UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

Roger Durand,
Linda Durand, and
Priscilla Durand

Plaintiffs,

vs.

Fairview Ridges Hospital,

Defendant.

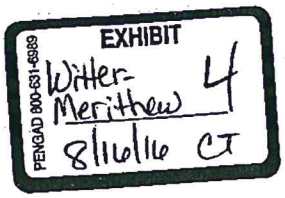
Civil Action No. 15-CV-02102 [RHK/SER]

Expert Rebuttal Report

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

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

6/29/16



ATTACHMENT 19

I. Executive Summary

I, Anna Witter-Merithew, have been hired to function as a rebuttal expert by the law firm of Gislason & Hunter, LLP, Defense Counsel, to offer consultation on issues related to communication with individuals who are deaf and the provision of interpreting services in healthcare settings as it pertains to the matter of Durand v. Fairview Ridges Hospital. Specifically, I have been asked to offer rebuttal opinion in response to the plaintiff's expert report, dated 4/6/16, submitted by Dr. Judy Shepard-Kegl.

In formulating my opinions, I relied on information from 1) Dr. Shepard-Kegl's Communication Assessment Report dated April 6, 2016, 2) the associated raw video footage from the assessment process, 3) the Interpreting Assessment of Priscilla Durand, submitted by Betty Colonomos at the request of Dr. Shepard-Kegl, 4) series of plaintiff and defendant filings in this matter, 5) research and literature from the field of ASL-English interpreting, and 6) my 40+ years of professional experience in working with deaf individuals as a certified interpreter, consultant, educator and diagnostician. A complete listing of the documents and literature reviewed appears later in this report.

I have reviewed the expert reported submitted by Dr. Shepard-Kegl[1] in which she sets forth a general foundation for what constitutes the work of an interpreter, the way in which professional interpreters are credentialed, when interpreters are needed, and the comprehensive and systematic language assessment she conducted on the plaintiffs in this matter. As well, she 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. As well, her general explanation of the work of interpreters, the processes involved in determining when and if interpreters are needed, and the way interpreters are credentialed to be accurate. To my understanding, the fact of whether Linda and Roger Durand are deaf, use sign language and that they use interpreters for some situations is not at issue.

After the comprehensive and systematic language assessment provided by Dr. Shepard-Kegl, the findings clearly demonstrate that Linda and Roger Durand are intelligent individuals with competent language use and sufficient English literacy to enjoy reading, the ability to use written English for various forms of communication, and to gain broader access through reliance on television captioning. They are gainfully employed, self-supporting, and raised a family to

[1] Shepard-Kegl, Judy (2016). Expert Report in the matter of Durand v. Fairfield Ridges Hospital

adulthood. However, like any number of individuals in the broader American society, and certainly in the Deaf Community, they appear to have some significant gaps in their fund of knowledge, particularly as it relates to being able to grasp the full intent of implicit versus explicit information. The question that remains is whether that gap in their fund of knowledge was sufficiently understood by the hospital staff and whether or not the gaps in their fund of knowledge would have been mitigated through the use of interpreters. This question will be explored in this rebuttal report.

Dr. Shepard-Kegl's reliance on the assessment of Priscilla Durand's signing competence provides insight into Priscilla's limited ASL capacity. What it doesn't provide is an analysis of how her communication ability fit within the framework of the Durand family communication dynamics, and most specifically, the degree to which Linda and Roger Durand understood Priscilla and other members of the immediate family. It doesn't account for the intimate manner in which individuals who live together within a shared context express themselves to one another and establish patterns that create ways of communicating and understanding one another. For that insight, this expert had to rely on the broader base of material provided—primarily deposition testimony by Linda, Roger and Priscilla Durand, that detailed the communication processes used by the family both during and external to time within the hospital setting.

In setting forth the implications of her findings for the provision of interpreting services, Dr. Shepard-Kegl's constructs a logical, albeit ideal, portrait of the services that should have been provided to the plaintiffs Linda and Roger Durand and offers some generalizations about the performance of professional interpreters. This expert will examine elsewhere in this report those generalizations about interpreter performance, particularly as it relates to the proposition offered by Dr. Shepard-Kegl that interpreters do all of the things that Priscilla Durand was not able to do due her communication limitations in communicating with her parents. The facts in this case suggest that even when interpreters were present and involved, the inability to grasp implicit versus explicit meaning was evident.

In addition to her own analysis of the facts and implications of the facts in this matter, Dr. Shepard-Kegl also relies on the analysis of Priscilla Durand's interpreting competence by Betty Colonomos. Ms. Colonomos provides an accurate description for the term CODA, which typically refers to individuals who can hear and are born into families with one or two deaf parents. As well, she provides an accurate and generalizable portrayal of the myths and assumptions

that often exist within the broader society about the ability of CODAs to communicate in sign language and/or to interpret. As part of this rebuttal opinion, a distinction between signing competence and interpreting competence will be made. However, given that the raw data of Priscilla Durand's interpreting performance were not available to this expert, I cannot comment on the accuracy of the observations. However, I can assert that it is my believe that given Ms. Colonomos' expertise, she is certainly able to assess interpreting performance accurately and effectively. The question that remains is whether the overall evidence in this matter supports the plaintiff's claim that she was "forced" to interpret for her parents.

Ultimately, it is abundantly clear from a review of all the materials provided to this expert that this is a complex case with significant emotional appeal because it provides a powerful illustration of the challenges associated with being deaf in a world that is dominated by individuals who can hear, and the extremely sad and heart-wrenching implications that can exist for families that have a history of complex dynamics related to communication, long-term health care management issues, and are placed in a more vulnerable state of stress with a health-care crisis that results in the death of a beloved family member.

Ultimately, the questions that this expert will offer opinion about are 1] whether Fairview Ridges Hospital refused to offer interpreting services, 2] whether the presence of interpreters mitigated the circumstances surrounding the communication issues that existed, and 3] whether the expectation for on-demand, face-to-face interpreters in this situation is reasonable and feasible. In summary, it is the opinion of this expert 1] that there is no compelling evidence that Fairview Ridges Hospital refused to offer interpreting services, 2] that the periods where interpreters were provided did not appear to mitigate the underlying issues of the plaintiffs' lack of understanding of the impending and probable death of Shaun Durand, and 3] that the availability of interpreters in emergency medical settings is a complex issue that goes beyond the capacity of Fairview Ridges Hospital to resolve.

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.

I currently am under contract as the Interim Executive Director for the Registry of Interpreters for the Deaf, Inc. [RID]. The RID is the national professional association of sign language interpreters and confers certification for generalist practice and some areas of specialization. In this temporary administrative role, I support a Board of Directors, national office staff, and a variety of volunteer leadership in their work on behalf of this organization. My primary duties are the overall oversight and management of the fiscal and operational aspects of the association.

On July 1, 2015, I retired from the University of Northern Colorado, where I had worked for fifteen [15] years as the Assistant Director for the 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.

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

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, and I continue a part-time contract with the university to continue this work until the grant expires on September 30, 2016. 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 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

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

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), 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 44 years. I am also trained and worked as a Video Relay Interpreter (VRS) and 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 – 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

May 2014 – Present—Consulting and Rebuttal Expert for the Defense in the matter of Priscilla Saunders V. Mayo Clinic, Case # 13-CV-1972 (JNE/JJG)

- Rebuttal report provided in October 2014

May 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.

- Expert Testimony in a Motion to Suppress Hearing scheduled for July 8, 2016.

July 2014 – February 2015—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

May 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.

- Expert Testimony in a Motion to Suppress Hearing scheduled for July 8, 2016.

October 2014- February 2015—Expert written report of language assessment of plaintiff and assessment of interpreting performance of individuals who served as defendant's interpreters submitted to Plaintiff's counsel in the matter of Trixy M. Betsworth, et al, Plaintiff v. San Bernadino County, Arrowhead Regional Medical Center and Does 1-10, Inclusive, Defendants, Case # 5:13-CV-01058-JGB (SPx).

- Deposition Testimony provided in February 2015

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, 4/6/16

- Raw Data from Dr. Judy Shepard-Kegl's Report

2. Case Files provided by Defendant's Attorneys

Plaintiffs' First Amended Complaint
Fairview's Answer to Plaintiff's First Amended Complaint
Plaintiffs' Expert Witness Disclosure from:

- Dr. Judy Ann Shepard-Kegl
- Betty M. Colonomos

Plaintiffs' Answers to Interrogatories, including:

- Plaintiffs' Second Supplemental Answers to Defendant's Interrogatories
- Plaintiffs' First Supplemental Answers to Defendant's Supplemental Interrogatories

Plaintiffs' Third Supplemental Response to Defendant's Requests for Production of Documents with documents

Fairview's Answers to Interrogatories, including:

- Defendant Fairview Health Services' Sixth Supplemental Answers to Plaintiff's Interrogatories to Defendant—Set 1
- Defendant Fairview Health Services' Sixth Supplemental Response to Plaintiffs' Requests for Production of Documents—Set 1 with documents
- Defendant Fairview Health Services' Fifth Supplemental Response to Plaintiffs' Requests for Production of Documents—Set 1 with documents

Transcripts of the depositions of:

- Plaintiff Priscilla Durand with exhibits
- Plaintiff Roger Durand with exhibits
- Plaintiff Linda Durand
- Ashlee Johnson with exhibits
- David Durand with exhibits
- Robert Royal with exhibits
- Ryan Snorek with exhibits
- Andre Athey
- Darlene Durand
- Pauline Durand
- Randy Washburn
- Robert Spicer
- Tamar Durand
- Craig Lynch with exhibits
- Diana Pennington with exhibits
- Tammy Kasal with exhibits
- Amy Klopp
- Amy Saladis
- Deb Huitt
- Dr. Doua Her
- Erica Otterstedt
- Julie Kahn
- Kathryn Lewis
- Lawrence Langston
- Tanya Payne

Medical Records of Shaun Durand from Fairview Ridges Hospital—May 7-9, 2013

3. Publications

Bauman, N. (2000). *Speechreading (Lipreading).* Retrieved June 1, 2016 from http://www.hearinglosshelp.com/articles/speechreading.htm

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

Cokely, D. (2012). Vanquished Native Voices—A Sign Language Interpreting Crisis? Street Leverage. Retrieved on 6/6/16 from http://www.streetleverage.com/2012/01/vanquished-native-voices-a-sign-language-interpreting-crisis/

Collins, Glenn. *The Family; Children of Deaf Share Their Lives,* http://www.nytimes.com/1986/12/15/style/the-family-children-of-deaf-share-their-lives.html, (June, 2016).

Crews, Kambri (2012). *Burn Down the Ground: A Memoir.* Villard. ISBN 978-0-345-51602-2.

Department of Justice (October 2003). *Communicating with Persons who are Deaf in Hospital Settings,* Americans with Disabilities Act: ADA Business BRIEF. DOJ, Civil Rights Division, Disability Rights Section. www.ada.gov

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.

Haffner, L. (1992). Translation is not enough: Interpreting in a medical setting. In *Cross-cultural Medicine—A decade later.* WestJMed—Special Issue, September, 157: 255-259.

Harmer, L. M. (1999) Health Care Delivery and Deaf People: Practice, Problems and Recommendations for Change. In *Journal of Deaf Studies and Deaf Education*, 4:2 spring, Oxford University Press.

Hoffmeister, Robert. *Open Your Eyes: Border Crossings by Hearing Children of Deaf Parents: The Lost History of Codas* (University of Minnesota Press, 2008), 207

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.

Preston, Paul. (1995-09-01). *Mother father deaf: living between sound and silence*. Harvard University Press. ISBN 978-0-674-58748-9.

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. & 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.

V. Opinions

1. There is no compelling evidence that Fairview Ridges Hospital asserted a refusal to offer interpreting services.

There are many layers of inconsistency that exist in this case. Definitely, the clear and consistent manner in which one requests and secures interpreters is one of the places where inconsistencies abound. Interpreters were definitely provided, but inconsistently. And, the availability of interpreters was inconsistent. There were times that an intention to have an interpreter was documented, but engagement of the interpreter was not evident. There were times when an interpreter was present, and there is a difference in opinion as to whether Linda and Roger Durand benefitted from the inclusion of interpreters. As a result of these type of inconsistencies, Fairview Ridges Hospital would benefit from a thorough review of the policies and procedures used for creating access to Deaf individuals seeking access to the hospital's programs and services.

With that established, there is even greater inconsistency in the testimony of Linda, Roger and Priscilla Durand about when, how and with who requests for interpreting services were made. They family is emphatic that requests were made, but often vague as to with who, when, how. They indicated that the use of interpreters was emphasized, but continually proceeded without interpreters without check-in or reasserted the request. Linda Durand provided deposition testimony that she only used interpreters sometimes. This was reinforced by Priscilla's deposition testimony about her mother only used interpreters in certain situations. In other instances, the plaintiffs and their experts, ascribed to interpreters the power of creating access that ensures understanding. Who was responsible for requesting interpreters and in what matter within the family seemed haphazard. According to her deposition testimony, it was Priscilla or one

of her siblings who typically asked, and the parents were passive in the process. This was reinforced in Linda's deposition testimony. The hands off approach of Linda and Roger Durand, which included a failure to self-advocate and ask for clarification when needed and when the opportunity existed contradicts the impact they now claim the lack of interpreters created.

This same inconsistency occurs in describing communication within the family. In her deposition testimony, Priscilla describes multiple instances of going to her parent's home to engage in lengthy explanations about what was going on with Shaun's health and prognosis, or coming to realize at the hospital that her mother lacked a clear understanding of what happened, and her efforts to re-explain issues to her mother. Yet, in Linda Durand's deposition testimony, she indicates that she and Roger typically had no idea of what was going on, and avoided any request for information out of concern for Priscilla. Likewise, she offered deposition testimony that she did not seek to ensure that the hospital was actively engaged in securing interpreters, because a request had already been made—even if not directly by her.

In the plaintiff's complaint, there is an emphatic statement that the hospital *required* Priscilla to interpret for her parents rather than secure interpreters. Yet, in Priscilla's deposition testimony, she admits that there was no pressure, but rather her perception that hospital staff left her no choice but to interpret—even though she was not qualified and made that explicit. Yet, her explanation of what transpired in these instances is not interpreting, but rather her explaining to her parents after the fact what had been communicated during an incident involving family members and hospital staff.

Signing differs from interpreting in that a signer is communicating his or her own ideas and has complete control over how information is expressed. Interpreting involves conveying the ideas of others and the shifting from one language into another. This requires the interpreter to have a broad command of subject matter and the ability to appreciate the thought-worlds and experiences of a broad range of speakers/signers—including cultural orientation and norms which impact meaning and ways of communicating.[1] This capacity has clearly been established as beyond Priscilla's capacity. And so, as a result, she was left to utilize the form of communication with her parents that had served as her way of connecting with them all of her life—her self-generated expression of ideas using signs and spoken English together in what the plaintiff's expert Dr. Shepard-Kegl referred to as *sign supported speech*. *Sign supported speech* is a common form of communication with deaf individuals who are competent lipreaders—which

again is how Dr. Shepard-Kegl described Linda and Roger Durand.

A deaf person's ability to understand what is being spoken through speechreading is influenced by the content of the conversation. If the person knows what the topic is, and is familiar with the language used, it will be easier to speechread. If the topic is unfamiliar, especially if it requires unfamiliar or technical vocabulary—such as that which arises in medical situations, speechreading will be very difficult, if not impossible. As well, a deaf person will be more capable of lipreading the speech of a family member or someone with whom they are familiar and share a common frame of reference than someone who is a stranger. So, given that this style of communication was central to the long-standing family communication dynamic, it appeared to work. Both Priscilla and Linda Durand reference instances at the hospital and external to the hospital where they engaged in this method of direct communication for conveying information back and forth to one another.

And, as a result, Priscilla Durand indicates several times in her deposition testimony [see pg. 92 for an example] that her parents knew of Shaun's condition and prognosis all along, that she had spent lengthy conversations with them to ensure they understood. On page 22 of Priscilla's deposition, she indicates she knew that a care provider could request interpreters anytime they believed it was necessary, and that she knew this as a result of training she took as an employee of Fairview Ridges Hospital. She also admits that in finding the information in the training lacking, she never told anyone that more information should have been included about how to communicate with deaf people. Nor, is there any evidence that the family attempted at any point to have a focused conversation with the staff about how to best communicate with Linda and Roger Durand. Plaintiff's expert, Dr. Shepard-Kegl suggests that writing down information, or creating an opportunity for clear spoken English communication and lipreading would be viable options for communicating with the Durands. Yet, there is no evidence offered that these options were identified by the family as they experienced delays in securing interpreters.

What these many inconsistencies demonstrate is a shared responsibility for the alleged failure of effective and appropriate inclusion and access for Linda and Roger Durand. The family, and particularly Linda and Roger Durand, failed to assert a clear directive as to what they required in order to achieve their desired level of access and understanding. Linda Durand, in her deposition testimony, expressed the faulty assumption that the hospital staff should have known what was needed and to provide it, even though she made no effort to self-advocate

for the communication access she expected, or to follow up to determine if requests were being fulfilled. As well, she acknowledged that when she failed to understand information, she did not request clarification, even when interpreters were present.

2. Periods when interpreters were provided did not appear to mitigate the underlying issues of the lack of understanding by Linda and Roger Durand of the impending and probable death of Shaun Durand.

Having conducted over 600 diagnostic assessments of interpreters, at least 50% of whom were certified at the time of the assessment, it is evident to this expert that the incidence of misunderstanding and error is significant and consistently present during interpreted events.[5] Evidence of this exists within the deposition transcript of Linda Durand as part of the documents provided to this expert—the interpreter(s) for the deposition had to seek clarification and offer correction several times. As well, there were multiple times that they did not offer correction and instead the errors stood as part of the transcript and/or the plaintiff's attorney provided correction. Illustrations of instances where interpreters did not self-regulate or self-correct can be found on Linda Durand's transcript pages 39, lines 21-25, page 71, lines 7-10, and page 76, lines 24-25. Illustration of where the interpreters were able to self-regulate and self-correct can be seen on page 41, lines 9-12; page 72 and lines 16-17. These examples are not all inclusive, but rather offer illustration of the point that contrary to Dr. Shepard-Kegl's claim that all the things that Priscilla was not able to do—including providing an equivalent message/meaning—would have been achieved if interpreters had been hired, interpretations may not consistently create access. Ideally, it would be the case, but diagnostic assessment data consistently shows that it is not the case. An inherent part of the interpreting and human communication process is misunderstanding or a lack of consistent clarity of meaning.

Further, to imply that the inclusion of interpreters on demand would have prevented the emotional devastation experienced by Linda and Roger Durand is not grounded in the evidence available in this case. As illustration, during the May 9th meeting between the family and Amy Klopp, the topic of *comfort care* came up as a focal point. Linda Durand testified in her deposition that even after that meeting, with an interpreter present, she did not have a complete understanding of what *comfort care* meant, or that it signalled the end of life

[5] 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.

status of Shaun. She did not seek clarification of meaning by asking, though an interpreter was present. As well, in her deposition testimony, even Priscilla Durand testified that she herself did not understand the severity of the situation and the fact that Shaun's death was imminent, until late in the day when a nurse mentioned that the provision of additional medication should be postponed. The point is that this family was dealing with a horrible and long-standing health crisis and they held fast to the hope that Shaun would once again gain sufficient recovery to be able to stay with them for a while longer. There is no evidence supporting the notion that after the many years of dealing with Shaun's ongoing health crises, repeated discussions between the family—independent of healthcare professionals and sometimes with healthcare professionals—that the inclusion of interpreters would have in anyway improved the level of understanding that apparently continues to elude Linda and Roger Durand.

Linda provided deposition testimony that even at the time of that deposition, there were elements of Shaun's condition and care that she did not really understand. Clearly, the impact of the grief has left this family very vulnerable. But, to attempt to put onto Fairview Ridges Hospital the responsibility for a long standing breakdown in communication within this family and/or a persistent lack of understanding by Linda and Roger Durand about the condition, prognosis and comfort care of Shaun is inconsistent with the evidence provided to this expert.

The ultimate source of the issue is not the lack of interpreters, but something that existed long before their engagement with Fairview Ridges Hospital and its healthcare providers, and according to their testimony, continues to persist today.

To fully appreciate the challenges faced in communicating with deaf individuals, it is important to consider the experiences of the average deaf person born in the United States. The central issue in raising any child who is deaf is language acquisition. Only a small percent of deaf children are born into families with parents who are also deaf and are able to engage the deaf child in the process of natural language development.[ii] Studies show that parental communication skill is a significant predictor for positive language and academic development in deaf children.[iii] However, the majority of deaf children born in the United States are born to parents who can hear and use spoken and written language to communicate. Most of these parents have no prior experience in communicating or living with a deaf individual and therefore are ill-equipped to address the unique language and communication needs of a deaf child. As a result, the majority of deaf children are deprived of exposure and access to a language-rich family environment.

The result of a lack of natural communication within their families is that deaf children commonly have tremendous language and information delays and enter the public school system significantly behind their non-deaf peers. Education for individuals who are deaf confronts a central fact—it is the sense of sight instead of hearing that conveys language symbols to the person who cannot hear.[iv] These issues also exist with a person designated as hard-of-hearing or hearing impaired, although typically not with the same severe implications. Depending on the onset of the loss, the degree of loss and the amount of benefit the child receives from amplification, the hard of hearing child is often able to understand at least some spoken language and to use their own speech to some degree.

Individuals who are deaf and hard of hearing differ widely in their home environments, the cause and extent of hearing loss, language development history, and the existence of complicating factors (e.g., mental retardation, motor or visual limitations, learning difficulties). So, a "one size, fits all" orientation to communicating with individuals who are deaf or have a hearing loss is not possible. Each individual will have unique needs and preferences as it relates to gaining linguistic access, and the unique needs should be clearly and consistently articulated when access is being requested.

3. The availability of interpreters in emergency medical settings is a complex issue that goes beyond the capacity of Fairview Ridges Hospital to resolve.

The field of sign language interpreting is in a state of market disorder that has serious implications for its ability to provide highly qualified interpreters in medical settings. Witter-Merithew and Johnson[6] 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.

[6] 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.

> 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. 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.

Another complication contributing to limited access to highly qualified 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[7]. 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 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.

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

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%)[8]. 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).

There is high probability that these factors contributed to the long wait periods between the requests for an interpreter by the Durand family, and the arrival of interpreters at the hospital. Further, this information may also account, at least in part, for the fact that in some instances, interpreters were simply not available, although requested. This reality impacts communities all across America and contributes to market disorder. To attempt to hold Fairview Ridges Hospital accountable for a reality that the fields of interpreting and interpreter education have been unable to resolve is misplaced and excessively punitive.

VII. 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

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

available is limited and does not meet the demand. 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.

As well, the unique needs of individual consumers, their preferred ways of communicating, and the intra-personal dynamics of a family's system of communicating with its deaf members, impacts the quality of access to healthcare programs and services. To ensure that the individual needs of deaf consumers is achieved, it is imperative that clear directives be imparted and/or a clear understanding of when a request is being made is established. This particular case is fraught with examples of all parties involved making a variety of faulty assumptions that led to a shared responsibility for the alleged failure of the hospital to provide the desired level of access.

Further, it is unrealistic to suggest that the Fairview Ridges Hospital is responsible for the market disorder that exists in the field of interpreting. Given the existing limitations within the market, it would likely not be possible to satisfy the specific expectations and preferences of the plaintiffs in this matter for consistent provision of services by highly qualified interpreters throughout the days leading up to Shaun Durand's death. Finding one or two qualified interpreters who would be available on demand and on short notice is highly unlikely. At best, it is more realistic that multiple interpreters would have to have been scheduled, resulting in less continuity in how information was conveyed, and serving to potentially exacerbate Linda and Roger's lack of understanding of Shaun's impending death.

Respectfully Submitted,

Anna Witter-Merithew

Anna Witter-Merithew, M.Ed.
CSC, SC:L, OIC:C, SC:PA, CI and CT
430 Clearwater Drive, NW
Concord, North Carolina 28027

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[i] Contemporary theories of interpreting are focused on the ability of the interpreter to convey a dynamically equivalent interpretation that results in the receiver experiencing the same reactions to original message, as would someone who received it directly. This view of interpreting is compatible with the notion of a LEP individual receiving a level of language access that similarly situates them as an English proficient person.

[ii] It is estimated that only five to ten percent of deaf children have deaf parents. Lane, H., Hoffmeister, R. and Behan, B. (1996). *A Journey into the Deaf-World.* San Diego, CA: DawnSignPress, p. 30.

[iii] Calderon, R. (2000) Parental Involvement in Deaf Children's Education Programs as a Predictor of Child of Child's Language, Early Reading and Social-Emotional Development. In *Journal of Deaf Studies and Deaf Education.* Spring; 5(2): 140-55.

[iv] Stokoe, W. (2001). The Study and Use of Sign Language. In *Sign Language Studies,* 1.4 (2001) 369-406.