training and Certification Program, she has been an instructor since its creation in 1993. She also served as the primary interpreter for the oral history project with the Navajo victims' families of the uranium mining. The project published a book titled, "The Navajo People and Uranium Mining" (Brugge & Yazzie-Lewis, 2006). She co-authored the first glossary in the Navajo language, English/Navajo Glossary of Legal Terms for the U.S. District Court for the District of New Mexico in 1985 (The United States District Court for the District of New Mexico [Glossary], 1985). She graduated from the University of New Mexico (UNM) in 1985 with a Bachelor of Science in political science, and earned a master's in public administration and a second master's in American studies at UNM.

Oral History

"The Navajo Nation in Arizona, New Mexico, and Utah is the world's largest Indian Nation. With more than 16 million acres of land, it is larger than Ireland and about one-fifth the size of Japan" (Brugge et al., p.1; See also Charles River Editors. n.d. [Book]). "In 1923, a tribal government was established to help meet the increasing desires of American oil companies to lease Navajo land for exploration" (The Navajo Nation Government). Esther was born on one of the Navajo Reservations in the state of New Mexico. She recalled.

I was born in 1950. The life on the Reservation was nice. We were not anywhere. The Reservation means an Indian country. It's our own Navajo land. We had hospitals. Some on the Reservation run by the Government. They called it an Indian hospital. They doctors were not Indians. Their language was Navajo. I don't think they had an interpreter. I think they had Navajo people who spoke English who can interpret the Navajo for them. They were just people, own family members who speak English, or Navajo people who worked at the hospital.

Navajo people lived so isolated from the rest of the country that people weren't exposed to languages other than Navajo. As a result, Navajo children had to start school life as

LEP students.

I studied English at school outside of the Reservation in the border town. I had a language barrier at school. I went to school when I was six, and everybody spoke to me in English, so other students wanted me to speak English. There were a lot of others that they didn't speak English. All were Navajos.

Esther worked with Navajo communities.

After I learned English, I was at the high school, finished and I worked for the Navajo Police Department. I worked for the Navajo Judicial Court, and then after I learned, I worked for the Navajo courts, and I moved out of the Reservation to go to school at The University of Albuquerque, in New Mexico.

In 1979, Esther was asked to interpret the oral testimonies of the victims and families who had lost beloved husbands because of the contamination from the uranium mining. Later she translated them and the book was titled, "The Navajo People and Uranium Mining" was published (Brugge et al., 2006). "[T]he experience of the Navajo people with uranium was a tragedy and a violation of human rights" (p. xviii). The work motivated her to become the founder and director of the Diné Spiritual Land Recovery Project, and to be a member and spokesperson for the Southwest Indigenous Uranium Forum.

I worked with the doctor out of Boston, his name was (DB). They were working against the Uranium mining. It was wrong. I thought it was in a wrong way that Uranium company did to the people. I thought they didn't let them know that the Uranium was dangerous, that they went down the mine without any kind of maps or anything, they just water down in the mine that they just never told people, people just didn't know. So, that was wrong with the government. I am an activist working with the environmental justices. I interpreted all the testimonies of people.

With her experience in mind, the federal court recruited her as an interpreter. She became the first Navajo interpreter at the federal level.

They needed an interpreter in the court, so I started to interpret as a freelance for the federal court, in Albuquerque, in New Mexico. I was the only one. My interest in legal interpreting was... there was a need, there was somebody needed somebody who interpreted in court settings. I was working in the county court. I already understood a life in the land enforcement. I wasn't applying for the job. I was recruited by The Federal Court. Now, I work every day from Monday through

Friday as a staff interpreter at the Federal Court.

A physician in one reservation in Shiprock, New Mexico, reported a severe lack of medical professionals especially interpreters. "Since communication between English-speaking staff and Nava-jo-speaking[as original] patients is a major problem, classes in interpretation methods have been instituted for the benefit of both the Navajo auxiliary health personnel often called upon to interpret" (Kane, 1971, p.738). Esther didn't remember when she was called to interpret in medical settings except that hospitals needed interpreters since early days.

Because there were no other interpreters, so hospitals were calling me because they needed interpreting, so, I was going to hospitals to interpret for their patients.

Native American cultural beliefs have been challenging for medical professionals to manage as highlighted by physicians. They observed Native Americans' beliefs and analyzed their dreams of the dead and perspective on illness (Putsch^{*9}, 1985/ 1988; Grossman et al., 1993). Anthropologists have focused on a difficulty for interpreting or intervening for communication among native people and physicians (Kaufert^{*8} et al., 1984; Kaufert^{*8} et al., 1985; O' Neil, 1989; Kaufert^{*8}, 1990; Kaufert^{*8} & O' Neil, 1990; Kaufert^{*8} & O' Neil, 1995; Kaufert^{*8} & Putsch^{*9}, 1997; Kaufert^{*8}, 1999; Kaufert^{*8}, O'Neil, 2004). Esther has coped with such challenging situations by playing a role of cultural broker.

The challenge was that non Navajo, the White people didn't understand the Navajo people. I just had to educate the attorney and the judges. The challenge was the same, and I would say the doctor didn't understand the culture of the Navajo people, even today. Some of the Navajo things, they don't eat fish, so some of the diet they get at the hospital, they don't want, they need certain treatment, they got by medicine people [traditional healers], they like certain things out of the diet. They don't want to eat egg, or something. It's part of the culture. However, medical professionals don't know why? How come you can't eat this? Because the Navajo people just can't do that. I just explain the culture and the meaning.

More interpreting services are needed now because of a change in the Navajo people's life style and their limited language proficiency in own language.

Because right now a lot of Navajo people are westernized. Unlike before, now the family can travel with the patients, [when they get sick during the travel], the hospital needs an interpreter to treat them so that is why they need interpreting. I

think it is now more important to have medical interpreters than before. ...Oregon, Idaho, California, other states where Navajo people live need Navajo interpreting, they get hold on me. Sometimes I travel and sometime I use phone.

Compared with former days, she noticed more Navajo people work as medical professionals, however, their presence has not improved language and cultural barriers.

That doesn't mean that Navajo medical professionals understand Navajo culture because they are westernized. They need Navajo medical interpreters to treat the Navajo patients for cultural reasons. Some of the Navajo people don't speak Navajo language. I think the majority speak English, like you know, agencies, metropolitan cities. I don't think the Navajo young people are really learning the Navajo language, but the young people in remote area, still they learn and speak the Navajo language.

Regardless whether settings were for legal or medical, the bottom line is to help communicate between two parties.

Both are for the life situations, we work so the judge understands and the defendant understands, how much time in jail or when I am there as a medical, there are surgery, or medication or examine, again it's about life and how you explain to a person, you know that a cancer, that's are all about life, I think a difference, I don't really see a difference, because I think the both sides whether legal or medical there always you have to explain what's gonna happen to them.

Regarding emergency medical services, in 1964 the Navajo Community Health Representative Program was established and in 1965, the Navajo Police Department launched ambulance service (Navajo Nation Emergency Medical Service, History, n.d.). Regarding the advocacy movement, she saw a limited influence of the Act of Civil Rights in 1964 for the Navajo people.

I don't know, I think there is another group called the American Indian Movement and other Indian people in this country, I think, benefitted for the civil rights movements. But the Navajo don't, you could say, it was the American Indians who put themselves to work with that movement.

In contrast, she highlighted that the Court Interpreters Act in 1978 influenced more on the Navajo's language issues, because this law mandated that qualified interpreters should be used for any criminal or civil actions, more importantly, it drove the state of

New Mexico to deal with the Navajo populations. In consideration of their geographical concentration in the specific states, the Navajo language was considered as a priority language to be served for court settings (González et al., 1992). Esther worked to develop the first glossary of the Navajo language for court interpreting for certification (The United States District Court for the District of New Mexico [Glossary], 1985).

A change to me [regarding the historical development of language services] is that we certified the Navajo language. We were developing the glossary within the Federal Court, glossary and then took it to Washington DC before Congress, and Congress certified the language for Navajo people in 1987. I think the federal certification, I already knew of a court proceeding, therefore it was a freelance interpreting. We made a glossary. I didn't realize I was creating a job for my job in the Federal Courts.

Her picture when she obtained the certificate has been posted on the website of the University of Arizona (The University of Arizona, Office of the Vice President for Research, Graduate Studies & Economic Development). As a pioneering interpreter and experienced trainer, she has been teaching at many courses, including the Navajo Interpreter Training Institute with the University of Arizona, which started in 1993. This institute was founded with a financial support from a philanthropist, and developed into an undergraduate degree curriculum based on a grant by the U.S. Department of Education's Fund for the Improvement of Post-Secondary Education (The American Translation Association Spanish Language Division, 2011). She worked with many academics, especially with the linguist who had established foundation of court interpreting and the founder of the National Center for Interpretation Testing and interpreting courses at the University of Arizona .

I think medical interpreting is important. It's the field that now it's emerging, and important we do this for Navajo people. We certified over 140 medical interpreters now as far as I know for three States, Utah, Arizona and New Mexico. We started legal interpreting in Navajo language, at the examination, we have an expert, on other compartment, they question about an accident, somebody injures, somebody killed, so we train at the Navajo Institute, we did culture, and we trained in medical terminology, internal body parts, so you study skin, bones, so the medical part alone, and you are to explain that terms and different things, for that the people that need X-ray.

In 2011, 33 applicants of this institute passed certification tests to work as interpreters

in the state of New Mexico and Arizona. A six-day training course aimed for both court and medical interpreting to help ensure an equal access for healthcare and justice for limited or non-English speaking Navajos (Ruiz-McGill, 2011, May 31[University news letter]). Esther also has presented at interpreters' conferences such as New Mexico Interpreters' Conference in 2010 and 2013.

Field Note

When I interviewed Informant (P), a community based physician who was highly interested in cultural and spiritual world of American Indians, I learned that Navajo interpreters were working in medical settings as early as in the 1960s. The literature shows that most of earlier research was conducted on Native Americans or Canadians, and several researchers have targeted Navajo interpreters as I previously described in Esther's oral history. Believing that it would be vital to contact Navajo medical interpreters to trace back to medical interpreting development, I didn't hesitate to contact the Curriculum and Systems Coordinator for the National Center for Interpretation of the University of Arizona. Thus, I was introduced to Ms. Esther Yazzie-Lewis. The coordinator added a comment, "Ms. Yazzie is only one of the few interpreters who possesses such federal certification. With all this said, there could not be anyone else more qualified to assist you than Ms. Yazzie."

Oral History Teller, No. 10

Name: Randa

Country of Origin: Lebanon

Language: Arabic, French, English

Profile

Randa has two jobs. She works for the government and also has been working as a freelance medical interpreter. She started own side-business in interpreting and translation. She immigrated into the United States from Lebanon and speaks Arabic and French. She also worked as a certified court interpreter.

Oral History

In Lebanon, what they called 'the Christian-Palestinian war' took place between 1975 and 1976. "It has been estimated that the bloody 15- year purge in Lebanon resulted in 71,328 killed and 97,184 injured" (Traboulsi, 2007, p.244). Amid political turmoil, thousands of people fled Lebanon. Christian families including Randa's, searched for a new place to live in. Randa's relatives including uncles and aunts came to the United States and settled down before Randa's family.

I made it here in 1983 because of political issues in the country. Actually I came here with my brother and sister then my mom and dad came after like a year later. We tried to locate a school, so we can finish our education. It was quite of a challenge.

Although her relatives who had settled earlier helped them, the children had to serve as interpreters for their parents in many social interactions, from going to grocery stores to speaking to their neighbors. Their ethnic community was going to develop but it took time to help such influx of people because earlier immigrants first had to make their own living in a new land.

My elderly mother and father were only native of their language. Dad didn't know any of English. We were there for the most of their doctor's appointments.

Randa felt her duty was to serve as an interpreter and a translator from the day of their immigration.

This is how I started. I came here like an immigrant, so I had to translate immigration paper from Arabic to English. From school, I had to translate scripts like English. I wasn't certified but I was doing a translation for somebody. I had to go to college to explain for them. It came naturally that I was kind of obligated to do

it. There was no choice.

She served as a child interpreter in medical settings. Later she found medical interpreting meaningful from her experience at a younger age and started to offer services as a professional.

There always are needs for medical interpreting. If you ask me why I am doing this, first you like to do this for your family, you want to help them, because somebody else doesn't help or offer the service or support.

In 1986, the state law was enacted to mandate the interpreting services for court settings. She once was a court interpreter but shifted to medical interpreting. She explained the reason.

I help more each other, more humanity[in medical settings than in court settings]. I knew more medical law settings, and if you like a small setting, nicer, hospitals are nicer than the court, even sometimes in bad situations in hospitals, but still I feel much comfortable with patients in hospitals than with criminals. No fun. It more like I enjoy more people in medical interpreting.

Randa recalled that people formerly didn't care for quality of medical interpreting in 1994 when she started to work.

In legal settings, they know always they are entitled. But in medical setting, medical interpreting wasn't a mandatory. So, they just call someone and you just see a doctor if they understand, it's OK, but if not, they don't care.

Since the enactment of the Emergency Room Interpreter Law(ERIL) in 2000, the situation has been different.

Medical interpreting is a mandate now and even if I go with my mother, they won't accept me as her interpreter. They have to call a professional interpreter. There are some hospitals with strict rules.

Randa recalled how the former working environment was for medical interpreters.

They [medical professionals] were not really accepting [medical interpreters]. Basically they didn't have an idea what was medical interpreting and medical procedures. So most of the time, I was in a situation, even I told the patients to do or told what they liked.

Randa observed LEP patients are more aware of their rights to medical interpreters, and acknowledges a change in status of medical interpreters.

I would say for the last five or six years, I see more interpreters actually [at hospitals]. They work by making the bridge between the doctors and patient. We are in the same position. Doctor can really rely on us and trust us more. I see medical interpreters are more involved in a treatment process. You will really give an interpreter an opportunity to tell the doctor and tell the patient what is going on.

Since Randa has a regular job working for the government, she has been working as a freelancer during her spare time. Her challenge was to acquire knowledge and skills as she states.

It wasn't easy, always it was a challenge. Especially when I first came here, I had to carry with me a dictionary, because the medical terms were always hard. And so, always even I was competent, I was always afraid that I was not doing a right thing. I took a training course, and I did my own studies. I have a self-dictionary of medical terms. Just comes with all the experiences, years and years. Patients cardiac conditions, like so and so, I just preparer myself.

Randa epitomized how cultural aspects differ although they speak the Arabic language and live in the same country.

I know that Egypt, Iraqi, Morocco, Syria, Lebanon, they have difference. They all form different communities. Everybody is aware of the difference. It's like more religion, religion is more involved. People greet differently. It's a challenge. You have to make sure about culture itself. Like the background, it's not only language, but culture. As I said earlier, communities have set religions, females are different, men are more respected, so you can see from the appearance, you sometimes see them how they wear. The language is not too hard to learn, but it's a culture. Culture is different in countries.

When she chose medical interpreting, she took advantage of the cultural competency she had learned from her life in her country.

I lived and I came from my country, which is very diverse. We are multi-diversified. A community has different religions and there are conflicts, being a religion of source of conflict. When we learn how their language and religion, we can live with them. We grew up together and we went to school there, you have to live and eat

next to a different type of people, even you speak the same language. But their backgrounds are probably different to certain things. You don't want to show your disrespect or anything.

I interviewed her at the kitchen and asked her, "Let me ask you, are you enjoying or it's sometimes very hard or not, because you have another job?", she replied as below.

Well, thing is a challenge no matter what's your job is, interpreting, child rearing or cooking a recipe. No matter how hard it is, it's just you are doing from a heart, and you know as an interpreter or as a volunteer for a long time. It's just like a complexity not really going to discourage for a good -- good interpreters from doing -- doing a work.

Her perspective on medical interpreting job was compared to her regular job while she was baking a cake for family party.

Well, I have to really tell you the truth. I love an interpretation job because I consider it as a hobby, and it's a paid hobby now, because I used to do it as a volunteer for a long time. Not just for me like a regular job, as I said to you, even if you work at home, when you try a recipe of baking a cake. You have an expectation to come up with nice... nice outcome. I feel like a small mission for me than a real job. I was a long time family's volunteer doing that. It [Interpreting] comes automatically, if I go there and they need me and I just do it for them.

Her advice for aspiring interpreters in Japan was organization.

You have to be unified, you have to be all go to the same goal. It will be one goal to get compensation you deserve really, because we always do volunteer jobs, but you have to be recognized as professionals by the government or the state.

Field Note

I met Randa at the conference IMIA 2006 and have been keeping in touch ever since. It was a mother's day. I was invited for a family party and spoke with her family and relatives on the day of the interview. I mainly interviewed her while she was cooking dinner. That is possibly one of the reasons for her metaphor expressions of cakes. Through my interactions with her relatives at the table, I asked at what age they immigrated. As a result, I noticed the age of their immigration was to some extent influential in terms of English fluency and their priority of language to speak with me. For example, her mother, the oldest invitee among them spoke with me only through

Randa's interpreting. Among about twelve invitees, some aunts who immigrated at earlier age, spoke English with me all the time and shared episode on how they had come to the United States and their hardships in adapting into new culture and social environment. One of the invitees was an interpreter of Randa's agency and I spoke with her to know that she just started to work as a medical interpreter for her. They were watching TV program aired from their country. They seemed to recover old memories in their country from what I heard in English. She took me to her church and introduced me to people in the community. The importance of their community was seen to help each other. Her husband from the same country drove me around with the eldest son and I spoke with her two sons and a daughter. The youngest son, a high school student, was interested in foreign language study and asked me about Japan. Randa was happy with his linguistic interest and said she would be happy if he would work as an interpreter. As a way of greeting, I shook hands with her husband without knowing men don't shake hands with women. I only knew it later from what I learned during her interview. I made apologies and she said, "Don't worry. It was just unintentional." I understood how culture matters as she stressed during the interview.

Oral History Teller, No. 11

Name: Ira SenGupta

Country of Origin: India

Language: Bengali, Hindi, Nepali, English

Profile

Ira SenGupta received her master's degree in English Literature from Jadavpur University in West Bengal, India. She taught Honors English at Loreto College, Darjeeling, India. Her career in interpreting began with the immigration system and court systems in Seattle, WA. She is the Executive Director of the Cross Cultural Health Care Program (CCHCP) which provides the Bridging the Gap course, nationally recognized training course. She serves as the IMIA Advisory Board Liaison. She was invited as a keynote speaker by a Japanese NPO for medical interpreting, Multi-language Interpreter Center, known in Japan as MIC Kanagawa in 2006.

Oral History

Ira SenGupta immigrated with her husband to the United States in 1972 and has been living in Seattle for the past 41 years.

I came over to this country with my husband 41 years ago. And I first came to Virginia, I stayed for 1 year with my husband and we moved to Seattle, Washington.

For having lived in India where at least 1,000 and almost 5000 dialects are spoken, she had a keen insight into languages.

In the late 1970s and 1980s, there was a huge influx of new immigrants and refugees populations in the Pacific North-west. It became clear that there was a great language access in hospital systems.

Compared with other states, the state of Washington was early in taking the initiative in developing own language service system. This state is one of few states which pay for language services (The National Health Law Program & the Access Project, 2004). In the late 1970s, the state faced an avalanche of refugees starting with Southeast Asians followed by Africans, Hispanics, and former Soviet countries (Chang & Fortier^{*1}, 1998). To deal with such huge needs, as early as in 1969, Altrusa Club of Seattle was developed by volunteers as a pool of interpreters and translators. In 1979, the Seattle-King County employed interpreters on regular bases to Southeast Asian refugees from war-torn countries. The staff were former refugees (Owens & Jackson, 2003, p. 14; See

also DivesityRx, 2009). A series of complains by LEP patients resulted in OCR's investigation and a pool of interpreters, Community Interpretation Services Program, was established in 1982 (Riddick, 1998). Amid such social environment, she worked first as a court interpreter.

I worked with the Berlitz language services as a court interpreter and as an examiner for the Bengali language tests for Berlitz.

Then Ira began to work more for medical settings.

I was requested to serve as an interpreter for public health. I was interpreting in 3 languages as I mentioned in hospitals and in the King County Public health clinics across the western region of Washington State.

A group of physicians with highest awareness to care for refugees shared common interest in helping LEP patients who needed cross-cultural care and language services.

The Cross Cultural Health Care Program (CCHCP) was starting up at the Pacific Medical Center. At that time, there was no hospital, but primary and specialty clinics. Previously the building served as armed forces hospital. The cross Cultural Health Care Program was founded by a group of concerned doctors who wanted to serve the needs of a changing population in a culturally and linguistically appropriate manner.

Ira recalled key players.

Informant (P) was one of them. He was a clinician in that clinic at that time. He along with other social minded physicians realized the for a special program that could provide training for both health care providers and medical interpreters to help serve LEP patients, minority communities in their clinics. And they also realized then they needed to formalize interpreter services and so they applied for a grant for Kellogg Foundation.

Ira was called to join them.

At that time, I was serving as an interpreter as I mentioned in public health, and I was requested by my boss to join the Board (BD) of CCHCP, because they wanted to have individuals who are multilingual. It was in 1992 when I joined the BD. There were almost 30 people. All the hospitals, clinical services, because they all were serving, all were facing challenges and all wanted to solve this. So, it was a kind of coalition. Definitely hospitals and clinics, the state agencies and we had a Public

Health, and local individuals like me, who are multi-linguals.

Ira served as the principal investigator for a needs assessment survey.

The Board decided that the four steps would be to conduct a needs assessment of the community and the barriers that they faced in accessing western health care models. We focused on a diverse multilingual, multicultural some of whom were newly arrived in the US and others who were traditionally underserved.

Ira detailed how the survey was conducted with a team work.

We started with 22 communities. The first thing I did in conducting was to find two partners on the BD, that had a MPH degrees, one of them (Q) was from Harborview Medical Center, interpreting services. (Q) and I held a special position on the BD, we were in charge of interpreter....since I worked as an interpreter and (Q) just had a degree in Public Health.... So we advised the BD and I was in charge of conducting this assessment as a volunteer and accepted that. (Q) helped me in tabulating the data.

Ira fully used her network as an ethnic community member and as a community interpreter.

So the first step was to find members of the community that we could interview. I was deeply involved in my community as the president of the community association and was in touch with other minority communities thorough my work as an interpreter. In the community, I was also quite a bit related to the school system as a PTA president at two different schools. Based on these connections I was able to contact communities, engage community members as interviewers. There was a stipend offered to the community interviewer. We selected 22 individuals from their communities to conduct 19,000 interviews.

Ira developed question guides.

I also had to create a qualitative assessment tool, with 12 questions. Then we had to teach them how to conduct the interviews, and meet them twice a week to make sure that everything was going well, and they were collecting data. Some communities were small and they couldn't find any people to interview. In some communities like the Haitian community there was a massive migration from Seattle to the East Coast so we lost quite a number of our informants. One more thing to share this time, we were contacted by the Public Health. They also gave

additional support and in return we did outreach for them while conducting the interviews [underline placed by OHT 11].

The results which depict how the situation in the state was in early 1990s.

Our assessment results pointed to quite a few barriers related to related patient-providers interactions, language gaps and, cultural gaps, provider bias common which community they served [underline placed by OTH 11], a lack of awareness of where the health care facilities, lack of knowledge on what kind of services were available, just a lack of knowledge of the whole system.

These barriers posted negatives outcomes to the communities.

This resulted in the community going to the emergency room services for simply primary care needs. There was also a lack of transportation, and a lack of child care. They came from countries, where they were part of large extended families, so they missed appointments and faced cultural clashes related to this. So the bottom line is that we realized that the health care programs would have served in culturally and linguistically appropriate ways.

The results provided some evidence for underlining needs for medical interpreting services.

The Board decided to offer training for bilingual community members to become medical interpreters. That was how the profession grew and developed in Seattle and CCHCP's Bridging the Gap training program was born.

The next step was to educate providers.

So after we started our Bridging the Gap Training Program, the interesting thing about the Bridging the Gap was we received a grant from the Region X for the Spanish version. And that was later expanded and that was done by two women, I don't remember, I try to look for it. (C) helped edit the training manual. (C) was 12 hours a week staff, at the Cross Cultural, She coordinated the process [underline placed by OHT 11]. That was followed by the expansion to 40 hours. That happened in the early 90s. So, by 1994, I believe, we had a program for the Bridging the Gap Training. Soon we developed the cultural competency training programs. We did the first training of cultural competency in The University of Washington. (P) and I, we did this training, our first cultural competency training.

The next step was to encourage hospitals to pay for the cost of interpreting services.

Then I did another study by looking at 8 hospitals' systems in the Seattle area to see how they pay and how they handle interpreter services. Do they use family and ad-hoc? Do they have staff interpreters? Do they know about Title VI? And how did they pay for it?

The purpose was to convince the state government for reimbursement of interpreter services.

So, we needed data, research to prove it. So, I interviewed whoever. And I realized some hospitals were spending quite a bit, because public hospitals had a lot of LEP patients. So, they were using back-up telephone interpreting. They would use not formally trained interpreters. Now we had two research projects, we were becoming well known in the nation, because some of them were written up.

In addition, she conducted a field research with (P) on hospital's CLAS standards applications for the Office of Minority Health (Putsch et al., 2003).

Field Note

I first talked with Ira SenGupta in 2006 in Japan and I have been exchanging information every year at IMIA conferences. Her passionate speech extended networks throughout the industry. At IMIA 2013 Conference, I nearly missed her on the way from the conference hall to a room where we would have an interview, because she was in between attendants who talked to her.

Oral History Teller, No. 12

Name: Joshua Van Ngo

Country of Origin: Cambodia

Language: Cambodian, Mandarin, Cantonese, Teochew, Vietnamese, and English

Profile

Joshua Van Ngo is a medical interpreter and language coordinator at the Tufts Medical Center, formerly called the News England Medical Center, known as a floating hospital for children in Boston, Massachusetts. The hospital is located in the China Town surrounded by Asian Communities. According to him, the average requests are 130 a day of which the 100 cases are for Asian languages only.

Oral History

Joshua fled Cambodia where he was born in 1952 and arrived in the United States in 1988. Soon he started to serve as a volunteer for the community until 1991. In the early 1992, he was hired as a freelance interpreter at the Tufts Medical Center, and in 1994 he became a full time interpreter. Although he does not work as a professional trainer, he has been working with OHT 20 to assist her for a training class. He won ‘The Saltonstall Award[in-house award] three times. “The Saltonstall Award honors employees who exhibit the highest standards of service and performance in their work and their interactions with staff members, patients and visitors” (The Tufts Medical Center, 2010, p. 6).

His oral history started by recalling his memory which explains why he speaks six languages.

Actually I am a Chinese. My parents who were born in China. I was born in Cambodia, but while I was in Cambodia, the civil war occurred at the Cambodia from 1970 to 75. I didn't have many opportunities and just I learned basic reading and writing at school. After the civil war ended in 1975, it was Pol Pot, so called Khmer Rouge, did genocide. The genocide didn't care who you are. And my parents, my sister and my brother were killed by them. They were killed. When I went to Vietnam, I did not speak a word of the language. How can I survive in those countries without learning language? So, I pushed myself to go to learn the Vietnamese language. And I met my wife in Vietnam. So, I was in Vietnam for ten years. I picked up my Vietnamese in Vietnam. But in 1988, we decided to come to the United States.

After moving to the United States, Joshua started to learn English for survival in this new land. While the community helped him, he helped his community, too.

I didn't even speak a word of English. ... when we came to the United States, we tended to face cultural difference, but I already had here a community, and people asked me to help, and try to learn language. But you have to push yourself to live in the country, a foreign country, to learn the language, you can survive. I had myself learning English, and also on the other hand, I took advantage of my languages that have been understood, so I became a medical interpreter. From then I have been here[at the Tufts Medical Center] for almost 22 years.

Joshua started from a community interpreter, then an on-call interpreter and finally a staff interpreter.

Actually I didn't push to become a medical interpreter. This came accidentally. I wanted to help people to see a doctor. On top of that, I took advantage of my languages to interpret for the patients who went to the doctor, and somehow, the doctor offered me a job to work for a part-time job and then for twenty hours a week, so I was aware and later I became a full-time medical interpreter.

A Chinese community near his hospital conducted screening health survey found “[o]nly 25 % of interviewees could speak and understand English. ...20% of the group were not aware of the existence of a medical center near Chinatown and over 50% admitted to having medicated themselves with a variety of Chinese herbs (Li et al., 1972, p. 539). His narratives also asserted that his hospital and the neighboring community had been taking the initiative in dealing with language issues on behalf of the LEP patients.

Our community ...Asian community, they supported us, they come up with some plans. We had to pull together to look for where we can get. We, interpreters, have to go out to the community and try to improve our services to the community. The community is also a very strong supporter for the interpreter services. For the community, in this country, the most of the young kids are either at schools, or are at work, so, they don't have enough time to take care of their parents, so we need some support from the community. We can create the service for them. So, it's very ...; so everybody has its own structure on how to build a medical interpreting service for our service to our community.

Joshua also recalled the importance of advocacy for the politicians and the hospital administrators.

My advice is to talk to the people at the Representatives or Senators, to tell them that we need the grants for our communities. Without interpreter services, even doctors can misdiagnose and everything from electric cardiograph, catheterization, MRI, to blood tests, etc. is too expensive. When they create interpreter services at hospitals for the communities, if we deliver the messages, the doctors can diagnose more accurately and less spending on testing or the technology. The patients don't need to take them [family members or ad-hoc interpreters] and the hospitals don't need to spend so much on them. Hospitals understand the interpreters are a team in the medical field. You can't make hospitals to spend a lot of money on extra tests that the patients don't need them, or you misdiagnose the patients, and if something happens to the patients, the hospitals have a liability on the patients.

His coworkers were also supporters by sharing knowledge and daily stressful experiences.

When I face patients, and find new terms, I try to put them in my memory, or at lunch hours, I sit at our lunch room and we share our stories, "Today how many encounters have you had?", "Which encounter gave you more headache?", "What did you learn?". You have to share with your co-workers. Sometimes the medical terminology you know it, but you aren't not as good as your co-workers, you ask them. So, it is very good. It is confidential so, as a medical interpreter, you can share it within your own group or with your coworkers. Whatever you understand or learn from the patients, you can't bring it home or state somebody else, only share with your own interpreters' group.

The interpreting service belonged to the Department of Social Work Service when it started in 1982. The hospital's monthly bulletin reported the advancement for a decade.

Since then, requests for translations[interpreting] have grown from 45 to 2,000 a month [as of 1993]. Interpreters provide assistance in 35 languages, ranging from Arabic and Greek to Indian, Russian and Thai. The service receives around 800 calls a month asking for a Chinese interpreter: Vietnamese, Spanish and Portuguese translators are also in high demand. ...The Interpreter Service relies on its on-call interpreters to handle the requests for translations[interpreting] that the office receives daily (The New England Medical Center, 1993).

MMIA was sponsoring monthly training sessions so interpreters such new comers. Hospitals also offered seminars for staff interpreters.

Every hospital has a seminar every two months. There you learn medical terminology and you have to learn on the job, too.

Joshua tried to improve working environment by training medical professionals on how to work with medical interpreters.

This is a big hospital, so we have visitors from pre-course of medical schools. We have here different medical students, physicians, so every year we have to train them. And you have to introduce yourself and [tell them] what your roles are, because every year we have different physicians. They don't know the rules. They don't know the clues.

Joshua exemplified his role as a cultural broker.

Because the young generation in this country, they do speak perfect English, but they don't speak their own native languages. We have to become cultural brokers for both parties. In our culture of our Asian communities, they don't want to tell that the grandparents or parents have a cancer. They just don't say that, or they try to cover the information. In this country, in the United States, the physicians want the patients to understand what they have. And also sometimes, the Asians don't want them to ask such a question directly to patients. Physicians don't understand. So we relay messages to see what this is and what they are, and we have to relay their messages back to physicians. For example, you say doctors that this is what the Cambodians don't like. They don't like you to touch the head. That's a part of the culture. Some time, the doctor says, "Why did you come today?" And if you are a medical interpreter, you can't interpret, "Why did you come today?" It is not acceptable for the patients [of our culture]. "What can I do for you today?" Although everybody knows doctors say, "Why are you here today?" They can't say "Why are you here today?" Use the other words, "What can I do today?" or "What's your problem for your coming today?" You have to interpret a little bit culturally to make the patients more comfortable, so they try to open their minds.

Field Note

I was introduced to Joshua by OHT 20. Since then every year I have visited him and talked with his coworkers. I know how stressful this job is, however, I found him always with smiles in his face without any complaint about daily assignments. I once asked him whether he had regretted having chosen this profession. He answered:

Yes, a lot, sometimes, I have dilemma, such as a patient passed away despite your

support. Those are dilemmas. You have to hold it in yourself, so you have to focus on your job, try to be calmed, and you have to strong, you have to support the family members, and you have to support the doctors. You have to be confident. You have to be their ears, because they can't express themselves.

Oral History Teller No. 13

Name: Liliana A. Zagaria

Country of Origin: Argentine

Language: Spanish, English

Profile

Liliana A. Zagaria was born in Argentine and studied finance and economics. She came to the United States with her family who worked for an American company in 1980. She has been working closely with immigrant communities. After working in the state of Minnesota between 1987 and 1990, she has been working as the Director of the interpreting service at the Lawrence General Hospital since 1992. She joined MMIA and became one of the members of the initial group. She is a member of IMIA.

Oral history

Liliana lived abroad before coming to the U.S. and experienced language barriers at a hospital in Switzerland.

I moved to Europe in 1979. I live there for about 2 years. The problem was the language barriers. I always took my children to a hospital. I had my friend who lived in Geneva, I always took her with me to a physician's appointment. I realized I needed to learn French. Before the end of the stay in this country, I needed to learn Swiss French, because they call the house keeper from Spain to help me communicate with the doctors. So I understood exactly what was going through with our patients.

According to the city's website, Lawrence, "The successive waves of immigrants coming to this city to work in the mills began with the Irish, followed by the French Canadians, Englishmen, and Germans in the late 1800s. Around the turn of the century and early 1900s, Italians, Poles, Lithuanians, and Syrians began arriving. The wave of Puerto Ricans and Dominicans started in the mid to late 1900s, and the newest arrivals have originated from Vietnam and Cambodia. The current population of roughly 70,000 is largely Hispanic and has given a Latino slant to the local economy and culture according to the this city's website" (City of Lawrence). She works at the largest hospital in this city.

The majority of the population is Hispanic, from Dominican Republic or Puerto Rico. Now we are seeing some change in the population, more Central America, Guatemala, Nicaragua, No, No, I am sorry, not Nicaragua, Guatemala and El Salvador. We had some Brazilians a few years ago, but now they are leaving

because the situation of Brazil is better. But basically on a daily basis, 99.9% of the requests are for Spanish interpreters. If I have to tell you, for example, I had 2 Vietnamese cases in the entire hospital, in one week, I might have one Chinese... Vietnamese.

Since 1989, Liliana has been working with Hispanic populations in this city and found an opening for the professional position at the hospital. The first challenge was a lack of training opportunities for the profession as recalled.

One day, I saw an ad for the position of Coordinator of interpreter services, and I saw the opportunity to keep helping the Hispanic population in this region. I applied, but no training was available at that time for medical interpreters. I was hired in March 1992, shortly after I was able to contact OHT 1. Desperately, I looked for medical terminology classes. I took a medical terminology class at the community college but in those days the classes were in English, so I had to do it in English and worked closely with my dictionary, to find the equivalent in Spanish. It was a lot of work! Yes, I took the medical terminology I and II, anatomy & physiology.

Since Liliana did not know about medical interpreting at first, she searched ways to find an in-house interpreter to learn from. One of her neighbors happened to work at the same hospital as OHT 1, so she could contact OHT 1.

I began to work here in March 1992. The organization (MMIA) didn't have a name at that time, but a group of managers and directors of interpreter services from the big hospitals in Boston were having conversations and meeting for a few years before I joined the group. The leader was (R).

Since early 1990s, several training courses were organized. The one in 1994 organized by one of the medical professional education centers was taught by OHT 3. Liliana completed this course (The Merrimack Valley Area Health Education Center, 1994). Her early days' challenge was not only English but also medical terminology.

I didn't know anything about it. From day one, I developed my glossary and I still have it. I didn't know much...I had to start from scratch.

Another challenge was a lack of recognition at work.

Last year [2011], we did 20,000 a year. The first year [in 1992], it was just 60, because the floors [physicians and medical professionals] didn't call me. Remember,

they used family members, or house keepers. They had a very very BAD HABIT[Capital letters wrote by the OHT13]. For a long time, I did a round and introduce the service, but I found that at first, the patients called me, not the providers[physicans]. The patients had my card, and they called me, "Liliana, can you help me?" And then I came to them.

Under these circumstances, what Liliana did was to improve skills and knowledge to prove she deserved respect by medical professionals.

I took the Bentley University certificate program. Now there are many courses such as the legal and medical interpreter program from the Boston University. The program started in The Bentley University and it was sold to the Boston University.

Liliana described an article on an in-house circular to disseminate some information on the service among the employees in 1992. The title was, "The Lawrence General Hospital New Interpreting Service Program Eliminates Language Barriers to Medical care", and one of the columns was "How to Work With an Interpreter" (The Lawrence General Hospital, 1992, August 21, p.1-2 [Newsletter]).

Each hospital has its own strategy. Liliana had coped with the needs by training own bilingual staff. Other initial group members helped her in teaching her staff.

I got in touch with OHT 3. I asked her to do training for the employees. She had a brief curriculum about 8 to 12 hours of training and she trained me and a handful of staff who were working without any training at the hospital. Shortly after , OHT 1 came and talked about the ethics. And after that, (M) started to get in touch with the Northern Essex Community College and the program started in the Northern Essex Community College, but OHT 3 was already training her volunteers at the Massachusetts General Hospital many years before program. Her program was exclusively with volunteers. She always said, "You cannot depend on volunteers, even if they have the best intentions many times [they] are not reliable. You trained all these people and when you need, them they don't come! So it is not reliable to run a program only with volunteers."

LEP patients were not the only foreigners in medical institutions. Several reports focused on some issues related to medical professionals with foreign origins in 1970s. "The rising utilization of foreign medical students (FMGs[Foreign Medical Graduates]) in health care delivery in the United States has generated heated debate. Analysis had

focused on the numbers of FMGs entering the United States, their growing representation in the physician pool (now comprising 20 percent of all the doctors in the United States) [...]the international ramifications of the increasing exodus of highly skilled manpower from Third World countries” (Williams & Brook, 1975,p.549-581). This study was partially granted by the Department of Health, Education, and Welfare (p.576). Another paper pointed out to their poor proficiency in English (Naerssen,1978). Liliana also temporarily relied on international medical students.

My hospital got a grant around in 1995 to help medical graduates from all over the world to pass theirs exams in USA and get into a residency program in this country, it was called, “International Medical Graduates”. Even this was a great program, funding lasted only a few years, it was great to have a pool of professionals who spoke German, Russian and there were a lot of Spanish speakers. We trained them as interpreters and they were happy to be exposed to the health care system in this country. They agreed to volunteer.

Her staff was reluctant to work, so she had to motivate them. Her approach was a combination of carrot-and-stick policy.

They get differential one dollar per worked hour. They always use their bilingual skills on their own department and we compensate them with a dollar. We tried different things before the monetary compensation. We started with a lunch-voucher 5 dollars, it didn't work so, after many years, this policy was to be changed around in 1997 and 1998. Their work increased. And you have to attend a workshop every year related with the medical interpreting field and to pass a written and oral evaluation to keep the differential.

Liliana saw a change triggered by the enactment of the state law (ERIL).

For over 20 years we had a bilingual employee in the front desk at the Emergency Center. After ERIL, we set up the policy that these employees' needs to have a minimum of 60 hours of training, to take an annual evaluation of skills and to attend a workshop/conference related to the profession. Effective 2014, a requirement of this position will be to have the National Certification.

Field Note

I remember having met with Liliana at the IMIA conferences and have talked at the same table. I was introduced by OHT 1 to her for the interview.

Oral History Teller, No. 14

Name: Shari Gold-Gomez

Country of Origin: U.S.A.

Language: English, Spanish

Profile

Shari Gold-Gomez has been the Director of Interpreting Services at the Beth Israel Deaconess Medical Center in Boston since 1992. Under her leadership over the 20 years, the department has grown from a staff of 10 to over 80 interpreters on payroll. She holds a Bachelor's degree from the Boston University in Economics and Spanish and a master's degree from the American Graduate School of International Management. She introduced a teleconference interpreting system. She was awarded "Latino Achievement Award" in 2011(The Beth Israel Deaconess Medical Center, 2011, October [Ceremony Flyer]).

Oral History

"Between 1870 and 1910, manufacturing employment in Rhode Island increased by 245 percent. [...] In 1915, about a third of Providence's population were foreign born, and another third were the children of immigrants" (Smith, 1985, p. 9/ 11). Her family was one of these families who started a new life in this city formerly known for textile industry.

I was born in Providence in 1963. My parents were children of Russian immigrants. So, my parents, the first generation, to speak English as the first language. I grew up speaking only English, and in my house, my parents didn't speak another language. Only my father spoke a little bit of the language, called Yiddish, which is now considered as close to a dead language, the language that Jewish people spoke no matter in which country they lived, so, some people do still speak it and one of my grandmothers only spoke this language.

Providence was a home to Italian and Jewish immigrants (Smith, 1985). Her exposure to such ethnic environment aroused her interest in languages.

My father was a business man, and he started his own small business which grew...and he imported machinery from Italy. And sometimes he would invite technicians and business people from Italy to stay in our home, so what, they only spoke Italian, so, I didn't speak Italian but my neighbors were Italian, so it would be fun to try to communicate using a dictionary and trying to figure it out and listened to it with my neighbors.

This neighborhood and her family atmosphere nurtured her sensitivity to cross culture, too. Her keen sense helped her lead a multi-ethnic department of interpreting.

In so many cultures we work with, family, together and rule and you know, celebrations, so when I work with the Cape Verdeans, what's important, family and food, and I work with people from Latino America.

Her father influenced on her choice of the language.

He was very practical, and my first language exposure was Italian, but he said, "Italian is just spoken in Italy, so Spanish, that language is to learn in many different countries". He already saw the influence of Latinos. And then after school, I took Spanish. And I love it. That's how the story began.

Her grandmother and mother influenced on her tenacity and determination.

My mother's father died at very young age and my grandmother had six children all alone. And it was a difficult time of the depression here. So grandmother for being very comfortable and having a first calling in the neighborhood when the husband died the money goes, losing, you know, the person who died rather early, so my grandmother had to go to work in a factory and put three oldest children in an orphanage[for five or six years], so she visited them. So, my mother had a hard life, but she never never complained.

Several oral histories by immigrants depicted how differently U.S. born daughters viewed life and career from their mothers (e.g. Smith, 1985; Fischer, 1986; Hickey, 1996) Shari was not an exception.

My mother really wanted to the best formation was a good mother, she didn't work outside the home, I think she was nervous about losing me to another country. She was a good mother and strong person but her emphasis was family and a home and keeping all the uncles, aunts, [OHT 14 was clapping hands], "You have to come for the holiday, be together so, so, her role in my life was I think the importance of family, culture and rule.

Shari was too ambitious to follow such a traditional role model and navigated the challenging world in search for a profession. She took a part time job and studied in Spain and Italy where she acquired the language skills, however, after her return to the United States, the job market was not attractive.

I didn't find interesting work. Even though I didn't think about it then as a young woman, I was asked questions in job interviews. "About how many words per minutes do you type?" I said "why?" I am a college graduate, Cum Laude, with honors, from Boston University, Economics, and Spanish and Italian. You don't need anybody who wanted to know how many words per minutes.

Shari obtained the MBA from the Thunder-Bird in Arizona where she studied not only business but language and culture. Then she searched for a real job.

I got job interviews again, back to temporary and un-full-filling work and then I got two jobs offers. One for the Beth Israel Hospital as an Interpreting Service manager and one for the AT&T, International Department in New Jersey, and I decided to reject the Beth Israel Hospital. That's the career ladder, I thought.

Shari started to work, however she didn't like a competitive atmosphere. She immediately took an action by calling the Beth Israel Hospital.

On the Day 2 at the AT & T! I don't think this is the right fit for me. I went into a cubicle [a telephone booth], and I called, the Manager (D) of recruitment at the hospital [The Beth Israel Hospital and said], "Hello, (D), it's me! I turned you down, Still the job is opened?", [OHT 14 imitating a serious voice of (D)], "Yes!". She [(D)] spent a long time talking to me [(D) asked me]. "Why isn't this job working for you in New Jersey? Tell me." She spoke tight. Then she said, "Well, you have talk to the Big Boss." So, I talked to the Big Boss.

Shari convinced the Big Boss, and was hired by the Beth Israel Hospital in 1992.

I knew nothing about medical interpreters. I would interpret for business for my family. I volunteered here at an immigrant center doing written translations but I never heard of interpreters in a hospital. I thought to myself, "But, that's so easy!!!!"

To her surprise, medical interpreting was not so easy.

A little did I know, that is complicated!! There was no certificate program, no training program. And I was supposed to be the Manager and a Spanish interpreter one day a week. And so I was trained with OHT 1[the first staff interpreter at the hospital] two days. I had to study words.

A state-wide survey found a 23 % of the total of 179 interpreters highlighted a lack of

respect by physicians (Kenny, 2008 [Survey report]). On the other hand, studies have disclosed medical interpreters have dilemmas over their roles and suffered from power struggle with physicians (Kaufert*⁸ & Putsch*⁹, 1997; Hsieh, 2006/ 2007/ 2008/ 2010). It was only through her own practice in medical settings, and guidance by expert interpreters that she could realize these challenges. With this in mind, she founded Latino Provider Group within her hospital. To deal with ethical issues, Shari appointed OHT 1 as the Interpreting Training Coordinator and Interpreter Ethics Liaison.

And so then, now 20 years and I am still learning. So many different situations and you know, ethical dilemmas, so management but also interpreter situations. We have a monthly ethic rounds, interpreters can talk about ethical things.

Shari has expanded the department from 10 staff interpreters to over 80 including 11 Spanish interpreters. She also led, “Welcome Campaign” targeting the diverse patient population. She founded Interpreter Services Collaboration, ISC, a Metropolitan Boston group composed of Directors of Interpreter services to share ideas, concerns, and resources.

The total number of face to face and telephone encounters conducted by our highly skilled interpreters reached 155,150 in the fiscal year 2010, a substantial increase over the previous year and an all-time high.

To increase efficiency of the service delivery and to save cost at the same time, she introduced a teleconference interpreting, also called Video interpreting.

In addition, recently rolled out are portable high-quality speaker phones mounted on poles which can be rolled into a patient’s room and hooked up to the bedside telephone in order to provide interpreter in situations where in-person interpretation is not required. This type of technology would greatly reduce the amount of time interpreters spend travelling between locations, allow them to help an even greater number of non-English speaking patients, and maintain a higher standard of infection control.

To comply with guidelines of the State, federal and the Joint Commission which require continuous training of interpreters, she has invited physicians as lecturers to speak about their specialty to strength her interpreters’ knowledge and skills. Comparing with Executive Order 13166, she felt the state law, ERIL, had more impact on the managements’ efforts to improve interpreting services. Looking back, she recognized changes in attitude of aspiring interpreters.

So, my twenty years, .I think so much has changed. I think in the beginning, many people if you interview them, found this work by accident. There wasn't necessarily a choice. And I think now, may be in the last ten years, it's profession or career that people choose.

Shari speaks to students of training courses to let them choose this profession upon knowing the reality.

If you come in here for the money, don't come. I will tell right now, it's not a job you gonna make a lot of money. You be better something else.

Shari encourages them by articulating rewarding moments.

I think, [it makes you] feel like you have touched another person's life and helped them at a moment of vulnerability. Some interpreters have told me, "There are not a lot of jobs where every day I come to work, someone thanks me and it's usually more than once." Many jobs, they say "Thanks." But not "THANK YOU" [With an accent and slowly said] "Thank you." And interpreters feel like really hope for bad day. So I think, the profession has changed, people are choosing it, many interpreters, depending on where they work, I think here feel recognized as professionals by doctors, by their colleagues, as expected.

Field Note

Shari welcomed me in 2006 as a participant of the hospital tours organized by MMIA. At the presentation, she introduced OHT 1 to us by telling, "She was my teacher." Her respect was evident to everyone. She took us to a room where engineers were working on newly developing equipment for Video interpreting. At that time, this type of own system was new to the industry. She stressed that the protection of personal information was vital. This time, I knew that she has been still improving the system in addition to using speaker phones. I have been close to several of her staff and have been visiting them almost every year. Some freelance interpreters underscored that the ethical concerns in this hospital have been more prioritized than other hospitals. I attended at the ceremony of the Latino Achievement Award in 2011. In her speech, she talked about how supportive her husband, an immigrant from Spain, had been for her career ladder and language acquisition. In this interview, she also referred to hardships faced by her husband, from language barriers to difficulty in finding jobs. He finally became a professional medical interpreter.

Oral History Teller, No. 15

Name: David Cardona

Country of Origin: El Salvador

Language: Spanish and English

Profile

Dr. David Cardona was born in El Salvador. He is the Coordinator of the Health Care Interpreter (HCI) Program at the Oregon Health Authority's Office of Equity and Inclusion where he oversees the implementation of the health care interpreters' law. He convenes multiple state agencies, government jurisdictions, community organizations and private sector to advance Title VI of the Civil Rights Act to improve access to services for LEP. He holds a medical degree from the Autonomous University of Santa Ana, El Salvador, and a master's degree of public health from the Portland State University. He had an executive management education from the Harvard University's School of Public Health and has a Scientific degree from the Swiss Tropical and Public Health Institute, at the University of Basel, Switzerland. He also works as a professional medical interpreter and is the co-founder and vice-president of the Oregon Health Care Interpreters Association, working to promote certification and training of health care interpreters. He participates in global health missions to El Salvador, serves as a member of the Advisory Board of IMIA.

Oral History

David was encouraged to study English by his mother. He studied in the United States.

When I was a child, my mother hired an English tutor for me to help me learn to speak English, and when I was a teenager, she sent me to the United States from El Salvador as a foreign exchange student with a program called, "Youth for Understanding". Once in the United States, I was sent to Indiana, where I completed high school. After graduation, I went back to El Salvador to attend medical school, where I graduated as a physician and completed my residency in surgery. When my residency training was over, I decided to come again to the United States to earn a Master's degree in public health. During my graduate studies, I took on part time work as a medical interpreter to pay for my education.

David recalled situations back in 1993.

Back then, we didn't have any training standards to become an interpreter. We didn't have any code of ethics or Standards of Practice, so anybody could be an interpreter. When I was working as an interpreter at a hospital, I noticed that

health care providers were using anybody who spoke a little Spanish to serve as interpreters. Those good Samaritans were ad-hoc interpreters. They were doing the best they could. They were trying to help patients, but they did not know how to interpret medical terminology. To me, the quality of interpretation was very important.

In 1990, the State of Washington spearheaded its own certification system after a series of investigations by the OCR on grounds of violating Title VI of the Civil Rights Act of 1964. The Washington case impacted hospitals in the state of Oregon.

In 1995, we didn't have any kind of standards, although they [hospitals] already were aware of the provision of interpreting services and the mandate of Title VI of the Federal Law of non-discrimination based on national origin.

Above all, the most striking lawsuit happened in Florida. A paramedic misinterpreted a Spanish word “intoxicado[nauseated]” as “intoxicated. Health care providers then assumed that he was just under the influence of alcohol or drugs and sent him to a medical ward to recover”. However, a day later the patient would not respond and additional tests were ordered which showed the patient had suffered a brain injury resulting in permanent quadriplegia. A lawsuit followed and the jury awarded \$71 million as compensation to the patient due to malpractice (Harsham, 1984). This case made headlines and influenced Oregon policymakers as he remembered.

In 1998, a group of concerned citizens lobbied the Oregon Legislature to pass a law to ensure interpreting services in public health emergencies, because of malpractice lawsuits that had gained national attention at that time, including the case in the state of Florida

The leaders of the legislative effort later formed The Health Equities Committee and continued to craft bills for legislation. The committee was a multi-disciplinary team composed of physicians, hospital managers, community advocates and local officials (The Oregon Health Fund Board-Health Equities Committee Recommendations, n.d.). He recalled this movement.

We took that story back to the Legislature. They didn't take it the first time, and we had to wait until the next legislative session. Later, the concerned citizens moved forward again and in 2001 the provision of interpreting services became law [the Health Care Interpreters Law, ORS 413-550] was passed asking the Department of Human Services (DHS) of the State of Oregon to create a program to qualify and

certify interpreters in the state, and create the Oregon Council on Health Care Interpreters

The leader of this civil movement (S), a registered nurse and active participant in medical interpreting field, played an instrumental role in promoting medical interpreting in this state by being vocal to urge the governors and testified before Congress. (S) expanded professional networks through the conferences. (S) participated in the National Conference of Medical Interpreting which was convened by Robert Putsch in 1998 (The National Working Group on Interpretation in Health Care [Attendants list], 1998). (S) gave presentation on Senate Bill 790 at MMIA's Eighth Annual National Conference on Medical Interpreting in 2004 (The Massachusetts Medical Interpreters Association, 2004 [Conference Booklet]). (S) served as the Board of Directors of NCIHC (The National Working Group on Interpretation in Health Care, 1998 [Attendants List]). (S) founded a community college and has instructed medical interpreting courses since 1998. (S) was David' mentor and taught him on how to practice medical interpreting.

When I was doing my Masters in public health at Portland State University, I took an selective class called, "Community management practicum" during a 6 months period. I had the good fortune to do it at the Oregon Health and Science University, Interpreting Department where I shadowed (S) as her assistant.

According to Dr. David Cardona, it took several years from the enactment of the law to the implementation of the law. He explained the reason for such a delay.

Well, after the law passes, you have to implement the law. The Oregon law was implemented by the creation of rules. And the rules were created between 2001 and 2006. Why did it take so many years? Well, because the law passed without a substantial budget. So, it was an unfunded mandate. In addition, this law was voluntary at the time and there was no enforcement.

His duties also include developing technical assistance, data collection, evaluation of compliance of health systems on language access service to LEP, develops training, testing and certification policies and procedures by giving importance to Title VI of the Civil Rights Act of 1964.

I have been very passionate about advancing Title VI of the Civil Rights Act that PROHIBITS[Capital letters placed by OHT 15] discrimination based on national origin.

Executive Order 13166 and the Policy Guidance issued in 2000 reiterated the importance of Title VI of the Civil Rights Act of 1964, by de fact mandating almost all the medical institutions to provide medical interpreting service to LEP patients. However, except few states such as Washington, medical interpreting services have not been reimbursed by state governments. The state of Oregon is not an exception.

This [the Health Care Interpreters Law, ORS 413 in 2006] only applies to interpreters who want to be qualified or certified as health care interpreters. The first step is to register as an interpreter in a central registry, the second steps is to get qualified, and the last step is to get certified. But this law doesn't regulate reimbursement for the provision of interpreter services. We follow Title VI of the Civil Rights Law that requires any institution receiving federal funding to provide interpreter services free of charge to limited English proficient clients. In regards to how much the interpreter gets paid for their work, we leave this to the market to decide. We don't have any specify mandate about payment.

According to the U.S. Department of State as of 2012, the United States is a home for 1.6 million people who left El Salvador for several reasons (The U. S. Department of State, Bureau of Western Hemisphere Affairs, October 4, 2013). The typical reason for leaving El Salvador was to escape the home country which went through a civil war between 1980 and 1992. Dr. David Cardona left his country around 1993 to pursue a career ladder in the United States. A part from his job as the Coordinator of the state' Health Care Interpreters Certification Program, he has been working partially for an agency mostly as a telephone medical interpreter. He explained his motivation as follows:

When I came to the United States, my mission was to get my Masters in public health. I had an opportunity to go to the Harvard School of Public Health for the Managing Health Programs in Developing Countries program. This was a global health administration program. When I finished it, I went back to El Salvador, where I worked as a consultant or independent contractor. I worked on many projects, helping the community, for the people of El Salvador. But after a couple of years I realized that when you work in public health projects, there is not much funding around and if there is funding, there are so many vendors working that it is very hard to get this funding. I felt it was difficult to continue in that market. After doing a soul search, I decided to come back to the US to pursue other opportunities. A position opened up at the School of Medicine at Oregon Health and

Sciences University and I became a faculty member in the Department of Public Health. So my passion to educate medical students and physician assistant students grew larger and I became more involved in health care interpreting training at Portland Community College, in the Health Care Interpreting Training Program, I became an advocate of language access for patients with limited English proficiency. Moreover, I have become a civil rights advocate for the LEP of the nation by serving as an advisor for the International Medical Interpreter Association's Board.

Field Note

I attended Dr. David Cardona's presentation at IMIA 2012, and 2013. Since then I have been keeping in touch with him. Among the oral history tellers, he is the only medical doctor.

Oral History Teller: No. 16

Name: Desmond B. O'Rourke

Country of Origin: Ireland

Language: English, Finnish

Desmond B. O'Rourke is a native of Ireland who is resident in the United States. Based on his skill and knowledge of Finnish, he has been working as a professional interpreter in a variety of settings. His interpreting skills have been acquired over a period of two decades in the context of legal and medical situations and by interpreting as a student guide while living in Helsinki., Finland.

Oral History

Desmond learned the Finnish language while living and working as an architect in Finland. He later concluded that translating/interpreting was to be his preferred profession.

I started interpreting after living in Finland for about fifteen years. I worked there as an architect. Gradually I came to love the language. From being an avocation, the language became a profession. I started interpreting with the Finland Alumni student organization, of which I was the president. These students came from different countries on scholarships given by the Finnish government. I conducted the students through the city's fine buildings, and interpreted the descriptions of these places by Finnish-speaking guides into English. It energised me when I interpreted Finnish. It made me feel alive!

Desmond took advantage of language skills he acquired while living a long time in Finland, eighteen years in all.

First of all, I possessed a good vocabulary. That was because I lived in Finland for many years. I was subconsciously adding to my vocabulary all the time. A large vocabulary is an asset for an interpreter. Although not a native of Finland, I can pronounce Finnish well. My pronunciation is said to be good.

However, Desmond made a great effort through self-learning in order to use rare opportunities to learn recent terminology in Finnish and to take language-specific training courses, compared with common languages such as Spanish.

Finnish, as you know, is a minority language. I worked with interpreters, in conferences, and have received their feedback. Additionally, I trained as a translator, obtaining the Board of Examiners certification for translating from Finnish into English.

Some of Desmond's Finnish clients differ from other LEP patients in terms of their need for interpreting.

Well, a client's knowledge of English may be good, but clients appreciate it when I interpret into Finnish. This is true in many situations, depositions included. Interpreting helps clients gather their thoughts. They hear what is said in English and think about it while listening to the interpretation. This allows them to formulate their reply more easily.

Comparing patient settings and court settings, Desmond shares his perspective on medical interpreting.

I feel I can be of more use as a medical interpreter due to the fact that without me, patients may not be able help themselves because of the language barrier.

By becoming a member of a professional association, Desmond extended his network, attending as many learning opportunities as possible.

I am a member of the American Translators Association, the National Capital Chapter of the American Translators Association. I am also a member of the National Association of Judicial Interpreters and Translators and Finnish Association of Translators and Interpreters (SKTL). I received an e-mailed invitation from IMIA to attend the 4th Annual National Medical Interpreter Certification Forum, and I thought this would be something that would advance my skills, so I attended the session in Washington D.C., where I met you.

When it comes to medical terminologies, Desmond adds to these through case experience.

I have worked on a variety of medical cases. A certain bio-implant was invented by a Finnish surgeon and I was contacted by a US law firm to attend the deposition of the inventor. In this case I interpreted both here in the US and in Finland, because the case required the deposition to be in Finland. Another case I worked on also required traveling to Finland.

He works as an independent interpreter.

I live in Virginia, which is part of the greater Washington DC area. I am a sole proprietor. I have contracts with the State Department, NIH, the World Bank, International Monetary Fund and other organizations. But most of my interpreting

work is done either in person at hospitals, or by telephone. Recently, there has been increased demand for the latter skill.

Thus, agencies don't help Desmond, but the state he registered with helped.

I have to say that agencies did not help me find work. When they need me, they call me. I have to inform myself. Teach myself the terminology to apply to each case, immigration, medical, legal or whatever. The State of Maryland helped me a lot. I became part of its registered interpreter network. I scored ninety-four points in their test. I have interpreted in the State courts. I have contacts with the law courts in the District of Columbia, but have not been called to interpret for them yet.

Since he started to work in 1995, he has seen changes in professional requirements for court interpreting.

There have been many changes. Earlier, I was not always asked for my credentials. So, I just sent in my CV. Since I am now registered at the Administrative Office of the Courts, I am called by the State of Maryland to attend as a court interpreter, and also in other situations, such as drivers' tests.

About advice for freelancers, Desmond has this to say.

Job opportunities have increased because my skills have satisfied my clients. You have to continually educate yourself. You must find the correct terminology. You must look around for resources. There are both online dictionaries and printed dictionaries. You should be familiar with both. Regarding your own glossaries, you should add new words as they come up in any given case.

Field Note

I met Desmond at IMIA Conference on April 30, 2010, in Washington D.C. I wanted to recruit him for several reasons. 1) He works with Finnish, a minority European language that I could compare with more common languages. 2) He was one of the few who were not members of a professional medical interpreters association. 3) He could provide me with information on how the interpreters of minority languages build their skills and add to their knowledge and vocabulary. I met him during two days. Based on our conversation on the way from the conference venue to the hotel, I then conducted the interview.

Oral History Teller, No. 17

Name: Dolkar

Country of Origin: Tibet

Language: Nepali, Tibetan, Hindi, Urdu, Panjabi, English

Profile

Dolkar is a Tibetan in her early 50s. She worked as a nurse before resettling in the United States. By using rare languages, she has been working for several hospitals in Boston, MA.

Oral history

Dolkar's parents settled in India with her sometime around in the early 1960's. It was her first big change in life. She acquired many languages there.

I was born in Tibet and my family fled to India because China occupied Tibet. I studied in India as well as I did work as a nurse, too. I went to school in India, Academy of languages. Because in India, where I went to school, we needed to learn 2 or 3 languages at school. Many languages are spoken in India.

In 1990 on November 29, Congress enacted the Immigration Act of 1990 (The Senate and House of Representatives of the United States of America in Congress, November 29, 1990). The Section 134 was titled, "TRANSITION FOR DISPLACED TIBETANS", and states "there shall be made available to qualified displaced Tibetans [...] 1,000 immigrant visas in the 3-fiscal-year period [...] giving preference to those aliens [...] who are most likely to be resettled successfully in the United States" (p.134). This legislation brought her the second biggest change in her life to come to the United States in 1992. She commented on her status.

I will add a few words, in the United States, they don't consider me as a refugee [status], I am one of the resettlement project participants and I came to U.S.A. in 1992. Congress passed the bill in the year 1990. They want to take one thousand Tibetan refugee people through the Tibetan Exile Government in U.S.A as resettlers [not as a visitor status]. I was already a refugee in India for about thirty years. Refugee status come only one time. I not a visitor, but a re-settler, because my parents came from Tibet. Our government sent us here.

The media reported as, "An unprecedented migration to the United States of Tibetan refugees [...] an unusual resettlement [...] The Tibetan government in exile had lobbied before similar programs, but failed. This time, supporters proposed a measure that required no federal assistance [...] A small Orange County group participating in the

volunteer effort hopes to raise \$30,000 to bring about 50 people to the area [...] All the newcomers must have jobs before arriving and take an orientation on life in the United States” (Dunn, 1992, January 01, [Newspaper]). Consequently local volunteers were “working hard to find sponsorship and concrete job offers, which are required for the special visa” for those Tibetans (Howe, 1991, August [Newspaper]). Her accounts detailed how she was offered those grass roots’ help.

I was helped by American volunteers at that time. One of the kind ladies named (MF), she did temporary sponsor for me. I did stay with her for three months boarding and lodging free. After that I did moved out and not to try depend on her.

At least in Boston, when she came, there was no Tibetan Association yet. It was formed after couple of years later. In other places, local grass roots groups, including Tibetan Alliance of Chicago (Tibetan Alliance of Chicago), and Bay Area Friends of Tibet helped them finding housing, employment, healthcare, English language teaching. Some still continue to offer help and their website carries the Tibetan families’ plights in finding jobs in this new land (Bay Area Friends of Tiber, 2008-2012 [Presentation slides]). Dolker secured her job as a medical interpreter in 1995 based on her former carrier as a nurse.

I knew this one [the state sponsored medical interpreting course for newcomers] when I went to help someone in the hospital. I remember, this hospital took me because I knew medical terms and experience, so they hired me in 1995.

Around the time she arrived in Boston, the nation as well as the state had to cope with a drastic increase and diversity of newcomers. “The Federal Refugee Act of 1980 created a uniform system of services for refugees resettled in the United States.[...]The Massachusetts Department of Public Health, Refugee and Immigrant Health Program, implemented the Refugee Health Assessment Program (RHAP) in 1995. Funding support comes from federal refugee medical assistance through the Massachusetts Office of Refugees and Immigrants” (The Massachusetts Department of Public Health, 1995). “In 1996, Massachusetts Division of Medical Assistance established an Acute Hospital Request or Application (RFA) process that developed quality measures for interpreter services. Through this quality improvement initiative, hospitals establish minimum standards of practice to ensure MassHealth member’s access to trained medical interpreters at all key points of contact through the hospital” [the Commonwealth of Massachusetts Executive Office of Health and Human Services Massachusetts Department of Public Health, Best Practice Recommendations for

hospital based interpreters: 3].

Studies in European countries provided some evidence that trained interpreters were vital for good communication to enable accurate diagnosis (e.g. Putsch^{*9}, 1985). Their articles were read by officers in charge of public health who were aware of the needs of training. Recent studies also for patients participation especially by immigrant women, trained interpreters were vital (Wiking et al., 2009 ; Brämberg et al., 2010). Accessibility of migrant and minority patients was improved by use of medical interpreters (Karamitri et al., 2013). For patients' adherence, trained interpreters are necessary (Seeleman, et al., 2012). However, medical interpreters lack for training (Herrera, 2008). According to her memory, the first training course was under multi-national environment and was sponsored by The Public Health. She explained how the course was.

I helped patients who didn't speak English, so I went to help them at hospital. That time one of the staff told me, "There is a course for medical interpreting." Many Indonesia people there, when I took the course. Two semesters. They offered free class to all immigrants' people. I was recommended by one of the directors of my hospital. So I took it. It was the medical terminology class for medical interpreters. The Office of Public Health sponsored it, and it was held at Diner Fiber Cancer Institution. They provided a big room. They hired a professor for us. [The course was] two days a week. Two semesters for one year course. There were many immigrants, from Russia, China, Indonesia, I don't remember, but Germany and so many international residents. Those I met them only in my class were 150. The class was taught in English and whatever language you speak, you translate it into your languages. So, I translated into my Tibetan language. We had to do homework and translated into our language and submit it.

The Refugee Resettlement Program was not provided only in the state of Massachusetts. In Vermont, a bordering state, the Department of Health and other agencies launched the same project early in 1995 and offered interpreting courses to have a pool of interpreters both for health and court settings (Miler, 1996)

MMIA also provided training courses under the leadership of OHT 2. Dolkar knew about MMIA.

When I went to the hospital as volunteer someday told me. They[MMIA] organized event with international people, get together knowledge, and experience sharing in

medical settings.

Currently she has been working in several hospitals. Since her languages are not classified as the major languages in terms of the needs, her working style is not for in-house services.

Whenever I am off, if the hospital calls me then I have to go to work.

Through work, Dolkar observed some change in origins of patients.

Currently hospitals are using services as Nepali, Hindi, Tibetan, and Punjabi. In 1995, Tibetan language and some Hindi. Those languages were needed because there were new comers here.... Nowadays more Nepali come from Nepal and Nepali patients need help.

Field Note

Dolkar and I first happened to talk due to an unexpected incidence at a venue hotel of the IMIA Conference 2007. All the hotel guests including the attendants at the dinner party had to evacuate from the venue. Consequently, 5 medical interpreters, including us happened to stay together in a make-shift shelter near the hotel. We started to introduce ourselves until a bomb squad team came and made sure about the safety. She was with her national costume and shared her story with us. Since that encounter, we met occasionally at annual conferences or otherwise I contacted her while staying in Boston. I was invited once to have dinner at a Tibetan restaurant and learned Tibetan culture from her. She presented a white scarf and wished my safe trip to Japan as well as a book on her homeland. She once said, "It was not easy from the starting for resettle down in this country. But everything has gone through smoothly by the grace of His Holiness the Dalai Lama. I am now proud to be a Tibetan American."

Oral History Teller, No. 18

Name: Oscar Arocha

Country of Origin: Venezuela

Language: Spanish, French, English

Profile

Oscar Arocha was born in Venezuela and his father was a diplomat. He has been educated and living in many countries, including Venezuela, Italy, Egypt, Iran, Spain, Japan, Austria, and Brazil. He holds a master's degree in healthcare management from the Cambridge College. As a front runner of the industry, he took part in the National Advisory Committee (NAC) of Speaking Together initiative by the Robert Wood Johnson Foundation. He became a member of MMIA then IMIA. He gave a presentation on remote medical interpreting system in Gunma, Japan, in 2008.

Oral History

As Oscar Arocha lived in many countries, he has many episodes regarding language barriers in medical settings. At the age of twelve, he got hurt his elbow during a Karate lesson and was in a hospital. He had to ask his Japanese driver who didn't speak English to serve him as an interpreter.

I had no clue what happened. All I knew was that he[the doctor] wanted to inject me the very big needle and I said, "No!" So they didn't. They did give me a pill instead.

Every time he had health problem, Oscar and his parents suffered from language barriers in foreign countries.

I was sick for three days, and me, my Mom and Dad, we didn't know what was happening to me at all. It was very scary. I broke my leg during my sports in Austria, I ended up in a hospital in Austria, and everybody spoke German and we didn't know what was going on. I ended up in a hospital also in Brazil, so, and in Venezuela, so , I am an "International Patient" [OHT 18 made double quotation marks with his fingers].

He saw his father, a diplomat, was relying on his interpreters. For having lived in many countries, Oscar has been flexible in adapting himself to cultural changes with a mixture of identities.

I believe of the citizen of the world. I don't feel I have roots in any particular place. I see myself as an American citizen than a Venezuelan where I spent seven years of

my fifty years so far. I consider myself a French because of the fourteen years of French school. One thing I learn from moving so many times as living with so many people in culture is that I can adapt very quickly and absorb the culture in a way that I am comfortable with that culture.

These memories as an international patient encouraged him to help LEP patients.

When I was doing translations, I was not thinking about this. When I went to interpret to a hospital, I started remembering my all the experiences.

He came to the United States as an immigrant to study music and merchandise in Miami in 1988. Among several professional options, he preferred medical interpreting profession to court interpreting.

I could have done a job at the court at that time. But I had loved the hospital setting, because some point in my life, I had wanted to be a physician and work to help people to be there to assist in their good time and bad times. You know, behind the scene, and the more I did medical interpreting, the more I saw things in human kind, and human race you won't see in the courts. Is very cold, black and white, you go free or you go to jail. There is tough and it's sometime unfair in hospitals. You have much more. You have much more humanity.

First, he started to work as a translator in 1990, then as a volunteer and he got more knowledge with medicine. Then one of his friends, a Haitian physician who was working as an on-call medical interpreter at night while studying medicine at day time introduced him to the profession. While training courses were scarce in the 1990s, MMIA saw a great need for training courses to advance the profession, and disseminated the Standards of Practice among the members for quality of the practice. Since these were the only opportunities, members took these courses. On one picture of MMIA Newsletter, Oscar was one of many members listening to the lectures. Regarding hospitals, due to the state's DoN guidance, major hospitals had to plan for interpreting services and saw a need to pay for staff training as stated by Oscar.

Exactly, so I relied on MMIA at that time and I relied on the hospital that I was working with to gain more training specific in medical interpretation. Also I go to conferences to get more and more knowledge and awareness and skills.

After working as a manager of interpreting service in a hospital in China town, he assumed the post of the Director of Guest Support Service since 1996 at the Boston City

Hospital where the first three medical interpreters in Spanish were employed in 1968. Since he started to work as a director of the interpreting service, he has been making every effort to develop medical interpreting. Kaufert^{*8} argued power structure between physicians and interpreters (Kaufert^{*8} & Putsch^{*9}, 1997). Hsieh found dilemmas for medical interpreters regarding mental distance with physicians (Hsieh, 2004/ 2007/ 2010; See also Norris et.al, 2005). As a medical interpreter, Oscar knew how important to win respect from physicians. The first thing was to build close connection with the physician (G) who had collaborated with (R) to develop the videos, the Bilingual Medical Interview, in 1987.

I think physicians really very important because they say, "I can't do my job well unless I have good communication. I need medical interpreters." One of the examples is (G). I mean (G) has enough voice and power to present the problems. He talks to doctors in his languages, doctors' languages with doctors, because in a hospital, in a medical setting, I mean everybody listens to doctors.

By using his business management skills, the next thing he did was to document data to convince the management people over the importance of medical interpreting services.

What I do is pretty much document, data, we have and by documenting what we have. By documenting this type of documents in other hospitals, we showed the number and what happened in medical settings with interpreters. You know, my job is to provide the data.

Because of an influx of refugees from African countries, Oscar had to find hundreds of dialects interpreters for African refugees. His struggle to find rare languages was quoted by media as follows (Rodriguez, March 14, 2002 [Newspaper]).

"I had to go to the books to find out what Dan was and what Dinka was," Arocha said. Dinka is spoken in Sudan. ...He found a Dinka translator, who is now on call at several area hospitals.

Scholars have documented the effectiveness of education to medical providers, especially physicians, on how to work with medical interpreters (e.g. Diamond & Jacob, 2009 ; Champaneira & Axtell, 2004). Oscar did his best to provide classes to medical students.

They [medical students] have classes where we talk about how to take history with a help of medical interpreters, for example, how to do the selective class for medical students who are in psychology.

For the last fourteen years, he witnessed many changes due to the state law (ERIL) in 2000, and the hospital's merger. He referred to them in various ways.

The new people are more aware of the basics. Sometimes they lack for experience. There are much more positions available with full time benefits, health care insurance, vacation time because more departments were established to increase job opportunities. Laws and regulation have increased their needs for interpreting services. Medical interpreters have become much more privileged than it used to be. As a result, salaries are also high. Medical interpreters actually make a living working full time. There are definitely more opportunities for training, and schools and workshops, much more than you could find twenty years ago. However, there are much more expectations today.

He has to say about performance depending on working style of interpreters.

Those who are full time employed seem to be better trained. I should say better trained, but seem to me more experienced, because they have a day to day more exposed to all cases. Freelancers have more limited time. If you are per-diem, you have to consider travel time, waiting time, administrative time, so your interpreting time is much more diminished and you have to work much more time to skill up.

Hospitals have been subject to the Joint Commission, an independent non-profit organization which accredits and authorizes hospitals and medical institutions. Without its approval, they can't work in the industry. This organization has been upgrading the standards and it upgraded some requirements regarding language services from patient-centered perspectives. However, the industry was at a loss without knowing how they should work to meet the new requirements. Oscar, as one of the front runners in the industry, he coauthored an article, "The New Joint Commission Standards for Patient-Centered Communication" to inform of new rules set by the authorization body. (Arocha & Moore, 2010).

Field Note

Since I met Oscar Arocha at IMIA 2006, we have been closely connected. Every time I conducted research, I visited his hospital. I am close to his family members. He is close to my family, too.

Oral History Teller, No.19

Name: Izabel S. Arocha

Country of Origin: Australia

Language: Portuguese, Spanish, English

Profile

Izabel S. Arocha had a master's degree in Science: Education and wrote her thesis titled, "Language Strategies Utilized by Hospitals in Massachusetts" in 2002. She has been teaching for several courses including medical and legal interpreter certificate program at the Boston University, the Venter for Professional Education as well as at the Cambridge College. She worked as a cultural & linguistic educator at the Cambridge Health Alliance. She served as president of IMIA since 2006 until 2012. She serves as the Executive Director of IMIA and also as the secretary general of Federation International des Traducteurs (FIT). She has been giving presentations at national and international conferences. She has been leading the profession in various ways. She has been researching on cultural issues.

Oral History

Izabel S. Arocha was born to a diplomatic family and had lived in many countries.

I was born in Canberra, Australia and my father was a diplomat representing Brazil, so both my parents travelled constantly, so after three years in Australia, we moved to Belgium and after Belgium we moved to Spain after Spain we lived in Japan and Mexico then Yugoslavia.

Researchers documented identity problems in various ways. Some edited essays by immigrants and refugees (Benmayor & Skotnes, 2009). Some analyzed cultural identity of people who lived for a long time during childhood and youth (e.g., Pollock & Reken, 2009; Moore & Baker, 2009). They called them 'third culture individuals (TCIs)' or 'third culture kids (TCKs)'. Izabel's accounts indicated that she was a third culture kid who typically felt cultural dilemma and identity problems.

When I moved to Brazil, it was interesting, because I thought very comfortable with my American friends but I felt different because I didn't have Brazilian friends. That was hard time for me because I was also a teenager, trying to identify... And you know a lot of people when they saw me, "She is total Brazilian", because I look Brazilian, I speak very well Portuguese, and so, I thought, I fit in, but then, when we started talking, I realized that I didn't really fit in...because it's like maybe like a person whose, you know, Nisei [the second generation] Brazilian or

someone, you aren't completely Brazilian, you are not completely foreigner, you are in the middle. You are kind of like, you don't fit in perfectly, you know, so, I didn't feel like at home, and I also felt different because I looked like everybody else but I didn't feel like everybody else.

Some researchers found stigmatic and self-blame perspectives among those children. "Multiethnic and cross-culturally experienced children may become chronically hypervigilant for cues about how to interact in order to be able to code-switch culturally appropriate behaviors several times a day" (Vivero & Jenkins, 1999). Researchers reported a difference in cultural value between parents who hold native value in country and children who were assimilated (e.g. Bodner, 1985; Kallen, 1998; Portes & Rumbaut, 2001). She had a difficulty with her father after returning to Brazil.

I saw one day my father picked up my son (E) and he looked at his and said, "How many girl- friends do you have?" I said, "Oh, no! I got to get out of here. I can't! " And there was a very "aha" moment. I realized if I stay in Brazil, my kids will be Macho kids...I saw one way, and my parents thought in another way. And cross-cultural parenting is very difficult, because the parents and the kids not only have the different ages, but different cultural mindsets, so, at least my kids and I, we have the same culture, we think alike, so I don't have that problem with them. I might have other problem with them but not that.

Izabel was sharpening her sense up and her insights drove her to start researching on cultural identity. Her teenage identity search motivated her to focus on culture for her dissertation as she described in her resume.

I enjoy a broad, strong social repertoire because of those multiple cultural frames of reference I had as a child. I am certain I will thrive in the multicultural and international cultural environment of Osaka University.

Izabel had been educated at American schools, therefore, she preferred the United States to Brazil to finish her study and get a job. Thus, she immigrated to the United States in the early 1990s. She recalled how she started to work in medical settings and compared translation with interpreting in medical encounters.

Seeing my mother work as a translator, I worked as a translator. Then I worked at a company doing market research, someone met me and said, "If you translate, don't you interpret?", and I said, "Not actually. My mother was a translator and I am a translator." But she invited me to work in an interpreting company. They

needed interpreters for medical evaluations. It was not in a hospital, it was in a doctor's office, and it was related to occupational accidents for patients who had an occupational accident and became disabled. I realized hospitals needed interpreters as well, and I started to work in the hospitals. Some companies sent me to hospitals and other hospitals called me themselves directly. I ended up being called more to interpret. Since I speak more than one target language, Portuguese and Spanish, they really wanted me because they could hire me for both languages. I really enjoyed and would come home feeling I really helped people in very difficult situations. Translation doesn't give you this feeling.

Izabel shifted from medical interpreting to other interpreting jobs for financial reasons.

I have six children. We had to grow financially. I found out that the court interpreting got a better pay. In the United States, there is a difference in the pay and medical interpreters are not remunerated as much as court interpreters and court interpreters are not remunerated as much as conference interpreters and business interpreters earn even more.

Izabel articulated that medical interpreting was not recognized properly.

It was a younger specialization, less understood, even within the interpreting community. As you moved up it seems that some interpreters looked down on others who were in other field. It's changing. I used to feel guilty because I loved to do medical interpreting and had abandoned it. I think all medical interpreters should earn a decent living and we should not have to choose our specialization based on finances only.

In 2005, Izabel returned to medical interpreting with a determination to educate and improve the professional status.

I got a master in Education in 2002 from the Boston University so that I could teach interpreting, because what was missing when I was an interpreter was that: There was no training available in the late 1990s. I had one of the courses, Bridging the Gap so that I could have a certificate in the Bridging the Gap in 2001, I got my master. I think, I can remember I also did the Training of Trainers Program of Bridging the Gap, training for one week of an intensive program. I started teaching interpreting in the Boston University and the Cambridge College. Untrained interpreters will damage the profession. We, professionally trained medical interpreters worry about it. Without an official and uniform definition of

competency, the professional medical interpreters could be concerned over the possibility of seeing unskillful interpreters damage the professional image.

Izabel contributed an article on the need for education on MMIA News (Arocha, 1997). Her accounts detailed requirements for good practice.

Education is the foundation for any profession. Education and credentialing are important, but credentials alone are not enough. You need to have training and a testing. You need to have an educational component and a testing component. Testing really tells if you are capable to do the job or not. But the education is one of two important parts: May be you can be a good interpreter, but you don't have background knowledge, a solid University level education. If you happen to have an educational background, it is great that you have good education, but how do we know if you can interpret accurately? So you really need both components.

Her experience drove her to apply for candidacy for President of MMIA (Arocha, 2006 [Candidate statement]). She described, “Here is what I hear we need the most: ***complete and unequivocal recognition of medical interpreter as a professional*** (Black and italic as original)”. She recalled how she was motivated.

When I saw that MMIA needed a president, I thought this is the perfect opportunity. All these years had gone by and then still they don't have certification, still a low status, they needed help. And I think, the education experience, the interpreting experience build. I am happy to promote the profession because I remember very well that without a good pay, training and good testing, it has not been attractive profession. There have been many skillful people who love to work and do this work and the work is needed, patients need us, providers need us and hospitals need us, but in order for them to hire really qualified people, you know, they will need to have good working conditions and a good pay. And in order for them to have a good pay, we need to get some form of insurance or reimbursement, so they are getting paid as any other healthcare workers.

Izabel was interviewed and highlighted a need for certification as follows (Wiggs, 2009, March 16 [Newspaper]).

I thing that [a growth in training programs] has really enabled there to be a pool of interpreters. But the one thing that's missing is certification. What we have is a huge diversity of level of medical interpreters – some much more qualified than others-and there's no standards qualifier in the state or the country.

In 2009, Izabel took the initiative in establishing a certification testing system under the National Board of Certification of Medical Interpreters (Arocha, 2010). Izabel said, “We are afraid that un-qualified, un-trained interpreters will damage our profession”.

Field Note

I talked with Izabel S. Arocha for the first time on the night before the 10th Annual National Conference on Medical Interpreting in 2006. She was singing on certificates of attendance for almost 600 participants. I remember having discussed challenges that we had been facing to develop the profession both in the United States and Japan. Since then, we have been exchanging professional viewpoints. We have been so close to talk about family issues. We have been working under the same professional organization, IMIA, and been studying at the same academic course of Osaka University. Under such circumstance, among the 29 oral histories, her interview data was the last one to be analyzed. I did need enough time to recognize my bias and take my utmost caution to avoid it from influencing on my writing. One of the goals was to analyze why Izabel has become a strong leader in transforming the association from MMIA to IMIA in 2007. I didn't question her on this point during the interviews, but I found that she had made utmost efforts to become a strong leader. When I visited her in a new apartment just after her removal, I went straight to the book shelf to know her choice of books. Izabel said she had to throw away many books before leaving the old apartment. There were around 70 books among which 10 were written about leadership. This discovery caught my attention. I asked her to borrow all the books and I checked her notes of scribble, underlined sentences, and yellow marked paragraphs. My finding on these books evidenced she had studied how to educate herself to be a strong leader. Some of the notes implied that she was searching ways to forge the organization in terms of finance and presence at international level as well as building certification system. Her decision in 2007 was challenging, but was made upon careful planning.

Oral History Teller, No. 20

Name: Y.

Country of Origin: Taiwan

Language: Taiwanese, Cantonese, Mandarin, Japanese, English

Profile

Y. was born in Taiwan and later lived in Japan while she was young and finished college study. She met her husband with Chinese ancestry, and after the marriage, they came to the United State. She has been working as a staff interpreter, coordinator, as well as professional instructor for several training courses. She has been also an active Medical Reserve Corp (MRC) member serving neighboring towns since 2007 to train medical interpreters for disaster preparedness. At the Boston Area Health Education Center, she has been serving as one of the lead trainer for the Introductory to Medical Interpreting. She has been volunteering for FEMA (The Federal Emergency Management Agency)'s training for medical interpreters.

Oral History

Y. speaks several languages through her education and marriage as she described.

My first language is Taiwanese, and then I attended the school in Taiwan, where the national language is Mandarin Pekinese that was my language, official language and then because my father was in the airlines, so when I was nine years old, we move to Japan. And then all the way to college and so that why I acquired Japanese, my third language, and my husband came from Hong Kong, he doesn't speak much Mandarin. Usually this kind of racial marriage is one person one party pick up the other party's language, so I picked up his Cantonese. And then because his parents were rural Cantonese, and in order to be a good daughter in law, you have to communicate well with them, again I picked up their language.

Y. also recalled while living in Japan, foreigners were not allowed to purchase land, and her parents had to rent a piece of land to open a restaurant, and she could not enroll in day-time classes at universities for not being a Japanese national. A part from her University curriculum, she took English class at a language school for two years. Therefore, when she immigrated, she was not a LEP person and was ready to work.

Compared to Japan, here in the United States, there is not such discrimination. If you want to work, you work, if you want to study, you study. This is a nation of civil rights. And I like the way it is the society.

Y. first worked for a bank and enjoyed accounting management for international transactions. After she became a mother of three children, most of her time was spent on child-raising. However she continued to look for opportunities to work in the society.

While living in Japan, I learned women after marriage generally stayed home without going out to work. If I would have married to a Japanese husband, I couldn't have done things as I liked. I am happy to be able to work even after marriage in the United States, where women who want can get job and work.

Y. recalled how she happened to work as a medical interpreter.

By accident, in a sense I was a volunteer at the Saint Elisabeth Hospital, I was a kind of volunteers for 154 hours in late 1970s and early 1980s. As a volunteer I did everything, I did gift shops and I did companies to patient t and travel in a role of assistance for patient to transfer patients to other places or just comfort the patients. One of my girlfriends in the dermatology at the center, her job was a reminder. She just called the patients of their appointments, and then she sometimes needed interpreter when she had foreigners, and she called me and she asked me for a particular day, because she needed me for free so I said, "Sure". I came and then I got a check and I was very happy I was doing something I liked and got a check.

Thus, Y. started her career little by little.

It was not much money, but I was just excited. Then afterwards, she called and I said "Yes." And they gave me more assignments, since I was working on on-call, I was able to arrange with my daily life times, I could come with after drop off kids or before I pick up kid, I could come to work. It was quite convenience for me. That is why I said this is my accidental finding. But I was always interested in medicine.

Her hospital is situated near the China town which urged surrounding hospitals, including her hospital to forge Chinese speaking staff and interpreters for their LEP patients since the 1960s when a snowballing immigrants and families settled generally near china towns (Li et al., 1972). However, it took time for hospitals to take appropriate actions. The state law of medical interpreting (ERIL) was enacted to mandate hospitals to provide medical interpreting services in 2000. It drove hospitals to increase a workforce and she was employed. She took advantage of her skill in five languages.

Y. recalled her most memorable encounter, the first delivery.

I was caught for the delivery for consent, but when I got there the patient was already in agony. She was in the position to have an any anesthesia. She was in the active labor, and interpreter was not able to leave, they needed interpreter's assistance, and I and we really helped the patient, puff and push, then you saw all these nasty and at the end the doctor came and a baby. I was there to celebrate the birth, and so the mother, grandmother and husband were all there.

Comparing with court interpreting, she likes medical interpreting.

I do not like court interpreting. One of the reasons is with court interpretation is very rigid interpretation that you were not be able to interpret the words other than what it meant. Sometimes it does make sense, but that is not interpreters' responsibility to have the clients understand the works, as myself, I feel that is unfair. You feel, you tend to be a lawyer or defense counselors, that you can be easily mislead, and so, this interpreter feels unfair, but with the medical interpretation, that because we all have the same agenda, patients get better and the physicians want patients to get better, interpreters make sure they are talking about to have patients to get better, so we have the same goal, and we still worth working in medical interpretation as long as we are able to interpret for the patients so they can communicate with each other, we are doing a good job, that these profession better suited for me.

Y. described challenging issues such as a lack of understanding of medical interpreting.

That the patient does not appreciate or that more demanding or that is basic, you feel one step back, you can't see because you are sick, so you are physically irritated and you shows your temper-wise, so it's forgettable, and then that upsets me is that people do not understand what is medical interpreting. They treat us differently and then when we do not react or respond what we were expected in their mind, when we get bashed or sometime we get upset or complained by the individuals that upset me because they do not know who we are.

Her way to relieve such stressful encounters is to rely on co-workers.

It's easy for us when we come back to the office, we are among interpreters and we talk about it. Joke about it, and by joking about it, you relieve some of the stress, and you learn some of the tricks that others were doing. You learn it.

Y. underscored the determination to acquire skills.

You have to help drive you want to be better. You are not be prepared for the occasion, so constantly you yourself , your best supporter, you learn. You had to have an inner drive to be better you want to be better helped to the others.

Y. prepared herself by taking several training courses. Some of them were paid by her hospital.

Back in 2008 there was two forty hours at the Children's Hospital and my instructor at that time, (L), she is teaching at the Cambridge College now for interpreting course. But she was a wonderful lecturer, we did anatomy, and she gave me a lot insight and I think I fell in love with her in the way she gave a lecture and the way she taught, as information, the knowledge, I did get enough more so I looked for more, then after in 2009, there was another course at the Children's Hospital for the Emergency Room training. I also went to that, and the Cultural Smart [a training school], the monthly training for diabetic clinic, asthma clinic, and mental, the illness specific. I am constantly looking for trainings for free or for the community. I always make time for them.

Y. noticed a change in a physicians' preparedness to work with medical interpreters.

Compared with ten years ago, now physicians are more educated in a sense that new physicians might have encounter or they have a new curriculum when they go to medical schools and learn how to work with medical interpreters. Versus ten years ago, that they were not such things as professional medical interpreters, or just family members. So, that the new staff, some of new interns or the fellows and the 30 % of them had taken a course already at schools.

Y. highlighted the need for education of physicians.

We still have to train the physicians, in such a way in the clinic, "Please look at the patient directly." and then that "Treat us a medical interpreter, we are not nursing staff." "We are medical interpreters." "We are not medical assistant, so, please do not ask us to take the patient to X-ray or tell us the please bring the wheel chair and take the patient out. We are not, we are not MA. Do look at the patient directly".

Field Note

I met Y. at IMIA 2006. Since then, she hosted me several times while I researched in the

United States. While she visited Japan, I hosted her as well. I met most of her family members including her mother and brothers. She knows my family members as well. In 2006 she took me to one of the training courses at the Boston University, and I could attend as an observer at the entrance exams for new applicants in Cantonese, Mandarin, and Spanish. I have conducted research at her hospital. I could shadow several interpreters and had an interview with the Directors. She introduced me to several key interviewees, including OHT 1, 2, 4, and 26. I always speak with her in Japanese, but for the interview, we spoke English.

Oral History Teller, No. 21

Name: Janet Bonet

Country of Origin: U. S. A.

Language: English and Spanish

Profile

Janet Bonet helped found the Nebraska Association for Translators & Interpreters (NATI) and served as President for four two-years and subsequently as Vice President, Treasurer and Board Member. NATI motto is “EDUCATE, ADVOCATE, ASSOCIATE For The Good Of The Profession” (The Nebraska Association for Translators & Interpreters[Mission statement]) reflects her personal perspective on professional development. She was a member of the Global Advisory Council on Medical Interpreting, and is a member of several interpreting professional organizations including ATA, NCIHC, IMIA, the National Association of Judiciary Interpreters and Translators (NAJIT) and the Iowa Interpreter and Translator Association (IITA). She has been working as a freelance translator and interpreter for over 25 years and is a passionate advocate for the profession. She is the Nebraska and Iowa State Certified Court Interpreter. She has been working as a medical interpreter for the last 20 years mostly for civil suits, personal injury, and worker compensation. Her grandparents came from Germany and Sweden in the 1980's. Her husband is a Mexican American.

Oral History

Janet Bonet was born in Omaha, Nebraska. According to the U.S Census in 2000, the state of Nebraska had the seventh largest foreign born populations in the United States. The state has always been a favorable destination for refugees and immigrants because of job opportunities in agriculture, meat-packing factories and most recently in the construction industry. Janet spent eight years as a student in Mexico and returned to her home state to find a huge need for language services.

My interest in interpreting began when I came back after studying anthropology and Spanish at the Americas in Cholula, Mexico. When I came home, there was a need for people who can help bridge the language and culture gap, especially in Spanish. The meat packing industry was very strong in my neighborhood, and many of the new immigrants who worked in those companies could not speak English or spoke very little English. So I began doing volunteer work as an interpreter helping at schools for parent-teachers conferences, helping people translate documents for their immigration papers and so forth. I soon realized that I could build a business in language services. After about ten years as a part-time

business, it became a full-time business for me.

Despite her strong language skills, Janet had a difficulty in getting face to face interpreting jobs. The challenge was her non-Latin appearance and surname.

Someone called me to do a translation job, if they didn't see me, I would get a job. But, if they saw me, they would hire a person named Garcia, or the woman who looked Hispanic, even the person was not qualified. They would hire them because of the incorrect hiring mentality that if a person looked Hispanic, then they should be able to do a better job than me just because I am an Anglo. So it took quite a while of hard work for me to work to get past these prejudices, and to an appointment. Over time I was able to build my reputation because as we worked toward professionalizing the image and skills of the interpreters in Nebraska, those who used our services learned that my ability spoke for me as a professional, not my name or my face.

In 1998, Janet started to gather people who share interest in language access issues. A Steering Committee was formed, composed of individuals including freelancers, managers of language services, healthcare providers, social services professionals and advocates from the community.

We needed to have a voice. We formed NATI because there were so many people were abusing patients and people in the courts by taking advantage of the need for interpreters but these so called interpreters were not doing a good job interpreting. So, those of us who took our jobs seriously, decided to start the professionalization of language access services in Nebraska. Some of us were interpreters and some were people in governmental agencies, non-profit organizations that served limited English populations, and some of the people who just knew that there needed to be a change to stop the unethical practice of some interpreters. We were pioneers. Our goal from the very beginning of the association was to bring people together for the good of the profession to improve the quality of services. We have a motto: Educate, Advocate and Associate for the Good of the Profession, which means NATI works to educate people-both the public and ourselves as professionals; and to associate among ourselves and with related professional associations to build a network of connections that benefit our members and the people we serve.

Another reason for forming NATI was to deal with a lack of training courses in Nebraska and near-by states as compared to the west coast and the east coast where

university based training courses were available.

We don't have the training programs in our educational institutions in Nebraska. We can go to go to Arizona for the University of Arizona's training session for 4 weeks. But it means taking vacation time, if you work for a living. Sometimes hospitals or other employers will help you pay for the tuition but not for the other expenses or lost work time. For the independent contractors like me, to go to even a four -day session, somewhere like Arizona, could cost as much as five to six thousand dollars. To recover five or six thousand dollars as an independent contractor, you would have to work for three thousand hours at a high rate of pay.

After discussions, the NATI Steering Committee took the initiative and organized a conference for the professional development of interpreters.

The energy and dedication of that Steering Committee was such that six months later, on October 12, 2000, the 1st Annual Regional NATI Conference "Professionalizing Translation & Interpretation In Nebraska and Region" became a reality. We expected 30 attendees. Joyous chaos ensued when 90 attendees from around the multi-state region showed up! The relationships formed as people who once considered themselves alone among competitors now come to see themselves as a part of a collegial group, working for the good of the profession.

NATI's members were generalists so their organizational focus has changed in view of the social needs.

In contrast to the IMIA or NCIHC which are just for either medical or judicial interpreters and translators, NATI is for interpreters who work in all types of settings ... medical, legal, community, educational, law enforcement, business, mental health, family counseling, etc. When we formed NATI, the focus of our first NATI conference was legal. Then, in August of 2001, Executive Order 13166 came from President Clinton and there was a national focus on language access. Our second conference in August of 2001 had a special focus on medical interpreting.

When Executive Order 13166 and the subsequent Policy Guidance opened the eyes of hospital administrators and they began to employ competent fulltime interpreters. As a result, many freelancers like her lost business opportunities.

Fair wages for really qualified individual was going to be much higher what the hospitals want to pay. So, independent contractors who had a voice like me began to say, "No, you can't hire us for a minimum wage. Independent contractors can't live

on that". So then some of the hospitals began to have a pool of the contractor or part-time employees or on-call interpreters. That's why I and others began to lose business as medical interpreters initially. Then because the most spoken language was Spanish, they hired bilingual staff that they use as medical interpreters.

Given the situation, Janet shifted from assignments in medical settings to court settings.

I was no longer called into hospital services much, however, because of my legal experience, I knew about workers' compensation courts. When workers are insured at work through their employers in the United States under Workers Compensation Laws, they have a right to appropriate medical care and their employers are responsible for that. And so the employee is able to suit the employer for compensation and loss of income making ability. But in the process, the employee has to go to doctor's visits and the employee must often go to independent medical exams, so someone should be available to interpret always during the doctor-patient interviews and medical procedures.

Janet explained her perspective on medical interpreting as compared to court interpreting.

I believe that in their hearts medical professionals want to help people unlike attorneys who are often motivated by the dollars, or the letter of the law. In the medical interpreter settings, healthcare is the objective that is appropriate care. I love the work, I love helping people. It was always fascinating.

Janet took advantage of her marriage to a Mexican husband who immigrated to the United States and together they started the language service business. He helped her in founding NATI as well.

Thirty-five years ago, I was a student. I began to interpret actually when I married Jaime in Mexico. My everyday life there was in Spanish, as was my household life. When we moved to the United States, things changed. ...He(my husband) needed to polish his English skills so we began to speak English at home to help him. We made a great team and our business grew. Jaime was also very active NATI member, serving as Treasurer for 6 years.

Although Janet never has been on the payroll as an employee of any hospital or company, her professional career developed through word-of-mouth recommendations

because she was very active in advocating for LEP populations in Nebraska and the United States.

Those same clients or patient whom I helped, would ask for me or they would recommend me for other cases or person who needed an interpreter. There was once, at the court, for four or five years ago, a man who still had my business card from the past. My phone number had changed, and my address was changed, but my name was there. So, when his attorney needed to have someone to interpret, he showed him my card, and the attorney looked for me under my name and found me.

Janet stressed emphasizes a self-recognition of professional identity as a key for success.

They, meaning the other professionals who needed interpreters, didn't value us as professionals. And many of us at that time didn't see ourselves as professional because we couldn't say we had a degree in translation or interpretation. My best advice to those who wish to enter the field is, "Be fearless, go forward, get training, recognize yourself as professional, and act as professional. Expect to be treated as professionals. And I believe you will open doors and people will begin to see what is that we have to offer—as professionals.

Tracing back to the beginning of NATI, she insisted from the start on reaching a critical mass of members and becoming a professional development organization for social recognition of interpreter as professionals.

If you don't have recognition of your status, do just what we did in Nebraska, that is, establish an organization for professional development. That is the essential first step because others can refer to for support and ethical standards. That organization has to have a solid identity and that other can respect and come to see as a resource.

Janet has been spearheading NATI not only as an organizational leader but as an advocate for the profession as a whole.

I see my strength begin in what I can do as a professional for the profession. That is the area of professional advocacy. I have connections in Omaha, Nebraska, I lobbied the state Senators and governmental agencies to establish more requirements for more formal education, for more testing and evaluation of the people who are being used to interpret for both court and medical settings, because we have so many people doing the job who were misinterpreting directions and mistranslating public

health information.

Many practitioners attended NATI's conferences to learn the skills needed by professional interpreters and translators. NATI's advocacy efforts for the minority populations in Nebraska were recognized when Janet Bonet accepted on behalf of NATI the Martin Luther King Jr. Humanitarian Award in 2010.

Field Note

I first met Janet Bonet at the IMIA's Board meeting in 2009. She was vocal in advocacy and national certification of professional medical interpreters. We became close since we knew that we had studied and lived in the same town, Cholula, Mexico, during the same period. Since then we have been in contact frequently. I took part in her lobbying activities on April, 2010, by accompanying her on offices visits to three Senators representing the state of Nebraska. One of her team members, a medical interpreter from Kenyan, articulated a case in which the wrong leg had been amputated from a patient for a lack of trained interpreters. During the talk with the officers of Senators, she referred to Title VI of the Civil Rights Act of 1964 over 20 times and demanded that policy makers give priority to reimbursement of language services. Today, in the states of Nebraska and other states, there are many insurance companies, hospitals and government agencies that offer fair wages to language access professionals. Laws are changing in the United States and some policies are specifically stating that qualified, certified interpreters must be used for medical settings.

Oral History Teller No. 22

Name: Jordan Javier Coriza

Country of Origin: Argentine

Language: Spanish, Portuguese, and English

Profile

Jordan Javier Coriza came to the United States first to study and second to work. He worked intensively as a medical interpreter for a certain period of time. At the time of the interview, he was working as the Director of Ethnic Media Engagement at the Massachusetts Department of Public Health. He led the project called, “You have the Right to an Interpreter” Campaign in Arabic, French, Haitian Creole, Khmer, Mandarin Chinese, Portuguese, Russian, Spanish, and Vietnamese to inform LEP people and the general public of their rights to a medical interpreter (The Commonwealth of Massachusetts, Executive Office of Health and Human Services, Department of Public Health, 2010). Regarding medical interpreting, he has been currently working only on weekends. He speaks Spanish and Portuguese. He is also a medical interpreting instructor.

Oral History

Jordan was born in Argentina and at the age of nineteen he came to the United States to study in 1998.

I started to work as a medical interpreter in 1999. I have been working as a MI[medical interpreter] since then. But at certain points, I worked full-time and at other certain point, I worked only on weekends, like now. I work on every weekend ends. Yesterday I worked all day.

His choice for the medical field came from his interest in medical profession.

At the time of my high school, I wanted to go to medical school. I liked the sciences. I liked medicine. But I never did it. ...I never think about it, but when I was a kid, I just wanted to be a doctor. Why, I don't know.

Before working as a medical interpreter, Jordan worked as a community interpreter.

I never worked as a volunteer interpreter. I always was paid for my work. I worked as a freelance community interpreter from 1999 to 2003. In 2003 I started working as a full-time, in-house medical interpreter until 2005 and from then until 2010 worked as a freelance medical interpreter. Overall, I have 11 years of interpreting experience.

His perspective on court interpreting is different from medical interpreting.

Those are contentious situations. You have two parties that are trying to win around who is guilty and who has to pay. The result is a sort of negative.

Although Jordan liked medical interpreting, he left it for better paid jobs. As a keynote speaker at IMIA 2010 Annual Conference, he inspired the audience.

Also like many of you I came to this country speaking very limited English, worked odd jobs (shoe shine, busboy, tutor), and went to college. What started as a way of earning extra cash – interpreting – became a profession. A profession I sadly left for a job with the state, a job with better benefits and better pay. Yes, you heard that correctly: A job with the state, better pay. An oxymoron, I know. But my point is I left interpreting. I left because I wanted more opportunities for professional growth, a better salary, and better benefits. I know I am one of many.

Jordan questioned the status quo by arguing a lack of recognition about medical interpreters.

I want to get back to talking about why so many people abandon interpreting. Why don't more kids grow up thinking they can become interpreters? How do we attract them to this profession? How do we keep working interpreters engaged? What other opportunities are there in this field? The questions are many – and the answers as complex as the task before us.

Jordan discussed the following four points based on his experience as a state officer and as a medical interpreter.

First, be a knowledgeable interpreter. ...what the current situation is in terms of certification, who pays your salary, what the law is in this and other states in regards to language access, where you might get a job, and so on. You should be able to answer these questions in a heartbeat. Secondly, never assume that other people know what interpreters do. Use every opportunity you have to educate patients, colleagues and providers about the work you do and the skills necessary to do it well. Thirdly, stay engaged. It's easy to become isolated and, what's worse, complacent. Get out of your hospital or office, volunteer in a committee, help organize an event like today, submit a workshop proposal, be a speaker, share your knowledge. And, finally, never lose sight of the power you have by virtue of being the voice of a patient and a provider. ...No matter what your day is like, be

compassionate; put yourself in their shoes, and understand the position of privilege you have and all the good you can do with it.

Field Note

I met Jordan Javier Coriza first in IMIA 2006. Since then we have been occasionally in touch with each other. In 2010, I visited his office to learn about the State' policy on language services, I learned he still worked on weekends as a freelance medical interpreter. This made me ask him for an interview, so he shared his perspective on the medical interpreting as a profession from the viewpoint of an officer of the state agency. On the week before my visit, he announced the campaign: You Have the Right to an Interpreter (The Commonwealth of Massachusetts, Executive Office of Health and Human Services, Department of Public Health, 2010, See <http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/health-equity/interpreter-services.html>), and informed me that he had gathered all his acquaintances from multiple-linguistic backgrounds to volunteers to make audio recordings of the scripts so as to air it in several different languages on the radio to disseminate it to newcomers who are not aware of their rights to a medical interpreter.

Oral History Teller, No. 23

Name: Milca Ortiz Rivera

Country of Origin: Puerto Rico

Languages: Spanish and English

Profile

Milca Ortiz Rivera came from Puerto Rico. She lives in Boston since 1990, and after working as a coordinator of interpreting service department, she was currently doing phone interpreting, also as a per-diem, and does overnight shifts as well. She works as a Spanish interpreter.

Oral History

Milca Ortiz Rivera was born in Puerto Rico. People from Puerto Rico have been uniquely situated within the United States since the United States' annexation after the Spanish-American war in 1898. This means, "Puerto Ricans are native born citizens of the United States whose native language is Spanish" (Fitzpatrick, 1971; p.142). For being citizens, Puerto Ricans can travel between the main land [the United States] and the island [Puerto Rico] freely for making money or for other purposes. For better public services, many settled in the United States. Since the 1940s, a massive influx of people from Puerto Rico traveled back and forth to work as cheap labors for sugar cane, however, in the New York city, home for many of them, their living and health condition was low (Fitzpatrick, 1971).

The reason for Milca's visit to the United States was totally different from these internal migrants.

We just come for healthcare for my husband. He had ulcerative colitis. He had episodes of diarrhea over a period of three months in which he lost weight and got dehydrated. He had bleeding and he would not work. He had to be hospitalized.

Milca decided to move to the United States for his treatment. Thus, she became a family interpreter for her husband and eventually for her friends, too.

I called Boston where I had my friend in Cambridge and she said, "Come, we can help him." She talked about the Massachusetts General Hospital, so we came. I did interpretation at the emergency room for the doctor for whole things about him, because he needed, then I interpreted for them, of course, I enjoyed it. After he was discharged, I interpreted for the appointments. Eventually I heard of the hospital, the Cambridge Health Hospital[CHA] had interpreters, but I never thought to become an interpreter later.

Milca first landed in a job at a nursing home.

While working at nursing home in a kitchen, I took the course of nursing assistance. So, I did my certification as a nurse aid, and then eventually the nursing home was closed, I became unemployed, and my next job was in a hotel in the bakery.

All three hospitals belonging to CHA ranked among top ten hospitals in the states regarding the number of interpreted sessions. Among the top interpreted languages, Spanish accounted for 43% of the total (The Commonwealth of Massachusetts, 2008). Under these circumstances, her experience as a family interpreter for her husband served her as an advantage in getting a regular job.

One day they had to take someone to the ER[Emergency Room] of the Cambridge Health Hospital and I interpreted. Then, the person who became my boss said, "Milca, why don't you come to work as my interpreter, we are interested in you." And she brought a job description and when I read the job description, I thought I can do this.

Milca challenged for a professional training.

It [test] was like a shadowing and then she said she would offer me a full time job. And then she also said, "You don't have a background of terminology, I am gonna bring you to a class in the Cambridge College." They are doing the medical terminology class for once semester, so I was working full time and the same time I was once a week for the class. So those were my first six months of my work. I became a full time Spanish interpreter.

CHA collaborated with the Cambridge College to develop a curriculum with internships at hospitals. Thus, Milca was given a chance to be formally trained as one of the first 36 graduates from that training course. Thanks to this training, she promoted from a baker to a professional medical interpreter. After the enactment of the state law of medical interpreting (ERIL) in 2000, media was active in reporting medical interpreting as a new profession. A local newspaper featured her.

Medical interpreters are the voices of patients. For patients from Spanish-speak-[original]ing cultures, she [OHT 23] said, a doctor who fails to greet the patient's family or is abrupt may be per-[original]ceived as uncaring and unkind, re-[original] sulting in loss of credibility. [...] [OHT23], who landed work as a coordinator after graduating in August, earns \$20 per hour, up from \$11 hourly

wage she made as a baker [at a hotel] (Lewis, 2001, December 23, p.H7,11[Newspaper]).

Milca became a coordinator of one of the three hospitals under CHA and developed the system.

What I like about being a coordinator is that I started the service at that hospital and it's totally different from somebody who goes to a place where this was already established. You have to educate people. You have to educate staff as interpreters. You have to educate the patients that they have the right to ask for the interpreting service. So, it all that, that thing began in the hospital and the service started, I love that part.

Her job description as administrating coordinator included providers' education.

Also you have to educate the providers. Many would resist the service [our job], because they are scare of using it. But that has been changing in the U.S.A. Now it's like a negotiation, you know, you as a patient, you have the power and you have the authority of your body. It's like a kind of fellowship with the doctor, both of them will come to the decision about your healthcare, so, that's why [it is] so important to communicate with patients and to know what patients want.

A psychiatrist found patients' symptoms were shown more strongly when their interactions were conducted in their mother tongue (Del Castillo, 1970). Another psychiatrist stated, "In interpreting for psychological evaluation and therapy, the accurate communication of language and its meaning is paramount for both the patient and the therapist" (Acosta & Cristo, 1981, p.476). Asked who respected more in medical settings, Milca remembered being respected as a team member by psychiatric doctors.

What I see the most is the psychiatric doctors. They are the best working professionals with the interpreters. They really know how to pick you as a professional, before you go and see a patient, you know what's gonna happen. So they prepare you. You have a pre-session. They treat you as a member of the medical team, so I see more respect. I think at the state level somebody is doing the good thing at the psychiatric division. And they really know that you are doing the right job or not. So, I don't know how they are trained, but they really know what to expect by working with interpreters. For example, there could be a tendency of fixing words or phrases, --providers[doctors] stop and say, "No, no, please tell me exactly what the patient is saying!" They need to hear from the patient, and it can

make a difference for diagnose of the patient and so, every psychiatric is the best. They are for me the most advancing to work with interpreters.

Her perspective on physicians in general was described.

The things have changed. Now I think the new residents are used to be trained to use medical interpreters. In the beginning, more of the old school of doctors they did the care in their own way. Whoever is the coordinator of the organization, interpreter services depend on how much education we will do to providers, nurses, on how to do with the interpreters.

Milca recalled how coordinators organized to exchange views and shared data and information to advance their positions at work.

I was also a member of the group of coordinators (FOCIS). In Massachusetts, we got to meet there every three months. We got together to use common tools for them. The coordinators are managing in their hospitals and everybody was, for example, something new, -- technology --, and a presentation to share it with others.

CHA grew steadily. The interpreted encounters in 2000 were reported as 70,000. It spurred to 120,000 in 2002 with the in-house interpreters surpassed forty with more than one hundred per diems expecting the budget for the year 2003 at \$2.6 million with (Saint-Louis, et al., 2003). However, CHA had to reduce the cost of interpreting by not only relying on face to face interpreting. She witnessed how CHA conducted the first pilot project to compare telephone interpreting by using speaker telephone, videoconferencing interpreting, remote simultaneous interpreting and face-to-face interpreting (Saint-Louis, et al., 2003).

When asked for advice ofr Japanese new interpreters, Milca conveyed the following message.

You have to really love people and you really have to love helping others. Many times you have to be hard physically. Because you want to help others you get there, its not really about the money, it's not about the working conditions because you really want and believe in what you are doing. To be skillful, everything you can read about medical, read it. Even things you never know, you will use it. Anything, go to a clinic with a patient, you find a brochure, information for enjoyment or whatever, you read it or having down time, you use the Internet remembering what you learned with a patient and research that. That's how you expand your

knowledge. And clarify it well. You can't know where and how you gonna stay and understand it well. I am proud of being an interpreter, what else can I say?

Field Note

Milca has been my host mother, a driver, and a care taker when I had a serious health problem. Every time I visited Boston for my research, I stayed with her and observed how she handled her assignments and her personal life. When I visited her in 2007, she worked as a coordinator, and I interviewed informally some of her staff interpreters. Milca was handling over 300 mails a day, and was extremely busy with coordinating schedules and dealing with every trouble caused in interpreting encounters. She mentored staff interpreters and negotiated on several issues with the management people. Since she shifted to a part-time and per-diem job, I witnessed how her beep sounded frequently in an unexpected way even while driving. When she was in charge of night shifts, she went to bed with a beeper at her waist. When it sounded, she waked up and without losing two seconds, she started interpreting. Frequently she immediately drove for emergency room. I observed her doing telephone interpreting at hospitals. She checked the screen of the desktop for details of the patients' information and interpreted. She speaks Spanish and English at home.

Oral History Teller, No. 24

Name: Linda Joyce

Country of Origin: U.S. A.

Language: English and Spanish

Profile

Linda Joyce started her medical interpreting career working as the Director of Language Interpretive Services at the Grady Health System in Atlanta, GA, between 2002 and 2006. Since then, she continues to interpret as a remote (phone) interpreter for several agencies. She is a professional trainer, language proficiency tester, and language access consultant. She is the State Chapter Chair for West Virginia and the former Board Director of IMIA, and is also a member of the American Translation Association (ATA), and NCIHC. She was the former Executive Director and now (2013) is the Testing and Certification Director for the National Board of Certification for Medical Interpreters (NBCMI).

Oral History

Linda Joyce became interested in interpreting at a young age. She travelled with her family to foreign countries.

My passion is interpreting. I've been passionate about it ever since I was exposed to languages when I was in the 9th grade, when my family went to Mexico City. That was when I fell in love with the Spanish language. I never knew about other countries, you are young, you don't realize when you travel that you discover another culture, language, poetry, history and more. I was fascinated and when I came back, I started to study languages.

Linda speaks many languages.

I studied Spanish and French, then I went to college and I studied Russian and Spanish. When I lived in Florida, I learned to speak Haitian Creole, when I lived in Germany, I learned German, and when I lived in Brazil I learned to speak Portuguese.

Before becoming a professional medical interpreter, Linda started to use her language skills for international advocacy activities.

I participated in the civil rights Movement. I volunteered for many progressive movements over the years, and I was an activist in the fight for women's rights, for Black rights, for immigrants' rights, and against unjust wars. I worked with the

unions, and I worked with farmers. We were fighting for peasants' rights in other countries, I traveled to many countries, and in this activist work, I served as a volunteer interpreter.

Linda also took advantage of her language skills to work for an airline.

I was in the Atlanta in the 1990s, and I was working in the international concourse at the airport and the September 11th attack happened. After that, the airlines laid off twenty thousand airline workers because no one wanted to fly anymore.

A friend who worked at the Grady Hospital in Atlanta told her that they were looking for medical interpreters because of a recent influx of immigrants. Atlanta transformed into a diverse city, and the hospital had to learn how to best care for people with limited or no English language skills. She was hired as the coordinator of interpreters along with 5 other new Spanish interpreters. None had a medical background, but at that time, the hospital did not understand the skills that interpreters needed to work in health care.

I remember they just threw us in there, and said, "Go and interpret." So, I went to the emergency room. I was there and the doctor used the word platelet - a part of the blood, but I had no idea what it was in Spanish. I used a dictionary and did the best I could, and after a few days of working in the hospital, I brought the whole team together and said, "OK, we have to study medical terminology."

Thus, Linda formed a study group by using her skills in organizing people, the very skill she had earned from her advocacy activities.

We had on our team a doctor from Colombia. Some of the other interpreters had been nurses, pharmacists, or physical therapists in their countries, but until they could pass exams to work in the U.S. in their professions, they were working as interpreters. They taught us medical terminology.

The group met twice a week to study with coworkers with medical experience and knowledge and also some of the staff at the hospital came to give classes in their specialties.

We studied medical terminology along with anatomy, and systems. We practiced role plays, note taking and memory skills. We went to the International Medical Interpreting Association [IMIA] conferences and eventually the hospital even funded us for these educational trips. We learned that there were CLAS standards,

and we studied and adopted the IMIA Standards of Practice. We joined our local professional organization, the Medical Interpreters Network of Georgia.

Linda and the team learned the skills on her way to becoming professional interpreters and she also began her teaching career.

I went to all of the conferences on interpreting that I could and took educational courses and then I started to do training.

The Grady hospital had 935 beds and is as a safety net public teaching hospital with 16 floors, 12 wings, and the only trauma level 1 ER in one hundred miles. The annual budget when she worked there was about \$800,000 for language services. LEP patients accounted for 12% of the patients and the top interpreted language was Spanish with 86%, followed by Mandarin with 5%. The number of medical interpreters increased from 6 to 16 full interpreting staff. To build the department, she tried to increase the number of “Champions”.

When I started, we found people and providers who supported language access and we called them “Champions.” In the United States, when you want to get something accomplished in the health care system, you need to find “Champions.” So throughout the health care system we found doctors, administrators, nurses and other providers who supported interpreter services and helped us. We had our allies.

Top management was reluctant because language services were not reimbursed. Scholars tried to assess the cost and benefit of the services (Hampers et al, 1999) . They evidenced that pregnant women with language barriers had paid more costs for example, because of a longer period of hospitalization, more procedures and Cesarean sections (Bowen & Kaufert, 2001). The use of interpreting services would lessen costs. What Linda Joyce and her team did was to convince the administration that LEP patients would be income generators for the hospital.

Management wants to know what the cost and benefits are. The hospitals were competing for Medicare and Medicaid money from the government. You have to speak the language of administrators. If you can prove better health outcomes and reduce costs in the long run, that is what helps convince them.

Linda has been working as a consultant and remote (phone) interpreter since she left the hospital when she and her husband moved away from Atlanta. She stressed the

importance of the quality of interpreting regardless of mode of interpreting.

There was an idea in the field at the time that face to face interpreting was the best, but now I realize that it not the modality, it's the quality and training of the interpreter who is on the telephone, video or right in front of you. Technology has broadened access.

Linda said the status of interpreters has improved, but gradually. She worked many years on national certification for medical interpreters.

When a lot of us started, we were considered "just" an interpreter. We had to move forward to professionalize in order to gain respect. Sign language and court interpreters were first to be certified and they had a code of ethics and standards of practice. Medical interpreters took their lead from them and then adapted these codes to fit medical settings. It was a challenge, but now we are going forward and have national certification for medical interpreters.

The bottom line has been her involvement in progressive movements. The civil rights movements in the 1950's and 1960's and the radical 1970's transformed many young people, including her.

When we went through the civil rights movement, and later the continuing struggle for Black rights, with figures such as Malcom X and Martin Luther King, and thousands of young people organized politically all over the world. They were revolutionary, struggles, and the Cuban Revolution and at that time, the Vietnam War and we organized. Title VI of the Civil Rights Act of 1964 is the basis for language access in the U.S. Many people do not realize that our being able to offer interpreting services comes from that tremendous struggle and is built on the back of the thousands of people who participated. Before the civil rights movements, minorities in the U.S. were relegated to menial work, they were not able to enter the professions. Without the civil rights movement, many of us wouldn't be able to be medical interpreters or offer language services.

Linda referred to several supporting organizations for language access such as local professional organizations like the Medical Interpreter Network of Georgia (MING), coalitions such as the Hispanic Health Coalition, and ethnic organizations, like the Pan Asian Community Services. She also referred to the Mexican Consulate, and national organizations such as La Raza [the Race]. After the state of Arizona and Utah passed draconian laws against immigrants, the state of Georgia passed an anti-immigrant law.

Some groups in the U.S. are opposed to language access and immigrants, and as you know, several states are passing anti-immigrant laws. There is also an “English Only” movement. Many of us are involved in organizations and movements that are pro-immigrant rights to help counter these backward tendencies.

Field Note

I talked with Linda Joyce at a dinner party in 2008, but we just had a casual conversation. On the night before the first day of IMIA 2009 conference, I volunteered to prepare handouts and she joined us. I remember her saying, “This is my life-long mission”. On the first day of the launch of the National Certification by the National Board of Medical Interpreters Certification, I knew that she had been at the core of the national certification project. On April 30 in 2010, she was a principal organizer of the lobbying activities for the Senators and Representatives. She also led our rally in front of Capitol Hill. I participated in this event. On the same day there was another big rally of immigrant advocacy organizations protesting against the anti-immigrant decision by the Governor of the Arizona. She and her husband participated in the immigrant advocacy rallies, too. When I had the interview, I really learned what would be her life-long mission, and why she had been so outstanding to advocate the profession in medical interpreting industry.

Oral History Teller, No. 25

Name: Anita Coelho Diabate

Country of Origin: U.S.A.

Language: English, Portuguese

Profile

Anita Coelho Diabate works as a Portuguese medical interpreter and adjunct Professor of Mental Health Interpreting at the Cambridge College. She has been working as a phone interpreter. She was awarded 2010 Interpreter of the Year at the Cambridge Health Alliance. She has been on the front line of mental health interpreting as well as serving as the Vice President of IMIA.

Oral History

Anita Coelho Diabate has a Brazilian-American background and acquired the language skills from her father's family in Brazil.

I was born in the United States and my father came from Brazil and my mother came from Maine. I traveled to Brazil three or four times, and during my childhood, during the summer times, because our school schedule is different, we went to school in summer time, and in Brazil, so I could socialize and integrate with the children in Brazil. As a result, the command of my language is rather strong, although the fact that my father was very young when I was born and he talked a lot of Portuguese to me when I was a baby, of the time my sister came alone for years later speaking much more English.

Anita had a marketing job. But economic situation in the United States was volatile and many people were laid off. After the September 11th attack, labor market was further shrunk. When she experienced the third layoffs, she decided to look for a new job.

At the seminar, what I heard was that grants available for people who are interested in changing their careers. I thought to myself, it would be a really good idea to look at some skills that might have, -- how I can secure jobs, how I can use my skills to earn a new career?

And what Anita chose was to use her language and cultural skills to secure job.

So, I do study to look into education in medical interpreting. There were grants I was able to qualify for a couple of them and I chose medical over judicial. As a result, I went to school for medical interpreting, and graduated from the medical interpreting course at the Cambridge College in Massachusetts. She holds a

post-secondary certificate in both medical and mental health interpreting from the Cambridge College.

Since the 1970s, psychiatrists acknowledged the difficulty in communication with LEP patients (e.g., Del Castillo, 1970; Marcos, 1979; Acosta, 1979; Finkler, 1980). Some articulated racial inequality in access to mental health (e.g., Sue, 1977). Some found cultural approach was necessary (e.g. Flaskerud, 1986; Westermeyer, 1987). Others stressed the importance of trained medical interpreters for refugees' mental health (e.g., Westermeyer, 1987). Mental health has been considered a sphere where specialized education was needed, however, training course for mental health interpreting was delayed in developing. The very college Anita graduated from started a pilot program for mental health interpreting. She had a chance to take this course.

Although I hadn't practicing one, my score was high and they were hoping into their program, because that was a pilot program. And they found a grant for me to do. I went to school and I had second course in mental health interpretation.

Anita took advantage of her specialty.

Since then I have been working as a full time medical interpreter mostly on the telephone. There are exceptions that I am sent to specialty appointments for mental health. And I also have been a trainer and giving workshops in mental health interpreting, telephonic interpreting, its best practices and most recently in national certification for medical interpreting.

Anita predicts the industry will see a polarization, and professional medical interpreters need specialization to survive the competition.

I think we are going to see many general interpreters or we gonna see people who have specific certain patients for example, for a cardiology, or pediatric or we will start to see more and more specialization, especially with the stage of the National Certification for medical interpreter.

Anita pointed out an advantage of telephone interpreting for hospital management and patients' benefits.

Mainly it's cost effective, and other thing is that it solves the delay problems for us. You have an instant access to interpreters. It avoids the interpreters from touring long distances between buildings.

Difficulty was highlighted.

The downside is that I have to extra care about checking to make sure they understand. Nonverbal communication is not available to you. See, you have to absolutely sure when they say they understood, you can't say, "Raise the pace" you can't pull your face while interpreting. You have to be a little bit more careful [than a face to face interpreting].

Asked about special efforts at work, Anita answered.

I get to talk to everyone and I learn so many new things on every single day.

Field Note

Since IMIA 2006, I have been in touch with Anita Coelho Diabate. I visit her office almost every year. This time, I could see her work and observed that she kept her tone of the voice at a comfortable level when she interpreted on the phone.

Oral History Teller, No.26

Name: Midori

Country of Origin: Japan

Language: Japanese, English

Profile

Midori was born and educated in Japan. She has been working as a freelance interpreter in Japanese for the last five years. She married to a physical therapist whom she helps at his office. She also worked as a court, business, and tourist interpreter before working as a medical interpreter.

Oral History

Midori came to the United States for a new life and learned how difficult to live in a foreign country.

While I was working in Japan, I used English, so I thought I was prepared to communicate in English. I was totally wrong. When I came here, first I didn't understand what people were talking. People talked so fast, really fast. My first shocking encounter here in the U.S, was at work at the Massachusetts General Hospital. One of my responsibilities was answering phone calls. I had to answer all kinds of phone calls. Physicians were from all over the world, and some physicians had heavy accents, and their names were almost impossible to memorize so I had a hard time. I lasted for only three months there because I was very depressed. I didn't have any knowledge about mental conditions at that time. I didn't have any clue why I was depressed, why I couldn't enjoy things I used to enjoy. But anyway, I quit and after that I stayed at home for a month. Many things worsened during that time. I even felt uncomfortable with having small talks with people at supermarkets. I was so ashamed of myself and my English.

Midori challenged for another possibilities.

Then I got my second job at a travel agency owned by a Japanese lady. Since it was a very pleasant work place, gradually my confidence came back. I started working as a freelance tour guide. I had to provide some interpreting as a tour guide, and I was comfortable with doing so I gradually shifted to interpreting jobs at the same agency. That is how I started as an interpreter. When my visa expired, I had to do something: either return to Japan, or apply for another kind of visa, and only option at the time was getting a student visa. I worked for a financial institution for seven years in Japan, so studying finance would be a good option. Since I already had

some knowledge about finance, it would offset the disadvantage of studying with my non-native language. I chose a school, a university, which I could afford. I graduated from the university within two and a half years.

She was decided to live in the United States as a spouse of a professional in medical sphere, who was the first person who encouraged her to be a professional medical interpreter.

After finishing Bachelor's degree, I worked in New York at a Japanese bank seven months later, and I moved back to Boston to get married. Because my husband is a physical therapist, and he has his own practice. I started working as a practice manager for him. It was very challenging for me. It was a major career change for me. I didn't understand terms, insurance terms, and of course, I hardly have any knowledge about health care. So, my husband recommended me to take a medical interpreting course. I thought it was a good idea. In 2004, I took the medical interpreting course, forty-hour training. I have got a very shallow and broad knowledge of the human anatomy, and basic diseases, such as diabetes, and also, spent so much for ethics, which is really, really important to work as an interpreter, like how to deal with patient's confidentiality and keep the impartiality.

She described that if she shouldn't have been encouraged by her husband, she wouldn't have thought of medical interpreting.

It was by chance, because my husband is a physical therapist and he has a private practice, I have to work for him, so I have to learn medical terminology, I didn't have any choice, but this, you know.

Her instructor at that medical interpreting course was the second person who encouraged her to do practicing since 2008. She works as a freelancer as of 2011, she works almost every day with an average 10 to 12 hours a week. At first, medical interpreting meant her a relief from stress as she stated.

It was a good and nice breathing for me. As I said, working for my husband's practice was not easy. ...When dealing with insurance companies, it is really frustrating to reach people in charge on the phone. However, because of my lack of knowledge, I may not be able to use the time efficiently over the phone. When I came to the United States, the first six months were hell. And I felt in the same way for the first six months at his practice. First, two and half years, I only worked for my husband felt like a wrong piece of puzzle of a picture. I moved to his house,

where he already lived for a decade and his families live close-by, and I work for him at his own practice. Everything belongs to him, do you know what I mean?

The first thing she learned from medical interpreting practices was how to handle difficult encounters.

Now I feel more confident and I can handle things at his office a whole lot better. Working as a MI[medical interpreter] has given me a good foundation of medical knowledge and good interpersonal skills as well. This interpersonal skill helps me a lot when I deal with incredibly rude patients.

The second thing she learned was to value herself.

By doing this medical interpreting, I became confident, and I felt good. If I work as medical interpreter too much, of course it kills me because I still have to work for my husband's practice and I have to work longer hours. So, keep balance is really difficult. But keeping two jobs is good for me.

The third thing she learned was to revalue her life.

It is challenging all the times. I have to go to different departments to cover so much broad area. However, it is very rewarding. I now appreciate things I had taken granted such as normal daily life. ...Once I started working as a MI [medical interpreter] in medical settings, I don't take things granted. So, tomorrow, it's not a continuation, you know, I can be sick, I can be hit by a car, and die, so you strongly value lives. You witness the death or worse thing, of course, but you also, -- you are witnessing deaths, definitely you value more daily life really.

The forth thing she learned was to play an important role in cultural interface.

I am enjoying working as a cultural broker. Born and raised in Japan, I am aware of cultural difference and I can use that to advocate patients. Quite often Japanese patients are reserved and hold back their questions. I always make extra effort and make sure they feel comfortable with raising any kind of concerns and questions.

Asked whether she has regretted for having worked as a professional medial interpreter, she repeated the same answer:

"Never!", "Never!", "Never!", "Never!" and finally we both laughed.

Midori observed certain difference in relationship among medical interpreters with

Japanese and Spanish speaking patients.

Japanese are, I think it is more formal compared to other languages pairs, for example Spanish. We, MIs[medical interpreters], are not allowed to touch patients, however; sometimes I observe that interpreters hug or shake hands with patients, so you don't have obstacles, right? Only time I touch patients when I assist patients' delivery. Actually I support the patient's head when they push.

According to a report entitled, Massachusetts New Americas Agenda, "24% of immigrants hold a master's degree or higher. Also, immigrants comprise 50.3% of all Ph.D's residing in the state" (The Governor's Advisory Council for Refugees and Immigrants, 2009, p.11). Her observation epitomized that educational register of Japanese patients was still higher than the state's average.

Probably ninety percent of them are college graduates at least Bachelor's degree. And a lot of times, they are researcher or researchers' family, so they have Ph.D. with high knowledge in medical area, so quite often I find well mannered, well educated really easy to interpret.

She has not seen any big change in the status probably for having been working only for three or four years, however, she noticed a change taking place where she has been working.

I don't know about other hospitals. This hospital [where we had the last interview] has implemented the medical interpreter system, completely, so at the registration, the hospital asks what language is the patient's primary language. If it is not English, automatically interpreter services will be notified every time patients with English is not their primary language make appointments. The problem is that even the primary language is Japanese, they sometimes are very good at English and they don't need me, but, that's fine, because in case they don't understand I can help them. That is not the issue, but when family members are there with them, sometimes they insist on interpreting and some are really offended by me, [by considering me as a] stranger, [and they want to] interpret for their family member.

She exemplified one specific case.

One time I had a real difficulty, not with this patient, but with a family member. He was even angry with me being there as an interpreter. I asked medical providers that if it was fine with them that I left and [they] used this family member as an interpreter. Fortunately, it was a simple exam so they let me go and I did not have

to get into an 'argument' with this angry gentleman. I reported this incident to the hospital interpreter services and the interpreter services concerned because if more complicate procedures or high risk associated, and something goes wrong, they can sue the hospital, if something goes wrong, right?

She viewed some of the encounters challenging.

There are times I have to provide simultaneous interpreting when a patient speaks so fast and gets emotional. This situation happens more frequently at psychiatric unit. Sometimes patients say something which does not make much sense or no real equivalent English word to interpret. It is very crucial to convey the intended message accurately at psychiatric unit. Providers need to assess the patient's mental status. Other situations where simultaneous interpreting is needed are when we have multiple medical providers and they talk each other in English, family members speak with providers in English, and at pediatric department, interpreting for parents when patients communicate in English with providers. At children's hospital most of the patients speak English and parents are the ones who need an interpreter.

Confidentiality is considered as the most important rule to obey for ethical issues, however, for freelancers such as her, this limits prior acquisition of patients' information.

Because of patient's confidentiality, I cannot get any information about their health so I cannot prepare beforehand. I carry my medical dictionary all the time, and I often learn quite a lot at the site.

She compared medical interpreting with court interpreting.

Medical interpreting needs to advocate patients so even patients don't ask questions but if I feel these patients are confused, I would raise that issue to providers. For a court interpreter, it is a big NO, NO. You cannot step out your boundary as a court interpreter, so, the job is that keep the LEP people at the same level as native English speakers at judiciary settings. It is their lawyers' job to make sure LEP clients understand what is said. I found this is a cold setting. It is not like we all there for the patient's well-being. Probably, juvenile court is the only one which is close to medical interpreting since everybody cares about the child's well-being. Well, the biggest difference between judicial [court] and medical is that in medical settings, still you have to keep your impartiality, but still people do care

about the patients' words. People have common goal for the patient's wellness so we do care what patients have to say. And in judicial courts, there is no such thing. They don't care about my client. So, quite often, other parties, lawyers are so mean to me, it's their benefit if I don't do the job

Asked for advice to Japanese medical interpreters, Midori was clear.

I give them one advice. As already I said, so the message is this job is very rewarding.

Field Note

I was introduced to Midori by OHT 20 at IMIA 2007. Their relationship was a student and an instructor. Compared when I interviewed her in 2007, I noticed her confidence and dedication in her words and on her facial expressions. Since the first encounter, we have been occasionally contacting either in Japan or in the United States. She came with her husband to Osaka University and gave a presentation on her activities in 2011. We normally speak in Japanese, however, I asked her to speak English for my interview to standardize the language for analysis. I noticed a slight difference in her speech. She spoke faster in English than in Japanese. She reviewed the transcription and edited carefully by deleting and adding her comments.

Oral History Teller, No. 27

Name: Joah

Country of Origin: Laos

Language: Hmong

Profile

After living several years in in a camp in Thailand, Joah's family fled to the United States in 1980. She went to high school and community college. After working as an IT engineer/operator in several states, she decided to work as an interpreter for agencies. She has been working at a hospital since 2005.

Oral History

Joah's family had to escape Laos because at the end of the civil war the communist regime occupied the country in 1975. She was one of 15,000 Hmong people who left the home country towards the United States.

I was born in Laos in 1965. Outside the Laos, we stayed for four years, and we came all on foot from Laos to Thailand. I was young and I learned the language [Hmong] there. I came to the United States in 1980. I came with all my family, my Dad, Mom and my three other sisters from Laos.

To deal with such a huge influx of refugees, the federal government enacted the federal Refugee Act of 1980, which authorized the refugee assistance program to provide federal funding to the states for assistance to refugees. Each state contracted Voluntary Organizations, called VOLAG^{*14} to assist refugees for a variety of activities; from receiving them at airports, taking them through health screening and supporting for their start of new life. The federal office of Refugee Resettlement provided refugee cash assistance as well as providing English learning opportunities and vocational trainings so they could be self-sufficient (Fediman, 1997). Some 1979 Laotians' refugees which accounted for 9.44% of the total arrived in the state of Oregon (Oregon state government, Department of Human Services). Her family lived for the first two years with a help of various kinds of assistance for refugees including a cash provision of the state government. Joah recalled her new life.

Church helped us in our learning and for everyday living until we are accustomed to the living situation. When I came here, I was so young, and I didn't know the language. My father actually interpreted for me while working. He studied English. I learned a little bit and understood. We had relatives who had come to the United States, they would help us. And I went to school. The ESL[English as a second

language/ class for one hour everyday had an interpreter who was a former refugee. There were groups of many Spanish speaking students as well as many Laos. There were already Hmong groups, who resettled between 1975 and 80 and those Hmong people helped us as interpreters for ESL class. [As for Hmong language I continue to learn] by reading and going to school, going to church to learn how to read articles in Hmong. When Hmong people move, they leave new articles. They had something written in Hmong.

Faced with such an influx of refugees, the state of Oregon couldn't support them because of a budget problem. As a result, the Hmong refugees moved to other states. Most chose to go to the state of California expecting higher level of welfare services. "The 1983 Highland Lao initiative, a three-million-dollar 'emergency efforts' to bolster employment and community stability in Hmong communities... offered vocational training, English classes, and other enticement for the Hmong" (Fediman, 1997, p.197). Consequently many Hmong people secured jobs as "grocers, carpenters, poultry processor, machinist [...] teachers, nurses, interpreters and community liaisons. Some young Hmong have become lawyers, doctors, dentists, engineers, computer programmers" (p.198).

We came and my parents automatically struggled to survive. My Dad right away went to work. And in 1980, I was 14 years old. I went high school and got a three year technical school, for college, I graduated with an associate degree in data processing, or like a computer programming. After graduating from college, I started to work for a few years, I moved into a computer operation and planning other systems, so I worked for 10 years.

Joah's sisters chose to work as a nurse, military service person, lawyer, and teacher. Joah once chose to work in IT field, however, she thought of changing her profession.

I moved to a different state. For computer, you have to stay updated, so for the move, I had to stop working for the computer field, and for the six month, I couldn't work in that field anymore, so I said, "OK, maybe I would do something else." So, that's how I looked into interpreting.

Other sisters replied in English to the parents although they understood little. She was the oldest of the five daughters and almost the only one who spoke in Hmong with her parents. She knew from a friend about interpreting profession.

I have a friend who worked for an agency before, she mentioned me, "Maybe you

can apply for language world to interpret.” At that time, I had a full time job, so, that was my side job, may be. That was different thing.

Her experience to take care of her mother served her as hands-on practice for her career as a professional medical interpreter.

I got married and moved away. When I was 15 and 17, I had to take my mother to the hospital. It was hard, because back then my English was very limited, it was a struggle for me. But it served me. I knew what would be medical interpreting before becoming medical interpreter.

After experiencing a wide variety of community interpreting assignments through agencies, Joah started to work four days a week as a staff interpreter at one of the general hospitals in the state of California since 2005.

When I switched the job, many Hmong people came as refugees. At first I didn't like it very much, because I took it as just a job. But with time, I liked it because it was rewarding that I was able to help those who had very little English, to make them feel much much better, to make them feel appreciating and happy. People said to me, “You know, the way long time ago in the 80s or 90s, there weren't interpreting services, and we were going to hospitals, doctors were so mean to us, we didn't understand what they were saying. We didn't understand them. They were so mean to me. People didn't know what to do. But now it's OK because you work as our medical interpreter.”

Hmong patients had been considered as difficult patients for physicians because they don't trust western medicine (e.g. Fadiman, 1997; Fang et al., 2010). For a lack of native interpreters, many misunderstanding hampered proper treatment to Hmong patients. The tragic history of Hmong family was documented. This book, titled, “The Spirit Catches You and You Fall Down” depicts how cultural difference and beliefs led a child with serous epilepsy episodes ended up becoming in a vegetative state (Fadiman, 1997). “If body is cut [surgery]...[that person]...may be physically incomplete during the next incarnation; surgery is taboo” (Fadimasn, 1997, p.33). Hmong interpreters face challenges for bridging between two cultures. “[A] Hmong leader in Merced [...] told me, “If the patient do [as originally written on the book] not do like the doctor want, doctor get mad at interpreter. If the doctor do not [as originally written on the book] do like the patient want, patient get mad at interpreter. I am in the middle...” (Fadiman, 1997, p. 266[Footnote]). Joah had similar cultural challenges at work, but her perspective was

positive.

Medical interpreting is more human. Sometimes, computer responds and corrects, but Hmong people, humans give happy responds or angry responds, you have to feel the emotions, you feel mad, except really not, they are really be there, the doctors and nurses are really mad, you can feel their anger or frustration, yeah, it's difficult but also rewarding.

Hmong patients' distrust of Western medicine, especially a low rate of cancer screening participation has been well documented (e.g., Tanjasiri et al., 2001; Yang et al., 2006; Thorburn et al., 2012). A researcher at the UC Davis Medical Center also disclosed "Hmong in California face rates of nasopharyngeal occurs...16 times higher than for non-Hispanic whites in California" (Morain, 2004). Given a lack of the word, 'cancer' in Hmong language, the University has "compiled a Hmong-English cancer glossary" and "launched a patient 'navigator' program in which a Hmong medical interpreter accompanies Hmong cancer patients to [...] understand and follow treatment plans" (Morain, 2004). This initiative provided an opportunity for Joaf to work as one of the interpreters at that hospital since 2005.

Despite a need, Hmong interpreters in general work as part timers or freelancer for agencies.

Working as a Hmong language interpreter, it is hard to get a full time job. Hospitals don't want to have full timers, so they always rely on agencies, because Hmong people are not enough like Spanish people, it is not that much the demand for interpreters. I know people who do a phone interpreting and they can't have a full time job.

Field Note

I read the book, *The Spirit Catches You and You Fall Down*, one of the books most recommended for new medical interpreters to learn cross cultural issues as OHT 2 introduced it on MMIA News. Since then I had been looking for a Hmong interpreter to learn how they could advance their practice by addressing cultural and linguistic issues specific to their language and culture, I have contacted several sources. I could contact Joah through managers I had met through a field research in 2010.

Oral History Teller, No.28

Name: Maria Padron

Country of Origin: Cuba

Language: Spanish, English

Profile

Maria Padron was born in Cuba in 1955 and came to the United States in 1970 as a refugee with her family. Since then she has lived in Los Angeles. She worked in the newspaper business since 1980 as a reporter and editor. She has been working with different ethnic communities for the last 20 years. After taking the medical interpreting course in the Mount San Antonio Community College, she immediately began working as a freelance medical interpreter. She has worked for the Federal Emergency Management Agency (FEMA) as a head of the Multilingual Department during many disasters. She is a member of CHIA.

Oral History

After the Cuban Revolution in 1965, the Cuban Government provided visas for Cubans who wanted to leave the country. Some 125,000 Cubans arrived in Florida by airplane. They were called, freedom flotilla. Cuban exodus started with elite class people in the early 1960s. After the enactment of the Refugee Act of 1980, the federal government of the United States started to deal with a massive influx of refugees, however, still the existing medical facilities were not ready to accept such a huge influx and had several problems. Some Cuban doctors who fled and settled down earlier served as medical professionals to help them go through health screenings, but language barriers were not addressed (Harsham, 1981, May 25). Refugees without sponsors remained in those camps. The public health authority in Florida faced multiple health issues such as epidemic of tuberculosis or mental health cases with more than 120,000 refugees (Biena et al., 1982).

Researchers specialized in immigrants study pointed out Cuban refugees in general were better treated by the federal government than refugees from other Latino American countries due to the nation's diplomatic relations. They also pointed out earlier refugees from Cuba had easier life than the refugees who left in the 1980s (Portes & Bach, 1985; Portes & Rumbaut, 2001). Maria Padron's family had to wait for five years for the permission to leave Cuba. In contrast with other refugees in the 1980s, her family's entry in the 1970s was smooth because of their family or friend who served as their sponsors in the United States. Sponsors were to take all the financial

responsibilities until refugees would become self-supporting (Biena et al., 1982).

I was born in Cuba, Havana and came to the United States as a refugee in December of 1970 with my parents because of the economic situation in Cuba. We came in here through a program, the Liberty Flights sponsored by the US Government. We landed in Miami and were received by the Catholic Charities [a resettlement agency] and in one week, we moved to California, where I had school mates and old friends who helped us find our house and took me to school, so I could enroll in high school. Two aunts were waiting for us.

What enabled her easier start was her connection with relatives and friends who welcomed her.

When I arrived at Los Angeles, it was the end of the semester, so I had to wait for two months to start again high school. During the summer, I had to learn English, although I knew some English but the English you learn in other countries is different, so you have to get used to the way the Americans sound, though depending on what geographical area you live, you sound and use different vocabulary, like in my country. So, I went to college, I got married and I had a daughter, but continued to study first without any goal in my life, ended up with becoming a journalist. Often it was difficult.

Maria remembered some incidence by the minorities.

In the 1970s, we used to hear about the Watt's Riots that had taken place in 1965 in South Los Angeles, from August 11 to 17, 1965. The six-day riot resulted in 34 deaths, 1,032 injuries, 3,438 arrests, and over \$40 million in property damage. It was the most severe riot in the city's history until the Los Angeles riots of 1972.

Maria recalled how her community helped each other.

When we came to the U.S.A in the 1970s, Spanish was not so popular like nowadays. Now there is a diversity of languages, cultures and different communities. In Los Angeles there are around 50,000 Cubans. We have events, when people know you are a new comer, people try to give you a hand and try to furnish your place.

Maria remembered having volunteered to work as a medical interpreter and later using her language skills in several ways.

I used to interpret for my friends, my neighbors, for my parents during medical

appointments. I used to work as an interpreter. I enjoyed, I liked it. I had a mission, since all my family was servicing. And when I became a journalist, I worked for a newspaper in Los Angeles. I mainly worked for Spanish newspaper. Later I became a news producer for the two major TV networks in the USA, after while I worked as a TV producer. One was, Al Mediodia[at noon in English], and the other was, Contacto [contact in English]. After while I was an employee and did translations, she [her employer] wanted me to do as a team.

Maria recalled how medical institutions have been implementing interpreting services since the 1970s.

Medical settings in the 1970s and 1980s were almost the same, doctors asking questions, we found few doctors who spoke Spanish, but sometimes you needed to see an American doctor. Now doctors are hiring bilingual staff to communicate with LEP patients. A change in atmosphere occurred, I would say in the last decade, because the law forced hospitals to be more careful about language services to have medical interpreters. Sometimes they hire bilingual staff, so that they can communicate with LEP patients.

The state of California has been known as the state with the highest number of language service laws. In addition, CHIA was established in 1996 and has been vocal in promoting the profession. The rate of interpreters' employment on staff was higher than the national average (Huang et al., 2009). However, her observation was conflicting possibly because medical interpreters were not visible at hospitals or there were too many bilingual staff and volunteers to distinguish staff interpreters from ad-hoc interpreters.

Until I knew from my friend who became a medical interpreter, I didn't think about becoming one. People didn't know about such a profession. I believe, at that time only people who knew about medical interpreting were translators, or linguists in that field, but not everybody knew about that profession. It was not a profession out there in the 1980s. One of my cousins had an interpreting agency and I used to work for her since 1998. I have been doing medical interpreting from before [but I didn't know about the professional status].

Maria heard about medical interpreting course from a friend who took the medical interpreting course and was doing her internship at a hospital. She took the course offered at the Mount San Antonio Community College which was financially supported

by the state government and aimed to provide opportunities for bilingual people to shift to medical interpreters. On the other hand, the state government intended to increase the number of qualified medical interpreters to eliminate language barriers. Her expectation was stated.

As an American you always have to have a second plan, whenever you have an opportunity, you study. I knew this school [the Mount San Antonio Community College] was far from my house, an hour of driving, but for five thousand dollar worth. The Mount San Antonio Community College was almost free. You only have to pay for the books. It is difficult to be employed in the United States, so I heard from my friend about it and I registered to take the course. There were fifty students. I did an internship at the National Rehabilitation Center Rancho de los Amigos, in Downey, California. It was useful because you were trained in the Mount San Antonio Community College. And the Rancho de los Amigos is the number one hospital of physical therapy. It was interpreting, it was nice, I learned how to interpret in different settings, in different ways for interpreting. The challenge was back to back. After interpretation you have to walk from building to building, twice a week four hours, after finishing the internship, I continued helping there as a volunteer.

Maria referred to challenge as a freelancer.

The problem is that they don't pay immediately and you have to wait for two months to get paid. An in-house interpreter position is not difficult if you like people and the job is not difficult. A lot of hospitals don't want to pay. They don't want to have full-time interpreters, but they just want to have when they have clients. The other term for full time is called a per-diem, which is a minimum basis, you know, when they need you, they call you, they don't want to pay you benefits. I have contracts with three agencies, when they need me they call me, for the minimum of two hours, and they pay \$50 and if the place is more than 50 miles, then they pay you 50 cents a mile.

Field Note

I participated in the course at the Mount San Antonio Community College in Los Angeles where OHT 6 was a chief instructor. Maria Padron was one of her students. Maria Padron invited me to stay with her family one night after escorting me around the town. I spoke with her husband who immigrated from Argentina. Maria and her husband were working for the project of the Census 2010. I was invited by them to take part in

one of their meetings. I talked with representatives from ethnic groups and minority groups including a leader who represented transgender groups who had not been counted as groups in the Census 2000. I learned how ethnically the team was formed and how vocal each ethnic group was. She was a team leader and spokesperson for this project with ongoing communications with all ethnic media outlets.

Oral History Teller, No. 29

Name: Song Que Hahn (韩 成奎)

Country: South Korea

Language: Korean and English

Profile

Song Que Hahn (韩 成奎) was born in South Korea in 1936. His Bachelor of Arts degree in English language and literature was earned in Korea, and he immigrated to the United States in 1983. He received his Master's degree in English Language Development. After obtaining a teaching credential, he worked until 2002 as a teacher at a high school for 19 years. As an extension of his ELD/EFL experience, he was employed by National University from 2001-2006, where he lectured the graduate course Language Development Methodologies in Secondary and Middle Schools. After retirement, at the age of 76, he started a new professional career as a staff interpreter at the Interpreting Service Department of UC Davis Medical Center (UCSMC) since May, 2013.

Oral History

Song Que Hahn reminisced about how he became interested in English.

I was exposed to the English language for the first time during the Korean War. I was very much fascinated by English because I learned some English as a first grader in middle school prior to the war. I was infatuated by the genuine native English pronunciation. My father and my siblings encouraged me to further study English by praising me for my good (according to them) English pronunciation, which inspired me to love English.

In his home country, Song Que Hahn taught English as a foreign language (EFL) at the secondary level (10-12) for 19 years in Korea. He had a passion to pass the exam for the Summer Institute for Korean English Teachers in California State University, Sacramento. This experience resulted in his major life transition.

I came to CSUS (California State University, Sacramento) in 1981 to attend the Summer Institute for Korean English Teachers. I had a dream to come back to the US in order to be immersed in the English context albeit my age 46. By taking the TOEFL, and my American fiancée's sponsorship, I was able to come back to the U.S. I took many courses at CSUS, and the CBEST (California Basic Educational Skills Test) to attain the teaching credential.

After immigrating in 1983, Song Que Hahn was positive in building his career as a

secondary school English teacher and a graduate school lecturer.

I taught English as a second language at the secondary level for about 18 years. As a member of the District's English Language Development (ELD) Curriculum Development Standing Committee from 1992 to 2002, I assisted in the development of the District's official ELD benchmarks based on state ELD standards. While with the District, I was the ELD Program Coordinator at Valley High School for 16 years. As an extension of my ELD/EFL experience, I was employed by National University from 2001-2006, where I taught the graduate course titled Language Development Methodologies in Secondary and Middle Schools.

To survive in the United States, language skill was important but another important challenge was to cope with different culture in his target society. Immigrants have to navigate among two cultures. A key in success was his flexibility in adapting himself to a different cultural environment. He exemplified his flexibility to acculturate to some differences.

In the school context, I was treated as if I had been a king, [because] the Korean education has been influenced by Confucianism. However, as I started to teach in the U.S. because education in America is student centered, infused with heuristic approach rather than algorithm approach, etc., Frequently, I was flabbergasted at some students' disrespectful and disruptive misbehavior. A teacher in America can be respected by students when the teacher is genuinely reputed as a good teacher among students. In Korea school context, eye contact is regarded as an impoliteness whereas in American it is quite to the contrary. Also during the classroom activities, students in America are encouraged to speak out, which helps them to be confident and articulate, whereas, Asian counterparts are expected to be docile in the presence of teachers, which helps them to be introverted and obedient. Another remarkable difference....A teacher is legally prohibited from laying even a finger on any part of a student's body. However, while I was teaching in Korea, corporal punishment by a teacher was allowed as long as it was based on the teacher's volition to teach out of love without being emotionally agitated by a student's misbehavior.

In addition to his teaching profession, since 1983 Song Que Hahn has been performing interpretation services in many different settings, legal, medical, commercial, and governmental, etc. After his retirement, he officially became a professional medical interpreter.

I work from 08:00 A.M. to 12:30 P.M. from Monday through Thursday and on Fridays I am on call. I have been dispatched to many different clinics in the UCDHS and have performed my interpretation services between medical providers and patients with an attitude to learn more about technical medical terminology, for example ‘thrombophlebitis’ and the locations of the UCD Health System.

Song Que Hahn attributed his motivation to several factors, first to his Korean family’s values and second to his daughter’s health issues.

[M]y father was an enlightened person in my hometown in the 1930s or the 1940s. He helped those people for free in different aspects. My father himself was bequeathed the concept of the noblesse oblige from his father, my grandfather, who was a businessman. When my grandfather became wealthy, he opened his house for the pedestrians passing by his home. My grandfather fed them well for free for many years. Probably I was influenced by my father to conceptualize the virtue of helping others in distress though my contribution is not as lofty as my father’s or grandfather’s noblesse oblige. Another factor that prompted me to help others in adversities was from the fact that my daughter has been a breast cancer survivor. I feel as if I should help others because my daughter was helped by many compassionate and caring people during her breast cancer treatment. I want to pay back what my daughter is indebted to those caring people.

Song Que Hahn could have chosen to work as a court interpreter. However, he preferred medical interpreting as his post-retirement profession.

*[M]edical interpreting is to help providers and patients to achieve multilateral goals of treating, curing, healing, and advocating patients based on our **affective factors** [originally stressed]. For instance, caring is involved not just professionally but emotionally, and sympathy and empathy towards patients makes medical interpreters more emotionally willing to engage personal interaction between three parties: patients, medical providers, and interpreters. Therefore, I believe medical interpreting is more worthwhile in caring for patients in the clinics not as clients in the court.*

Song Que Hahn shared his perspective on medical interpreting compared with the teaching profession.

In Korea there is an adage, which goes, among three professions such as a judge (pansa 判士), a doctor(euisa 醫士), and a teacher (gyosa 教士), even though the

income is the lowest, the teacher has a best profession because s/he interacts with young hopefuls or aspirants of tomorrow rather than criminals, or patients. Teaching involves guiding (counseling), befriending, and instructing but medical interpreting between medical providers and patients or their guardians is merely helping them to communicate through the conveyance vehicle of discourse.

Song Que Hahn exemplified challenges in medical settings.

A difficulty I encountered was to interpret between medical providers and patients who have developed marginal bilingual proficiency. In other words those Koreans who have lived in the US for 20 or 30 years have developed limited bilingual proficiency; that is, their Korean has become rusty, while their target language English is limited. I had to grope for a patient's Korean language proficiency appropriate Korean terms, which might have given an impression to a medical provider that I was not proficient in Korean medical terms.

Song Que Hahn observed how Korean patients behave with physicians.

Culturally, probably thanks to Confucianism, most immigrant Koreans were taught to revere enlightened people such as scholars, medical doctors, professors, teachers, and high ranking government officials. Therefore they tend to bow to a status of a person rather than to the characteristics of a person. Especially the medical doctors in Korea are respected as if they were superior human beings; therefore, the Korean patients have tendency to unconditionally follow the doctors' instruction/advice without questioning or without being doubtful. In the UCDHS clinics and other medical settings, more often than not I witness many Korean senior patients politely bow to their medical providers before and after their diagnoses or treatment or procedures.

Looking back to the 1980s, Song Que Hahn underscored the community's assistance to newcomers for their securing a new life and job.

The 2010 United States Census reported that the Korean-American community is one of the fastest-growing Asian groups in the United States. Sacramento had a population of 466,488 at the 2010 census. The Korean makeup of Sacramento population was 0.3% Korean. For nearly 30 years, it [the Korean American Community of Sacramento] has been helping recent immigrants with bilingual paperwork and medical and occupational counseling. It also assists local residents through language classes taught by the Korean School of Sacramento. The

association sponsors community events such as festivals and the annual Korean Day celebrations. Also Korean-American lawyers association in Sacramento annually holds pro-bono type legal services for Koreans with legal issues.

Song Que Hahn also stressed that the Korean-Americans are determined to be economically self-reliant.

I would like to proudly state that most Koreans take pride in being self-reliant in their target country because most of them are ashamed of being dependent upon the AFDC or the state welfare. It is obvious that this type of volition to be self-sufficient as immigrants motivates them to train themselves albeit limited English proficiency, run businesses employing all types of paralinguistics because of their LEP status, in order to help their second generation achieve their American Dream.

Field Note

Since I conducted a field research at the Medical Interpreting Services at the UC Davis Medical Center in 2005, I have been reading Cultural News, a series of newsletters. Song Que Hahn (韩成奎) was featured on the issue of May 2013. I contacted the managers who introduced me to him. His passion and mission are evident from his words.

“[T]he asset I have is not money but my English-Korean bilingual competency with which I think I can help other LEP Koreans and English monolingual medical providers to communicate with each other bilingually. Furthermore, when I make some extra income by working as a medical interpreter, I am able to dote on my grandson by buying him somewhat expensive Lego toys. Lastly by being a medical interpreter I feel I belong to some entity that gives me a sense that I am still a useful 76-year-old retiree as I can have a sense of belonging without becoming a lone indolent couch potato.”