UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

Priscilla Saunders and
Jason Branden

Court File No. 13-CV-1972 (JNE/JJG)

Plaintiffs,

vs.

Mayo Clinic,

Defendant.

Expert Rebuttal Report

Submitted by: Anna Witter-Merithew, M.Ed.

CSC; SC:L, OIC:C, SC:PA, CI and CT

10-22-14

I. EXECUTIVE SUMMARY

I, Anna Witter-Merithew, have been hired to function as a consulting expert by the law firm of Felhaber & Larson, Defense Counsel, to offer consultation on issues related to the provision of interpreting services in healthcare settings as it pertains to the matter of Priscilla Canamer Saunders v. Mayo Clinic. As well, I have been asked to offer rebuttal opinion in response to the plaintiff's expert report submitted by Dr. Judy Shepard-Kegl.

In formulating my opinions, I relied on information from 1) Dr. Shepard-Kegl's language assessment expert report, 2) the associated Saunders v. Mayo- Plaintiff's Expert: Report Video Files—Disc 2, 3) a series of published sign language needs assessments by the National Consortium of Interpreter Education Centers, 4) research and literature from the field of ASL-English interpreting, and 5) my 40+ years of professional experience in working with deaf individuals as a certified interpreter, consultant, educator and diagnostician. A complete listing of the literature reviewed appears later in this report.

I have reviewed the expert reported submitted by Dr. Shepard-Kegl[1] in which she sets forth the comprehensive and systematic language assessment she conducted on the plaintiffs in this matter, and sets forth the implications of her findings for the provision of interpreting services to the plaintiffs. In general, I find her assessment of the plaintiffs' language use to be thorough, well conceived and well executed. She concludes that the plaintiffs are fluent users of American Sign Language (ASL). She further concludes that Ms. Saunders, who has been deaf from birth, is comfortable reading and writing English at a level of fluency beyond the average for the Deaf population, but that she does not use speech or speech reading at a functional level. These findings are predictable for a Deaf person who is a 5th generation ASL user, born into a family with Deaf parents and siblings, who attended Schools for the Deaf and a university specifically for the Deaf.

Dr. Shepard-Kegl also concludes that Mr. Branden, also prelingually deaf, is a fluent, near-native user of ASL with excellent comprehension skills. He uses speech reading and spoken English for basic communication purposes when the content is predictable—providing indication that he has benefitted from some residual hearing capacity. Dr. Shepard-Kegl states that Mr. Branden's speech reading skills are "very good". Until recent years he used hearing aids, which assist with access to spoken language. He is able to read somewhere at or above a 5th grade reading level, but below the 12th grade. For schooling he attended both public schools with an interpreter and Schools for the Deaf, including a university specifically for the Deaf. At least one of the K-12 programs he attended emphasized the acquisition of oral-aural skills. This training, along with his family background, contributes to his speech and speech reading skills. Again, these findings are predictable for a Deaf person with Mr. Branden's profile.

[1] Shepard-Kegl, Judy (2014). Plaintiff's Report-Clean Copy in the matter of Saunders v. Mayo Clinic

In setting forth the implications of her findings for the provision of interpreting services, Dr. Shepard-Kegl's constructs a logical and ideal portrait of the services that should be provided to the plaintiffs and states that this ideal is both necessary and easy to secure. Unfortunately, the ideal of native competency in interpreters and the expectation for the consistent availability of highly qualified certified interpreters with native competence is far from the norm nationally due to the wide-spread market disorder which exists in the industry of sign language interpreting.

It is my opinion that the Mayo Clinic sought to mitigate the shortage of available interpreters by hiring certified interpreters to work on staff and be available on demand. The staff interpreter whose work is the focus of this action, Linda Rasmussen, acted ethically in informing the consumers when she did not fully understand them and asking for clarification or adjustment so that she could convey their communication accurately. To suggest that because she needed to do what the majority of certified interpreters need and should do [ask for clarification or negotiation of meaning when understanding is not achieved] by declining to provide the service to these plaintiffs denotes an insufficient conceptualization of the work of staff versus free-lance interpreters. She had a contractual and ethical obligation to provide services to both the plaintiffs and physicians/healthcare personnel. In the absence of complete understanding of communication from the plaintiffs or healthcare personnel, she had an ethical obligation to seek understanding and to correct known errors when they arose. She brought to her staff position specific training in healthcare as a licensed LPN. This level of training and medical experience, coupled with training and certification as a sign language interpreter, is a rare and valuable combination. She held a certification status recognized by the National Association of the Deaf and the Registry of Interpreters for the Deaf—the predominant certifying body of interpreters—as meeting minimum standards of competence to work as an interpreter. As well, she conformed to the expectations of her employer in calling to their attention concerns that had been raised by plaintiffs and made herself available to discuss and negotiate resolution to the concerns expressed. As a staff interpreter, her duty was to the whole of the situation—including internal policies and procedures, and the requests and preferences of the healthcare personnel. She also elicited assistance from the proper leaders within the access services system of the Mayo Clinic to help her in addressing and resolving the concerns. These individuals also made themselves available to address and attempt to resolve the concerns.

Plaintiffs' dissatisfaction with the interpreter services provide for her appointments in late 2010 and early 2011, despite Mayo's progressive strategy of hiring certified interpreters to create linguistic access for Deaf and hard-of-hearing patients on demand, may be unfortunate. But it is far from the fault of the Mayo Clinic, or the interpreter who provided the services in question, that the ideal was not achieved—it was an unreasonable expectation for several reasons. The core source of the issues which surfaced are the consumers preference for a different interpreter—one who had been released from her employment at Mayo—compounded by the result of the nationwide market disorder that exists related to the provision of interpreting services. To expect that a dismissed

employee could be engaged on a contractual, free-lance basis to provide the interpreting services was simply not realistic and would have constituted both a real and perceived conflict-of-interest on the part of the dismissed employee. As well, without direct evidence of demonstrated systemic errors or incompetence on the part of the staff interpreter with respect to Plaintiff Saunders, it is not realistic to expect that the staff interpreter be replaced with an outside free-lance interpreter. Further, correcting the disorder that exists within the interpreting industry goes far beyond the capacity of the Mayo Clinic and will require a collaborative and industry-wide strategy. What constitutes appropriate and reasonable accommodation by any entity must be put into the context of what resources exist and how they impact reasonableness.

All Deaf people deserve the most highly qualified and competent interpreter for their medical interactions—as well as all other life events when interpreters are needed. It is a sad reality that such a degree of access is not available to the Deaf population in America. This expert has dedicated 42 years of her career to trying to change this reality, but the variables prohibiting the attainment of this ideal are deeply rooted and complex. Instead, in order for healthcare entities, [among other entities that serve the public such as schools and courts] to provide linguistic access, the majority of the time it is the adequate standard that is applied/available versus the ideal.

When the demand exceeds the supply and highly qualified and native resources are limited, how is it decided who gets the "best"/ideal service? It certainly can be argued that in the context of limited resources, and the choice to undergo a self-selected medical procedure, such as the vaginal birth after cesarean (VBAC) procedure, that the more highly language fluent and intelligent Deaf individuals—as Dr. Shepard-Kegl describes the plaintiffs on page 97 of her report—can manage with adequate interpreters in order to ensure that the less advantaged, like Deaf immigrants or Deaf children who have yet to master language or are able to self-advocate, receive the most competent services. To insist that it shouldn't be this way and that the more privileged Deaf individuals are entitled to the best/most highly qualified interpreters, or to hold the Mayo Clinic responsible for this reality is ineffective—because the adequate standard is the prevailing reality nationwide.

Later in this report, this expert will opine on the factual and fuller context and status of ASL-English interpreting in the United States, and specifically in the north central portion of the country. As well, I will opine on the implication of this context for the provision of qualified interpreting services in medical, and potentially all, interpreting settings.

II. QUALIFICATIONS

I am an ASL and English bilingual having acquired both languages from birth. My parents and one of my mother's siblings were deaf. My parents used American Sign Language in our home and during frequent involvement in the Deaf Community. In my daily interactions with them and the Deaf Community I used American Sign Language (ASL). As well, I had regular interaction with

extended family members who spoke English and I used English in my interactions with them and members of the broader society. I was educated in public schools in English. Since 1972, I have dedicated my career to ASL-English interpreting, teaching, diagnostic assessment, program evaluation and program administration. As a result, I continue to use both ASL and English on a daily basis.

I completed a Bachelors of Professional Studies (BPS) from Empire State College in 1979 with an emphasis in interpreting and linguistics. I completed two graduate certificates—one in Teaching ASL and Interpreting from the University of Colorado-Boulder in 2001 and one in Distance Education and Technology from the University of British Columbia in 2002. I completed a Masters of Education (M.Ed.) from Athabasca University in 2007 with an emphasis in instructional design and technology.

For the past fourteen years I have worked as the Assistant Director for the University of Northern Colorado Distance Opportunities for Interpreter Training Center (UNC DO IT Center)[2]. The DO IT Center is a distance learning organization that delivers a baccalaureate degree in ASL-English interpretation and four (4) certificate programs. Two of the certificate programs are graduate certificates—one in Leadership and Supervision and the other in Interpreting in the American Legal System. These programs are offered primarily online with summer onsite requirements. In my capacity I am responsible for advising students, teaching, leading and managing the centralized design team responsible for curriculum and instructional development, conducting program, course and faculty/staff evaluations and assisting in the development and implementation of program policy and procedure.

As well, the UNC DO IT Center hosts the Mid-America Regional Interpreter Training Center (MARIE)—a federally funded project focused on increasing the number of qualified sign language interpreters serving Deaf and Deaf-Blind individuals[3]. MARIE is a member of the National Consortium of Interpreter Education Centers (NCIEC), which is comprised of five regional centers and one national center. In the fall of 2010, I took over the directorship of the MARIE Center. MARIE is the national center of excellence on legal interpreting. As part of my work with MARIE, I lead a national workgroup on interpreting in the legal setting that is responsible for researching, evaluating and documenting best practices of ASL-English interpreters in the legal setting and developing training materials that will benefit interpreters, Deaf and hard-of-hearing consumers and the judiciary. As well, I frequently partner with projects with members of the CATIE Center, housed at the University of St. Catherine's. The CATIE Center is the center of excellence on healthcare interpreting.

Previously, I worked for the Georgia Registry of Interpreters for the Deaf and Georgia Association

2 See UNC DO IT Center website at http://www.unco.edu/doit/ for fuller description of programs and services.

3 See MARIE website at http://www.unco.edu/marie/ and the NCIEC website at http://www.nciec.org/

of the Deaf (in a joint office) managing a program responsible for the coordination, delivery, and evaluation of interpreting services within city and state government statewide. In this capacity I worked with various city and state government agencies in creating, implementing, and evaluating policies for language access and interpreting services for Deaf and hard-of-hearing citizens of the state of Georgia.

I also worked at the National Technical Institute for the Deaf (NTID)[4] on the campus of the Rochester Institute of Technology where I was the Coordinator of Interpreting Services. In this position I was responsible for the scheduling and management of 55 fulltime and 40+ part-time and/or student interpreters delivering over 1,000 hours of interpreting services per week. Interpreting services were provided for classrooms and non-curricular campus-based activities such as sports programs, resident life programs and theater. As well, interpreting services were provided for campus-based health care and security/law enforcement services. This position involved working with a wide range of college administration, faculty and staff to create policies and procedures ensuring communication access for the 1,200 deaf and hard-of-hearing students on campus. This position also involved the administration of a summer Basic Interpreter Training Program designed to prepare and recruit new interpreters to meet the staff needs of Interpreting Services. As both the training programs and interpreting services grew, two departments were formed and I became the Chair for the Department of Interpreter Training which began implementation of an associate degree program in interpreting and offered a wide range of in-service training programs for the interpreting staff.

I also served as teaching faculty for the interpreter education program at Central Piedmont Community College. In this capacity I taught all of the courses in the interpreting major, served as the developer of the program curriculum, advised students and provided service to the institution.

Throughout my career I have served as a teacher, consultant, evaluator, diagnostician, project/program developer, program administrator and presenter to a wide range of entities including Schools for the Deaf, state Departments of Education, state Administrative Offices of the Courts, interpreter education programs and interpreter organizations and associations. The number of consultations, presentations and/or technical assistance I have provided during my forty-two-year career exceeds 700. Topics addressed include program development, policy and procedures related to the provision of interpreting services, assessing ASL and interpreting competence, interpreting, and leadership. As well, I have provided international consultation and presentation in Germany, Italy and Sweden. I have also conducted over 600 diagnostic assessments of interpreter performance and over 200 assessments of ASL performance.

I am the co-founder and former Vice President of the Conference of Interpreter Trainers (CIT),

[4] See National Technical Institute for the Deaf website at http://www.ntid.rit.edu/. NTID is the world's first and largest technological college for deaf and hard-of-hearing students.

which is the professional association of teachers of ASL-English interpreters, and a former Vice President and President of the national Registry of interpreters for the Deaf (RID), which is the professional association and certifying body of ASL-English interpreter practitioners. In 2006, I was the recipient of the Mary Stotler Award, a joint CIT and RID award for significant contributions to the fields of interpreting and interpreter education.

In my own practice as an interpreter, I have specialized in community interpreting and interpreting in the legal and court setting. I have interpreted over 300 legal proceedings and trials over a span of 42 years. I am also trained and worked as a Video Relay Interpreter (VRS). I possess six (6) certifications from the Registry of Interpreters for the Deaf which include the Comprehensive Skills Certificate (CSC), Special Certificate: Legal (SC:L), Special Certificate: Performing Arts (SC:PA), Oral Interpreting Certificate: Comprehensive (OIC:C), Certificate of Interpretation (CI) and Certificate of Transliteration (CT).

In the past ten years, I have had nineteen (19) articles or texts published in several different peer-reviewed journals, conference proceedings and commercial publications. All of the publications are related to some aspect of interpreting, teaching interpreting, program administration or evaluation. A complete listing of publications can be found in my resume.

My hourly rate for consultation and/or report preparation is $150 per hour and my hourly rate for testimony during trial or deposition is $200 per hour.

III. PRIOR EXPERT WORK

In the past five years, I have provided expert reports and/or offered testimony in the following matters.

April 2007—Expert written report, regarding assessment of interpreter performance during custodial interview, submitted to Defense in the Matter of State of Nevada v. Keith Bookman, Case No. C227537X

- Testimony provided during Motion to Suppress Hearing in July, 2007
- Follow-up report in the matter in November, 2007

June 2009—Expert written report regarding communication assessment of defendant submitted to the Court in the Matter of State of Minnesota v. Abdidaq Farah Boton; 62-CR-09-6095

February-June 2010—Expert written report, regarding the provision of interpreting services within government systems, submitted to the Defense in the Matter of the Equal Rights Center, et. al, v. District of Columbia, 07 CIV. 01838 (RCL).

- Deposition testimony provided June 2010

December 2010—Expert written report, regarding assessment of interpreter performance during custodial interview, submitted to the Federal Defender's Office in the Matter of The United States v.

Dennis Salois, CR-10-65-BLG-JDS.

April – September 2011—Expert written report of interpreter issues and language assessment of defendant submitted to the Defense in the Matter of State of Minnesota v. Kofieh Ryan; 62-CR-10-8078.

- Expert testimony provided in a motion to suppress hearing September 2011

February-November 2012—Expert written report of interpreter issues and language assessment of defendant submitted to the Defense in the Matter of State of South Dakota v. Jesse Johnson; CR-12-208225.

- Expert testimony provided during motion to suppress hearing in October 2012

February 2013—Present –Expert written report of interpreter issues and language assessment of defendant submitted to the Defense in the Matter of the State of North Carolina v. Wellington Perez; 11CRS243716, 11CRS243938.

October 2013 – August 2014—Expert written report regarding assessment of communication and interpreting performance submitted to the Plaintiff in the matter of Thomas J. Thomas v. Mitsubishi Motors Corporation, US District Court for the District of Utah, Central Division, Civil No. 2:12-cv-01215- DBP.

- Follow-up report to rebuttal reports submitted in February 2014
- Deposition Testimony provided in July 2014

July 2014 – Present—Expert written report regarding language assessment of defendant and assessment of interpreting performance of Law Enforcement Officer, submitted to the Defendant in the matter of State of Florida v. Lothar Schafer, #CF13-3065.

- Deposition Testimony provided in September 2014

September 2014- Present—analysis of interpreter performance during law enforcement interrogation, in process of preparing expert written report to submit to the Prosecution in the matter of State of Tennessee v. Andrew Clayton Parker, White County Case, #CR6081.

IV. MATERIALS CONSIDERED

In addition to my personal and professional experience, I considered the following materials in formulating my opinions in this matter.

1. Expert Report

Judy A. Shepard-Kegl, Ph.D., Certified Interpreter, Linguistic Consulting Service, 52 Whitney Farms Road, North Yarmouth, ME, 04097, August 7, 2014.

2. Publications

Baker-Shenk, C. & Cokely, D. (1980). *American Sign Language: A Teacher's Resource Text on*

Grammar and Culture. Gallaudet University Press: Washington, DC.

CATIE Center Practitioner Needs Assessment Survey Results (2009). National Consortium of Interpreter Education Centers. Retrieved on October 4, 2014 from http://www.interpretereducation.org/resources/need-assessments/

Cokely, D. (1992). *Interpretation: a Sociolinguistic Model.* Burtonsville, MD: Linstok Press.

Cokely, D. & Winston, E. (2009). *Comparison Report: Phase 1 & 2 Deaf Consumer Needs Assessment.* National Consortium of Interpreter Education Centers, National Center @ Northeastern University: Boston, MA. Retrieved on October 4, 2014 from http://www.interpretereducation.org/resources/need-assessments/.

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Cokely, D. (2011). Sign Language Interpreters—Complicit in a Devil's Bargain? *Street Leverage*. Retrieved on 6/25/14 from http://www.streetleverage.com/2011/12/sign-language-interpreters-%E2%80%93-complicit-in-a-devils-bargain/.

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Colonomos, B. (2013). Sign Language Interpreters and the Quest for a Deaf Heart. Street Leverage Publication. Retrieved on 6/6/14 from http://www.streetleverage.com/2013/02/sign-language-interpreters-and-the-quest-for-a-deaf-heart/.

Fant, L. (1990). *Silver Threads: A Personal Look at the First Twenty-five Years of the Registry of Interpreters for the Deaf.* RID Publications: Alexandria, VA.

Marschark. M. & Spencer, P. E. (2003). *Deaf Studies, Language, and Education*. NYC, NY: Oxford University Press.

Marschark. M., Peterson, R. & Winston, E. (2005). *Sign Language Interpreting and Interpreter Education: Directions for Research and Practice*. NYC, NY: Oxford University Press.

Moser-Mercer, B., Kunzli, B., & Korac, M. (1998). Prolonged turns in interpreting: Effects on quality, physiological and psychological stress. University of Geneva, École de Traduction et d'Interprétation. *Interpreting, 3*(1), p. 47-64. John Benjamins Publishing Co.

Registry of Interpreters for the Deaf (RID, Inc.). Types of RID certification. Retrieved on October 4, 2014 from RID website at http://rid.org/education/overview/index.cfm/AID/44.

Suggs, T. (2012). A Deaf Perspective: Cultural Respect in Sign Language Interpreting. Street Leverage Publication. Retrieved on 6/6/14 from http://www.streetleverage.com/2012/08/a-deaf-perspective-cultural-respect-in-sign-language-interpreting/.

Taylor, L. (2013). Modern Questor: Connecting the Past to the Future of the Field. Street Leverage Publication. Retrieved on 6/6/14 from http://www.streetleverage.com/2013/02/modern-questor-connecting-the-past-to-the-future-of-the-field/.

Wadensjo, C. (1998). *Interpreting as Interaction*. New York City, NY: Longman.

Williamson, A. (2012). The Cost of Invisibility: Codas and the Sign Language Interpreting Profession. Street Leverage Publication. Retrieved on 6/6/14 from http://www.streetleverage.com/2012/11/the-cost-of-invisibility-codas-and-the-sign-language-interpreting-profession/.

Witter-Merithew, A. (2013). Stepping Out of the Shadows of Invisibility: Toward a Deeper Conceptualization of the Role of Sign Language Interpreters. Street Leverage Publication. Retrieved on 6/6/14 from http://www.streetleverage.com/2014/04/stepping-out-of-the-shadows-of-invisibility-toward-a-deeper-conceptualization-of-the-role-of-sign-language-interpreters/.

Witter-Merithew, A. & Johnson, L. (2004). Market Disorder Within the Field of Sign Language Interpreting: Professionalization Implications. In L. Roberson & S. Shaw (Editors) *Journal of Interpretation,* pp. 19-55. RID Publications: Alexandria, VA.

Vidal, M. (1997, Winter). New study on fatigue confirms need for working in teams. *Proteus, (6)* 1.

3. Media provided by Plaintiff's Expert

Saunders v. Mayo- Plaintiff's Expert: Report Video Files—Disc 2 that contains 21 video clips of the plaintiffs (only) engaged in various tasks associated with the language assessment process

4. Documents provided by Defense Attorneys

- Rough draft of the 05/08/14 deposition of Jane Frances Hughes
- Rough draft of the 05/08/11 deposition of Linda Mae Rasmussen
- Deposition of Tracy Bell Slater, Vol. 1 condensed transcript of 05/15/14
- Deposition of Tracy Bell Slater, Vol. 2 condensed transcript of 8/13/14
- A PDF document titled Tracy Bell communications, consisting of a letter on Minnesota Department of Human Services letterhead dated January 4, 2011 and an email dated January 13, 2011, both from Tracy Bell

- A PDF document entitled Plaintiffs Document Production containing a series of emails—one dated December 16, 2010 from Priscilla Saunders to David Voller, and one dated December 16, 2010 and another dated January 4, 2011 from David Voller to Priscilla Saunders, an email from Patty Gordon to Heather Gilbert dated September 4, 2012, and an intake form with the heading CSD Emergency Statewide Advocacy and Training Project that includes 25 bulleted statements addressing Ms. Saunders complaint about interpreting services received from the Mayo Clinic

V. Rebuttal Opinions

1. The field of sign language interpreting is in a state of market disorder that has serious implications for its ability to provide highly qualified, native competent interpreters.

Witter-Merithew and Johnson[5] define market disorder in the field of interpreting in the following way.

> "***Market disorder*** is a concept used in the field of economics to describe those periods of increased uncertainty about the safety and liquidity of the economy arising from a wide range of market variables (Phillips, 1997). During these periods of market disorder, market participants look to government regulators to establish public policies and regulatory structures that will mitigate the negative effects of market disorder. Without such policies and structures, market disorder can lead to market disaster, such as the Stock Market crash of 1987.
>
> When this concept is applied to a specific aspect of the broader economy—a particular type of business or profession—it can describe the difficulties a business or profession has in securing and maintaining control over the variables that impact operations and delivery of goods or service. For the purpose of this discussion, market disorder in the field of interpreting is being used to refer to the current state of the interpreting market that reflects significant instability related to minimum standards for entry into the field and a lack of consistent and reliable control over the variables impacting the effective delivery of interpreting services (e.g., induction of new practitioners into the field, working conditions, job descriptions, role and responsibility, wages)(Karasek, 1979; Watson, 1987; DeCaro, Feurerstein & Hurwitz, 1992: Dean and Pollard, 2001)." p. 20.

The implication of this market disorder is significant. The demand for interpreters is greater than the supply of well-qualified practitioners. The field of interpreter education has not yet been able to produce a sufficient supply of highly competent practitioners to meet the needs of the market place. The "gap" between program graduation and work readiness has been a topic of concern in the field for nearly two decades and the ability of the field to close the gap has been minimal. Although the RID set a bachelors degree as part of the requirements to sit for examination in 2012, only 31 of the 147 interpreter education programs nationwide are at the baccalaureate level. The vast

[5] Witter-Merithew, A. & Johnson, L. 2004. Market Disorder Within the Field of Sign Language Interpreting: Professionalization Implications. In L. Roberson & S. Shaw (Editors) *Journal of Interpretation,* pp. 19-55. RID Publications: Alexandria, VA.

majority of programs are housed in two-year community colleges (114)—even though it is widely known that an associate degree provides insufficient scope and sequence to teach someone American Sign Language, as well as the complexities and mastery of interpreting. Consequently, because of the demand for practitioners, these less-than-ready graduates enter the field and are hired to work. When this is coupled with the fact that the industry of interpreting has yet to create a systematic and consistent approach to inducting new practitioners, it exacerbates an already serious problem. The result is a wide and diverse standard of competence among interpreting practitioners.

Further, there is not industry agreement about what constitutes a qualified interpreter. There are several different certification systems—each purporting to measure a minimum standard of competence and each granting "certified" status to practitioners. As a result, entities with the obligation to provide linguistic access are severely disadvantaged without a reliable standard to rely on when employing interpreters. When state laws indicate that practitioners should be "certified" to practice, this standard is subject to a wide range of interpretations and assumptions.

Fant (1990) offers an explanation of this phenomenon. It is important to note that he is someone born into a Deaf family and so is referred to as a CODA (child of deaf adult), he was one of the founding fathers of the RID, an educator, an author, a highly esteemed interpreter nationally and internationally, certified, and a highly esteemed leader in the field of interpreting.

> "Somehow we have failed to convey to our consumers a clear understanding of what RID certification means. As a result, consumers have unrealistic expectations of RID certified interpreters. Consumers have come to expect all certified interpreters to be equal in their abilities and to operate at the highest level of expertise. Instead of competency analogous to a BA degree, consumers expect competency represented by a PH.D. *magna cum laude."* p. 50.

Fant draws attention to the fact that what certification means to consumers—both those who are Deaf and those who are not but who rely on interpreters in providing services to deaf people—varies and is often based on faulty assumptions and individual preferences. With respect to individual preference Fant (1990) states the following.

> "Consumers tend to base their acceptance or rejection of interpreters upon two factors: skill and personality. If the signing is clear, easily understood, and meaningful, the interpreter is adjudged to be skillful. Unfortunately, if the personality of the interpreter is perceived to be unattractive, a concept too subjective to be further defined, the interpreter will not be adjudged to be competent.
>
> Overall, personality and specific character traits exert a powerful impact upon the consumer's perception of an interpreter's competency. It is regrettable that such intangible subtleties often decide whether the consumer will like or dislike an interpreter, but it is a fact we must live with. It would be folly to imagine we could transform personalities, even if we knew what traits are desirable to instill. Training programs cannot alter personalities, and certification does not measure their attractability quotient. We are left with no alternative save that of explaining to consumers that they must not confuse competency

> with such things as attractiveness, likeability, warmth, friendliness and any other traits that might come to mind." p.50

Another significant element of this market disorder is the demographics of the pool of individuals who constitute the current workforce of sign language interpreters. Historically, when interpreters were inducted into the profession, members of the Deaf community played a central role in the process. This involvement ensured that the interpreter had the appropriate skills, temperament and character to serve the community. In essence, the selection process served to protect the community from outside interlopers. This vetting protected the interests of the community by ensuring that interpreters were skilled and compassionate and able to collaborate in the interpreting process. Numerous authors have talked about the dramatic shift that has occurred relating to the process by which individuals who can hear become interpreters and the diminishing role of Deaf people in the vetting process (Cokely, 2011, 2012; Williamson, 2012; Taylor, 2012; Suggs, 2012; Colonomos, 2013).

Prior to the establishment of certification standards, laws requiring linguistic access or the proliferation of interpreter education programs, Deaf people led the process of vetting interpreters. This vetting served to protect the Deaf community and ensure that interpreters had a sufficient connection to the community (Cokely, 2011, 2012). Deaf individuals often directly recruited individuals to serve as interpreters and invested personal time and energy guiding their acquisition and mastery of ASL, their immersion into the Deaf-World, and their induction into interpreting (Witter-Merithew, 2013). Many of those who were recruited were CODAs—including this expert—and other family members. Some were individuals who worked with Deaf people in some professional capacity where their use of American Sign Language was a necessity. This is no longer the norm.

The current and prevailing norm for the past 25+ years is that less than 25% of the current workforce have native competence in ASL—the remaining 75%+ are second language users, many acquiring only basic conversational competence before attempting to acquire interpreting skills. Yet, these non-natives comprise the majority of the workforce. *As a result, it is much more common for Deaf individuals using interpreting services to work with an interpreter who is a non-native, than it is to work with an interpreter who is a native.* And, currently, in the majority of interpreter training programs and in all of the current national certification systems, there is no requirement to demonstrate native—or even near-native—competence in ASL as a pre-requisite to employment or certification.

On page 96 of Dr. Shepard-Kegl's report she states, *"Ms. Saunders and Mr. Branden are just asking for what most other patients who are provided interpreting services get, native level language interpretation."* This statement, although an indication of the ideal and what anyone who is a strong ally of the Deaf Community should advocate, is *just not a realistic expectation* given the current demographics of the workforce and state of interpreter education. Perhaps Dr. Shepard-Kegl was speaking of the condition that is more commonly present in the field of spoken language interpreting, where the majority of interpreters come from within the language community they work with. Conversely, the majority of sign language interpreters are native English users, not native users of ASL…or even near native. They are second-language users, most acquiring signing skills as an adult.

As well, as part of the reality that the majority of working interpreters are not native-users of ASL, the need to negotiate meaning is also the norm within the majority of interpreting situations. It is understandable why Deaf consumers are put-off or concerned when asked to clarify something they have communicated or when they are asked to somehow adapt to the limitations of the workforce. It should not be this way…but it is. Ideally, the communication would flow smoothly, almost seamlessly, but, in the experience of this expert, this is rare. An interpreter's request that a Deaf consumer clarify or repeat herself is not an indication that the interpretation being provided is ineffective or that the interpreter is unqualified. If it were, this expert would have been deemed so many times over. Having conducted over 600 diagnostic assessments of interpreters, at least 50% of whom were certified at the time of the assessment, it is evident that the incidence of misunderstanding and error is significant and consistently present during interpreted events.[6] Further evidence of this exists within the deposition transcript of Tracy Bell Slater as part of the documents provided to this expert—the interpreter(s) for the deposition had to seek clarification and offer correction several times. This is an inherent part of the interpreting and human communication process.

It is common in the discourse of the Deaf Community that Deaf consumers have to do additional mental processing when receiving information from interpreters—having to go through the additional mental task of reinterpreting the information they receive to understand it. This is often because there is English intrusion or influence in what the interpreter is signing[7]. Likewise, students of interpreting are taught to seek clarification and to ask for adjustments when they are not able to understand. An ethical and responsible interpreter would let a consumer know when they did not understand and ask for clarification, or that the information be repeated [including in a different way], or that they indicate what they did understand and ask for assistance in comprehending the rest. Of great concern, which is often the case in the expert analysis work of this expert, are the instances where interpreters do not understand, but do not intervene and let the consumers know or seek to remedy the situation. When this happens, or forms a pattern, it constitutes a serious ethical breach. In such instances, there can be an appearance that all is going well, when in reality misunderstanding—sometimes of serious magnitude—has occurred. Like all human communication, interpreting is a collaborated and relational event and the need to negotiate meaning is an inherent part.

2. The availability of highly qualified interpreters who are native users of ASL is very limited.

In her report, Dr. Shepard-Kegl states that the request of the plaintiffs for a CODA interpreter, or an interpreter with native competence in ASL, "could have been easily accommodated and should have been (p. 96)." There is no evidence offered to substantiate this claim. The experience and findings of this expert would indicate the contrary.

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[6] Cokely (1992) did doctoral research into the nature and types of miscues occurring in interpreting performance of highly qualified and certified interpreters—half of whom were native ASL users—and found that the amount of time available to and used by the interpreter to process and understand the message had implications for the number of miscues.

[7] Baker-Shenk and Cokely (1980) discuss the influence of English in the signing capacity of most hearing individuals who work with Deaf people and the reality that Deaf people have had to learn to accommodate this reality as part of the communication continuum that exists in the Deaf Community. The ability of a Deaf person to make this accommodation is dependent on their degree of mastery of ASL and English.

The Registry of Interpreters for the Deaf (RID) database shows there are 536 certified ASL interpreters in the entire state of Minnesota. Of this total, 230 possess NAD certification—43% of all the interpreters in Minnesota. Of the 230 individuals with NAD certification, 63.5% possess NAD Level III—the majority. Only 68 individuals in the state hold an NAD IV and only 16 hold an NAD V. Assuming that the NAD V would reflect the most highly qualified interpreters in the state, and even going so far as to assume that these individuals all possess native or near-native competence in ASL, they represent only 7% of the NAD credentialed interpreters, and only 3% of the total RID certified interpreters in the state.

Add to this the reality that not all interpreters in the RID database do free-lance interpreting on a full-time basis and/or may only be available within limited timeframes to provide service, the possibility of securing one of these highly qualified interpreters on a consistent and regular basis is highly unlikely. The competition for these limited highly qualified and native interpreters is high. Thus, as previously stated, the use of adequate interpreters is the prevailing norm.

Another complication contributing to limited access to highly qualified and native interpreters is that not all available interpreters are willing to do medical interpreting assignments, according to national survey results. In 2006, 2009 and 2012 the National Consortium of Interpreter Education Programs (NCIEC), a federally-sponsored collaborative of five regional and one national centers with the goal of advancing the fields of interpreting and interpreter education, conducted practitioner needs assessments to identify emerging trends and new or changing needs of interpreters. The surveys were conducted by the National Interpreter Education Center located at Northeastern University. Each of the surveys was disseminated to the approximately 8,000 national Registry of Interpreters for the Deaf (RID) members in electronic form. There was a 49% response rate to the 2006 survey, a 34% rate to the 2009 survey, and a 40% response rate for the 2012 survey—all well above the minimum response rate needed to have statistical confidence in the findings.

In the 2012 survey, 92 of the national respondents were from Minnesota—approximately 3%. 51% of the respondents reported that they held full or part-time staff interpreter positions—meaning their availability for free-lance interpreting would be limited[8]. The three settings in which the majority of staff positions were held were K-12 (33%), post-secondary (20%) or VRS (60%)—a total of 69% of all staff positions. Nationally, only 4% of staff positions were held in medical situations—indicating the hiring of staff interpreters in the healthcare setting is still an emerging trend.

The vast majority of practitioners reported that they were available to provide less than 5 hours a week of free-lance interpreting services. Nearly all others indicated they were available to provide less than 10 hours a week of free-lance interpreting services. Of those that do provide free-lance services, 59% reported they do not provide any services in the medical situation. This means that nationwide, 59% of free-lance interpreters responding to the 2012 survey do not provide services in healthcare setting. This has significant implications for the pool of individuals available to provide services—and further reduces the likelihood of securing someone from the small percent of native and highly qualified practitioners.

Related to this is the fact that 53% of the respondents report an increase in the demand for their

[8] See page 3-10 of the 2012 NCIEC Practitioner Needs Assessment Report

services—another 22% indicate the demand has remained basically the same. This type of data provides insight into the issue faced by entities that work to schedule free-lance interpreters in any number of settings—the availability of practitioners to do the work is limited, thus continuing to drive up the need. For this reason, it typically takes multiple contacts and follow-up to find someone available to fill a given assignment. Nor is it uncommon that the system making the request for the service is asked to change the requested appointment time to accommodate the availability of interpreters. Therefore, the wise and responsible response to the shortage is for entities that are truly committed to providing consistent, certified interpreters for on demand service is to hire staff interpreters—which is what Mayo has done for some years.

Again, in the 2012 survey, when respondents were asked to identify training/education needs, both freelance and staff interpreters indicated the same top three categories—legal (50%), medical (36%) and mental health (35%)[9]. It is important to note that these three categories have ranked as the top three (3) training/education needs of practitioners across all three surveys—2006, 2009, and 2012. Thus, competence to interpret in medical settings has been a prevailing need of working practitioners over an extended period of time—including the timeframe involved in this particular matter.

When this data is considered in its totality, it provides a clear snapshot of the status of interpreting in the United States and specifically as it relates to healthcare interpreting—the pool of available certified interpreters to work in this setting is small and the majority of interpreter practitioners consistently report the acquisition of competence in healthcare settings is one of their top training/education needs.

Consumer reporting of interpreter shortage reinforces the practitioner data. In a 2009 Consumer Needs Assessment Report prepared by the National Consortium of Interpreter Education Centers consumers reported that health settings were the most difficult setting in which to secure interpreters (48% in Phase 1 and 52% in Phase II). The next highest setting was their job or employment settings (42% in Phase I and 26% in Phase II).

3. Certification of sign language interpreters in the United States has been in flux since its inception.

Another factor contributing to market disorder is that of certification and defining minimum competence for practicing interpreting. The valid and reliable testing and assessment of interpreting performance has been an ongoing issue and topic of significant debate since the inception of certification examination by the Registry of Interpreters for the Deaf, Inc. (RID). Its history is complex and impacted by a variety of factors—including but not limited to the political activism of the Deaf Community[10]. The following historical perspective on the certification of interpreters is important in understanding the issues that have been raised in this matter regarding

[9] See page 46 of the 2012 NCIEC Practitioner Needs Assessment Report

[10] The term Deaf Community is used to identify persons who share a common means of communication (ASL) that provides the basis for group cohesion and identity, as well as a common culture. Typically, it refers to individuals who are deaf and are involved in matters affecting the Deaf Community, or certain hearing individuals who share the language, understand and can relate to the culture, and support the goals and values of the Deaf Community (Baker-Shenk & Cokely, 1980).

whether or not an NAD Level III certified interpreter was sufficiently qualified to interpret for plaintiffs.

The RID is a national organization of sign language interpreters, established in 1964, with the initial purpose of promoting recruitment and training of more interpreters for the deaf and to supply consumers with a listing/registry of competent interpreters. The historical roots of the RID are strongly tied to the Deaf Community and the National Association for the Deaf (NAD). The NAD, established in 1880, is the nation's premier civil rights organization of, by and for deaf and hard-of-hearing individuals in the United States[11]. It was the NAD that sought and received federal funding to establish a national office for the RID in 1967[12].

This funding obtained by NAD to establish a national office for RID included the expectation that a national certification examination be established and implemented. Utilizing a model of interpreter evaluation implemented in Texas since 1968, the RID began implementing a similar system in 1972. This system, under which many currently certified interpreters were tested and certified, was not scientifically developed or subjected to the rigors of psychometric validity and reliability.

After many years of complaints related to testing materials, rating process and bias against candidates by local evaluators, the RID sought and received a grant in 1986 from the Fund for the Improvement of Post Secondary Education (FIPSE) to develop, validate and make reliable certification examination[13]. This expert was Vice President of the RID at this time when a full time administrator was hired to take on the task of guiding the development and implementation of the test that led to the establishment of the Certificate of Interpretation (CI) and Certificate of Transliteration (CT). Actual implementation began in late 1987.

However, simultaneous to RID undertaking efforts to secure funding to create a new valid and reliable test, the NAD begun its own exploration into the establishment of a certification examination system. This effort was based on NAD's growing dissatisfaction with RID's old certification system—the inconsistency in who passed, the decreasing involvement in Deaf individuals in the test system, the lack of feedback to candidates, and the growing demand for more certified interpreters. So, in 1986 the NAD membership voted to form a study group to explore the feasibility of establishing an alternative system to the certification offered by the RID and in fact began implementing its own system in 1991—a few years after the RID's new system began.

NAD's implementation came after a 1989 RID convention motion to require all certified RID interpreters under the old/original certification system to be recertified failed. This expert was president of the RID at the time and openly endorsed the importance of all interpreters being recertified as a mechanism for eliminating the concerns with the original/old test and reinstating our credibility with the Deaf Community. However, a majority of the RID members felt they did not need to be recertified—although some readily took the new exam and gain CI and CT certification.

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[11] NAD website http://nad.org/.
[12] Fant, Lou (1990).
[13] Fant, Lou (1990). *Silver Threads: A Personal Look at the First Twenty-five Years of the Registry of Interpreters for the Deaf.* RID Publications: Alexandria, VA., p. 47.

This decision of the RID membership to not require recertification under the new system further deteriorated NAD's confidence in RID certified interpreters and their commitment to correcting what they perceived to be a failing system was deepened.

The three distinguishing features of the NAD test were 1) the system was tiered, allowing for five distinct categories of competence/proficiency (RID's system was a simple pass/fail related to a minimum standard), 2) candidates received a summary of areas for improvement (RID's system provided no diagnostic feedback) and 3) the use of a live panel that included three (3) Deaf raters (RID system filmed candidates and sent the tapes to raters and only used one deaf rater). Soon, proponents of the NAD certification system—which included many Deaf-related social service agencies (many government funded—such as Commissions for the Deaf, and Deaf-advocacy organizations, began touting those interpreters with NAD certification as having a stronger "stamp of approval" from the Deaf Community than those certified by the RID. For over a decade, the political lines were drawn in terms of perceptions of loyalty and commitment to the cause of the Deaf Community gaining control over its right to linguistic access through interpreters. As a result, some RID certified interpreters sought to gain additional certification from NAD. Others sought only certification from NAD.

Although the NAD certification system recognized five (5) levels of competence, it only identified three of those levels as certified—Level III, IV and V. The first two levels were considered novice levels that were not yet qualified to interpret. Appendix A provides a description of the three (3) certification designations awarded by NAD. These descriptions are also present on pages 10-11 of Dr. Shepard-Kegl's report.

In 2003, the NAD and RID entered into an agreement that the RID would recognize NAD Certified Interpreters—Levels III, IV and V—as RID certified, assuming individuals holding that credential joined RID and complied with the same continuing education requirements and ethical standards as RID certified interpreters. In exchange, NAD agreed to stop administering its multi-level certification program.

Although Dr. Shepard-Kegl indicates that in practice, it is NAD IV and V that are recognized, this is not published anywhere that this expert was able to identify in a literature review. In fact, the RID website (rid.org) clearly recognizes NAD III as certified status and provides the following illumination regarding all certificates it awards/recognizes.

> **Types of Certification**
> Most RID credentials indicate that an interpreter was assessed and awarded certification by RID. This includes the NAD-RID National Interpreter Certification (NIC). However, RID also recognizes credentials assessed and awarded by others organizations. This includes NAD certifications and the EIPA (RID awards the Ed: K-12 for recognition of the EIPA). Before such certificates are recognized by RID, the testing instruments are put through a thorough psychometric evaluation to make sure they are valid and reliable.
>
> All RID certifications are classified into two broad categories:
>
> - **RID Generalist Certifications**– Certifications classified as generalist signify

skills in a broad range of general interpreting/transliterating assignments. Certifications in this category include the NAD-RID National Interpreter Certification (NIC) and RID certificates such as CI, CT and NAD Level III, IV and V.

- **RID Specialist Certifications**– Certifications classified as specialist signify skills in a particular area or specialty of interpreting assignments.

In defining certifications, the website goes on to state the following.

> "Generalist certifications recognize professional interpreters who have met or exceeded a nationally recognized standard of minimum competence in interpreting and/or transliterating. Individual certifications vary in their scope, so it is important to know what each credential means.
>
> **NAD Certifications**
>
> - **NAD III (Generalist) - Average Performance**
>
> Holders of this certification possess above average voice-to-sign skills and good sign-to-voice skills or vise versa. This individual has demonstrated the minimum competence needed to meet generally accepted interpreter standards. Occasional words or phrases may be deleted but the expressed concept is accurate. The individual displays good control of the grammar of the second language and is generally accurate and consistent, but is not qualified for all situations."

It is clear that NAD III is indicated as certified status, is not ranked as below ANY other RID minimum standard certified category and denotes part of the composition of practitioners who have satisfied an adequate standard to be considered ready for professional practice.

Summary

Interpreters are engaged in nearly every aspect of the lives of deaf people—their healthcare, their business transactions, their employment settings, their education, their religious experiences, their legal transactions and any number of other situations. In all instances, access and inclusion is only available to deaf individuals based on the availability of practitioners. The base of practitioners available is limited and does not meet the demand. As well, the base of interpreters is represented by individuals with a wide range of competence—the majority possesses adequate but less than native or even near-native competence in American Sign Language.

There has been a major shift in the demographics of the interpreter workforce—the vast majority now being individuals who acquire ASL as adult, second language users. As a result, many of these individuals have an English influence on their signing. Consequently, Deaf consumers frequently have to adapt to the limitations of the existing workforce and to participate in negotiated interactions where intent and content are clarified in order to ensure understanding.

And, because there is a significant disconnect between the length of, and scope and sequence of, most interpreter education programs and marketplace needs, there is a well-known gap between program completion and work readiness. The availability of native, or near native, highly competent, certified interpreters is extremely limited. As a result, the national standard in employing interpreters is to rely on an adequate standard in the vast majority of situations.

Further, over the past 4 decades during which interpreters have been certified, the definition of what constitutes a minimally competent interpreter has been subject to great interpretation both in terms of testing procedures and perceptions and preferences of consumers.

These realities are all a part of the market disorder that exists within the fields of interpreting and interpreter education and gravely impact all entities attempting to provide interpreting services to the Deaf and hard-of-hearing population.

The Mayo Clinic sought to mitigate the shortage of available interpreters by hiring certified interpreters to work on staff and be available on demand. This was a progressive and responsible decision and reflects a commitment to serve the needs of its Deaf and hard-of-hearing patients. The certified staff interpreter whose work is the focus of this matter, Linda Rasmussen, was consistently available and acted ethically in providing the most component services possible and seeking to negotiate meaning and understanding with the plaintiffs as needed. When issues arose between the staff interpreter and plaintiffs, the interpreter appropriately reported concerns and elicited supervisory support to address and try to resolve the issues.

Mayo had an internal system of supervising and managing interpreting services and attempted on several occasions to activate this system in an effort to address, understand and clarify the issues expressed by the plaintiffs in this matter. That the plaintiffs were unwilling to work with the internal system that was available is not the fault of Mayo. It remains unclear why the Plaintiff's refused to interact or meet with representatives of Mayo's Language Department in order to help Mayo understand why Plaintiffs felt the interpreter services provided to them were problematic, and how Mayo could tailor assistance to Plaintiff's specific situation, skills and needs.

It is unrealistic to suggest that the Mayo Clinic is responsible for the market disorder that exists in the field of interpreting. Given the existing limitations within the market, it would not be possible for the Mayo Clinic to satisfy the specific expectations and preferences of the plaintiffs in this matter for consistent provision of services by highly qualified interpreters with native ASL competence. It is the opinion of this expert that the Mayo Clinic responded in a responsible manner both in the use of certified, staff interpreters, in the establishment of procedures and practices related to the requesting and supervision of interpreting services, and in their effort to address the concerns of the plaintiffs.

Respectfully Submitted,

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