2023 FALL

Caduceus

Medical division

Publication of the Medical Division of the American Translators Association

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1a

LETTER FROM OUR ADMINISTRATOR

Dear Medical Division Members,

We are proud to present the Fall Edition of Caduceus prepared by our Caduceus editorial team with the contribution of some very special guests such as ATA president Madalena Sánchez Zampaulo. We are so excited to celebrate the Medical Division's 20th anniversary with all the previous administrators. We plan to have more from other previous administrators in the next issue of Caduceus.

Continuing our policy of promoting other associations, we have a report on the 2023 NAJIT Conference written by one of the MD Leadership Council members, Carmen Gonzalez. As always, we invite you to send your articles to caduceusnewsletter@ata-md.org and we will be happy to share them with your colleagues. You can also email us and to join the Caduceus editorial team, which always welcomes new editors. Also, as part of the 20th anniversary celebration we decided to add a new page to our website in honor of all the previous Administrators that had a role in the Medical Division's success and improvement over the years https://ata-md.org/past-md-officers/.

The Medical Division offered a third free webinar this year on August 19th on remote interpreting. The free webinars will continue throughout the year. The next webinar will be by Sara Greenlee on the topic of **Vaccines.** Keep your eye out for the next MEDTalk announcement. The Resources page on our website has been updated again this month with some great medical resources. If you are a member of the MD Facebook page you know that every Tuesday, Sara Greenlee posts about a new wonderful medical resource. You can find these on our Resource website page as well. We will continue having our networking events periodically.

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As you may know, this is the fourth year that I am serving as the MD Administrator and my term will end in October at ATA64 in Miami. I am so proud of our achievements in the last four years and invite you to attend our Annual Meeting in September 2023 to hear a summary of what we have achieved, what you can look forward to, and meet the new MD Administrator and Assistant Administrator. We will send the announcement with


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registration information via email and MD social media. The Annual meeting will be virtual via Zoom and all ATA members are invited to attend. Mark your calendar for the weekend of September 23rd, more details will be announced.

This is the last time I write to you as the MD Admin, but I promise you it is not the last time that I write for Caduceus. After October, once I have more time on my hands, I plan to work on "The Interpreters' Corner" column, hopefully with your help. I invite all MD interpreters to write for that column and send their article to caduceusnewsletter@ata-md.org.

We are currently recruiting team members for the new MD Podcast initiative. If you are interested and would like to contribute and join us, please write to me at divisionMD@atanet.org.

Antoni Maroto, the MD Social Media Moderator is conducting a membership annual review. If you are interested in staying on as a member of the Medical Division social media groups, please log in to check your ATA membership profile and make sure that you have selected the Medical Division as one of your divisions. It's important that you take this step soon, to log into your ATA profile to check your division memberships.

Regarding the ATA64 conference, I am so happy to announce that this year, the Medical Division is having a joint dinner event with the Science & Technology Division on Thursday October 26, 2023 in Miami. Registration is already open with limited seats available, so make sure you get your ticket because it will be a great networking event in a wonderful setting. We reserved the Garden room of the restaurant, with a great menu. Come and join us if you are attending the conference.

Some more exciting news: the Medical Division will have a Forum at ATA64. Please join us for a very interesting discussion with lots of new ideas and information on how to expand your business and explore new lines of business that need your expertise and services. The MD Forum titled: "Broaden Your Horizon" will be held on October 27th, at the Lecture Hall of the ATA64 hotel. We cannot wait to see you there! Have your electronic devices with you, we are going to have some fun activities! We are going to think outside the box, exchange ideas, share experiences, and brainstorm together how to further expand our careers.

This year, the Medical Division Distinguished Speaker at ATA64 is Dr. Sam Pournezhad, presenting on Thursday, October 26th and also Friday, October 27th. Please check out Dr. Pournezhad's bio on the Distinguished Speakers ATA64 webpage https://www.atanet.org/ata64/education/distinguished-speakers/.

I would like to finish by wishing you a lovely fall and great conference if you are attending ATA64. I enjoyed serving you as the Medical Division Administrator and will stay on as a Leadership Council member. Feel free to reach out to me with any questions. I will be happy to help our members in any way I can.

~ Yasha Saebi

1b

LETTER FROM THE EDITOR IN CHIEF

June 29th marked the 20th anniversary of the establishment of the ATA's Medical Division. For this important milestone, we feature two interviews with previous administrators—Tony Guerra and Madalena Sánchez Zampaulo.

This summer we reached out to former administrators and assistant administrators with interview questions. We hope you enjoy reading about Tony Guerra's journey as assistant administrator for two terms, alongside Madalena Sánchez Zampaulo who also served for two terms in the position of administrator. Thanks to Luz Elena Miranda Valencia for the pertinent interview questions.

Dr. Elaine Hsieh´s article on healthcare interpreting as a specialized area of research brings to light what practicing healthcare interpreters know well: that culture and context matter. Dr. Hsieh touches on the topic of equality and says, "Healthcare interpreters are essential in helping both the providers and patients negotiate the meanings and outcomes of **quality and equality** of care." Citing previous research, she includes the caveat that "interpreter-as-conduit model is likely to reinforce and maintain the structural inequity and injustice within the system."

Carmen González shares with us her experience at the 44th NAJIT conference. She testifies to its value as an educational opportunity, among other benefits. And reminds us what can happen at a really good quality conference—you just can't always get to it all and eagerly await for next year's conference.

Our next issue will be published after ATA64. We wish you safe travels to Miami if you are attending.

~ Silvia Villacampa

2a

FEATURE: 20 YEARS OF THE ATA MEDICAL DIVISION –WORDS FROM OUR PAST ADMINISTRATORS

MADALENA SANCHEZ ZAMPAULO

1. What was on your mind when you decided to join the team and be part of the creation of the Medical Division? What did you hope to share with members?

While I was not one of the original founders of the Medical Division, I was thankful to those with the vision to propose and form it. The Medical Division is where I found my first professional home within ATA. At first, I didn't know what I had to share with other MD members, but as I grew in ATA, I was able to share more with my colleagues, serving twice as the Medical Division Administrator from 2011 to 2015.

2. What goals were you pursuing?

When I joined the Medical Division, I hoped to connect more with colleagues in translation and interpreting who worked in my field of practice. I didn't know that many colleagues in my geographic area who were healthcare interpreters turned medical and life sciences translators like me, but through the Medical Division, I found the folks who would inspire me to continue my work in the world of T&I and continue to grow as a professional. For me, it was mostly about networking at first, but I quickly found that I also was able to meet lifelong colleagues and friends through this ATA division.

3. How has the Medical Division changed over the years as you moved through new responsibilities in your career?

The Medical Division has evolved so much over the past many years that I've been an ATA member. The division has become more visible and MD members are known for their collaboration and inclusivity. I am proud to call the Medical Division my first ATA division, as well as the one I have been most active in from the start of my career. The division has been led by a great group of administrators, assistant administrators, and leadership council members over the years. I also enjoy the resources our colleagues create and share and hear the same from other ATA members!

4. As you may know, the last issue of our newsletter *Caduceus* included an article about dealing with stress. What does mental health mean to you?

Mental health is of utmost importance in today's world. Stress is coming from so many directions today, whether related to everyday demands or due to technology and the nature of world and political events. Without our health, we cannot perform our work well or be the best versions of ourselves at work and home. Mental health is finally being discussed more today, and I appreciate seeing more and more resources available today to support T&I professionals. Let's keep this up!

5. What was your favorite job at the Medical Division? What was your least favorite part? What was the most rewarding, and what was the most challenging?

I greatly enjoyed being the Administrator of the Medical Division from 2011 to 2015. My favorite part was working closely with other members and colleagues. During my two terms, Tony Guerra, the Assistant Administrator, was a joy to work with. I also got to know several other colleagues well due to my involvement in the division and ATA. Perhaps my least favorite part of this role was organizing the division dinner at the Annual Conference —only because it's a massive amount of work and stress to put on a dinner for such a large division. You can't always make everyone happy. ;)

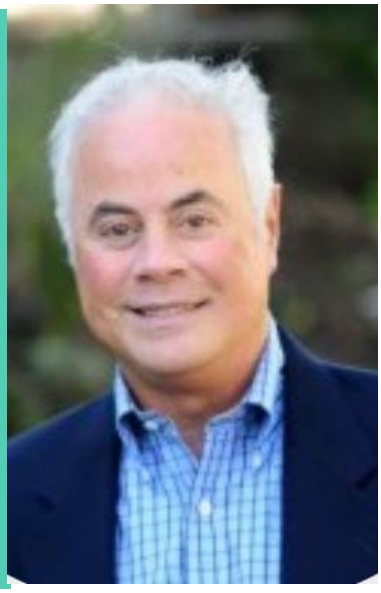
6. Is there anything we haven't covered that you want to say? What is one final thought that you want to leave our readers with?

I would like to encourage ATA members to get more involved in their divisions. This is where you will meet your colleagues and friends for life. Divisions are also the place where many future ATA leaders begin their journey in leadership. I would never have thought 12 years ago that I would one day be ATA President. Even if joining the ATA Board or becoming ATA President is not your goal (it wasn't mine!), you can learn so much from volunteering and staying involved. The benefits of being active in ATA divisions are numerous—the gift that keeps on giving, I'd say. You never know where your volunteerism will lead you, or the amazing professionals you'll meet as a result.

2b

FEATURE: 20 YEARS OF THE ATA MEDICAL DIVISION –WORDS FROM OUR PAST ADMINISTRATORS

ANTONIO "TONY" GUERRA



1. What was on your mind when you decided to join the team and be part of the creation of the Medical Division? What did you hope to share with members?

I didn't know what to expect as the incoming Assistant Administrator. I was told I'd been nominated and asked to step in and didn't even know Madalena until the opening reception of the conference when we were assigned to take over for Patricia Thickstun. She said basically, your main challenge was to organize the conference dinner and select a distinguished speaker.

2. What goals were you pursuing?

To get a greater sense of the vast community, knowing that it was one of the largest divisions. I'd been a medical translator and interpreter, so I had my own experience to draw from.

3. What was one idea that you think inspired you to start?

Both Madalena and I saw a great need to pull together a diverse and disconnected community, and especially bring more recognition to medical interpreters. Like ATA, the division was heavily skewed towards translators.

4. What qualities were important for you in a Medical Division?

Relevance, inclusion and representation, current and innovative industry developments, a reliable resource.

5. How has the Medical Division changed over the years as you moved through new responsibilities in your career?

It has improved tremendously with the wonderful input and energy of many talented and dedicated volunteers.

6. As you may know, the last issue of our newsletter Caduceus included an article about dealing with stress. What does mental health mean to you?

That is a very broad topic as it may include dealing with everyday stress any of us face, trauma in its multiple iterations, severe cognitive behavioral disorders and even autism. We are challenged to be trained, adapt, and respond to any one of these or even often in combination.

7. What is the biggest challenge you've overcome in regard to your mental health?

Vicarious trauma. After so many years, not allowing the stress/disorders of patients to affect my own wellbeing and also to limit the commuting times and distances to reduce traffic induced stress in maintaining a professional and punctual interpreting practice.

8. What values are important to you when you think about the evolution of ATA´s Medical Division?

Organization, Vision, Patience, Humility, Openness, Commitment and Cooperation.

9. What was your favorite job at the Medical Division? What was your least favorite part? What was the most rewarding and what was the most challenging?

Working closely with Madalena and organizing several successful Division dinners was fun and rewarding. Recruiting willing and capable volunteers was a struggle. Meeting and engaging with countless super smart and accomplished colleagues was consistently a real pleasure. Researching and securing a distinguished speaker that would fit the stringent criteria and be of interest to our constituents was both very challenging but ultimately also rewarding once they were accepted and delivered brilliantly.

10. Is there anything we haven't covered that you want to say? What is one final thought that you want to leave our readers with?

As with all my other ATA volunteer positions, through my experience I became a better interpreter, a more successful professional, and established long time friendships.

I do want to add that without the invaluable, consistent, and generous support throughout each term from Jamie Padula in HQ, our jobs would have been a lot more difficult and time consuming. He will be sorely missed, and I sympathize with current divisions having to carry on in his absence.

Dr. Elaine Hsieh (Professor and Chair, Department of Communication Studies, University of Minnesota) paved the way for a communicative, interdisciplinary approach to interpreting studies. An award-winning author and NIH-funded scholar, Dr. Hsieh's Bilingual Health Communication Model guides the theory development and clinical practice of healthcare interpreting. Her latest book, Rethinking Culture in Health Communication, examines the complexity and nuances of culture through social interactions in health contexts.

3

WHY CONTEXT MATTERS: CULTURE, POWER AND HEALTHCARE INTERPRETING

DR. ELAINE HSIEH

Healthcare interpreting as a specialized area of research and practice emerged in the 1990s from the larger field of interpreting studies, a discipline that first gained its professional identity during the Nuremberg Trials after World War II (Hsieh, 2016). As a result, the early development of codes of ethics for healthcare interpreters has been heavily influenced by the conduit model, focusing on the "neutral," "faithful," and "accurate" relay of information from one language to another (Dysart-Gale, 2005; Loach, 2019). However, researchers have long questioned the myths of invisible, non-interfering interpreters (Aranda, Gutiérrez, & Li, 2021; Hassan & Blackwood, 2021). The conduit model of interpreting assumes that both parties share equal footing and similar cultural and communicative norms. In addition, the model assumes that all parties are competent speakers to communicate and negotiate their tasks, identities, and relationships. Such assumptions can be particularly problematic in healthcare settings because providers and patients often experience significant differences in medical knowledge, access to resources, and institutional power in clinical settings. As a result, a blind adherence to the conduit model in healthcare contexts can inadvertently compromise the quality and equality of care (Hsieh, 2016; Schwei et al., 2019; Watermeyer, 2011).

By recognizing the complexity of social and power dynamics in healthcare settings, healthcare interpreters and researchers have led the larger discipline to challenge and reconceptualize interpreting as a communicative activity. The goal-oriented nature of healthcare delivery (e.g., improving patient satisfaction, optimizing health outcomes, and ensuring the quality of care) allowed healthcare interpreters to reexamine their roles and functions beyond the texts uttered by other speakers. As we look beyond the conduit model, we inevitably need to consider the various types of contexts at play in interpreter-mediated medical encounters.

In this article, I want to explore three contexts that are under-investigated but are essential to effective and appropriate interpreter-mediated medical encounters. The following discussions are primarily based on my research in the last two decades and the emerging trends.

Host Community-Patient Dynamics

In the literature, few studies examine whether and how interpreters require different skills and strategies when mediating provider-patient interactions due to differences in their language combinations or their patients' demographics. Although we often conceptualize language-discordant patients (i.e., patients who do not share the same language with the host community) to be a part of the vulnerable populations susceptible to discrimination and marginalization in healthcare settings, this is not necessarily the case for all patients (Hsieh, 2018; Terui & Hsieh, 2022).

Healthcare interpreters often need to mediate differences in language as well as the challenges in sociopolitical and sociocultural dynamics in provider-patient interactions. Depending on the social, cultural, and historical contexts of the host community, a patient's language, culture, and race may shape their healthcare experiences. For example, in Taiwan, a German-speaking patient is more likely to receive a privileged status than an Indonesian-speaking patient (Lan, 2011). Similarly, in the United States, a White patient from Spain is unlikely to have the same healthcare experiences as a Non-White patient from Guatemala, even though both speak Spanish.

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Language barriers do not mean the same thing for different patients. Whereas for some patients, their language discordant status signals their privileged status and compels the locals to accommodate; others may find language barriers make them vulnerable to hidden discrimination and health disparities and require them to adopt unique strategies to negotiate their agency and power in a hostile environment (Canagarajah, 2013).

Historically, under the conduit model, interpreters leave others to address issues of disparities and injustice. Such practices can be problematic when a patient lacks the knowledge about what questions to ask or lacks the agency to advocate for oneself (Hsieh, 2013; Hsieh & Kramer, 2012b). Similarly, structural privilege and discrimination can be invisible to both providers and patients. As a result, an interpreter-as-conduit model is likely to reinforce and maintain the structural inequity and injustice within the system (Loach, 2019).

Thus, to effectively address structural dynamics in interpreter-mediated interactions, interpreters need to be not only sensitive to the meanings exchanged in provider-patient interactions but also vigilant against how the host community-patient dynamics can impact the quality and equality of care (Hsieh, 2018; Terui & Hsieh, 2022). Quality and equality of care is not an abstract concept (Hsieh, 2016). In interpreter-mediated encounters, the communicative process can be an essential indicator of the quality of care (e.g., interpreters should maintain transparency and ensure that all speakers are able to exercise agency and control over the communicative and/or decision-making process). For language-discordant patients, quality of care cannot be separated from equality of care (i.e., the extent to which language-discordant populations share comparable access to and effectiveness of care with language-concordant populations). Healthcare interpreters are essential in helping both the providers and patients negotiate the meanings and outcomes of quality and equality of care. In other words, it may be useful to consider how interpreters need to be attentive to different issues (e.g., privileged status vs. historical marginalization) as a result of host community-patient dynamics in order to protect quality and equality of care.

Clinical Specialties as Contexts

Another context that researchers have just begun to explore is how clinical contexts may require different types of interpreting strategies. When looking at the codes of ethics for healthcare interpreters, one may assume that "good" healthcare interpreting looks the same and relies on the same set of practices and skills. However, different clinical specialties often require healthcare providers to adopt different roles and relationships with their patients to achieve short-term tasks and long-term goals (Hsieh, 2015; Hsieh & Terui, 2015). For example, emergency physicians may be more concerned about the speed of information

solicited for medical decision-making rather than maintaining a trusting, supportive relationship with the patient (Cox & Lázaro Gutiérrez, 2016; Taira et al., 2020); in contrast, a mental healthcare provider may view provider-patient trust as a necessary element to achieve any therapeutic objectives (Chang et al., 2021). An OB/GYN physician may shift from a casual, comforting chat during a check-up to an all-hands-on-deck emergency based on a sudden change in the fetal heartbeat. From this perspective, interpreters need to respond to the emergent shifts in providers' and patients' communicative goals by adopting different roles, functions, and strategies in interpreter-mediated encounters (Hsieh & Kramer, 2012a; Suarez et al., 2021).

Two issues are particularly important here. First, studies have demonstrated that providers, regardless of their clinical specialties, share some universal expectations for healthcare interpreters (Hsieh, Pitaloka, & Johnson, 2013; René de Cotret, Brisset, & Leanza, 2020). On the one hand, all providers expect interpreters to act as a professional (i.e., an independent professional who is capable of making independent decisions and interventions). On the other hand, they also expect interpreters to act as their proxy, assisting them in their communicative goals. It is important for interpreters to recognize that providers' communicative goals are not necessarily limited to their therapeutic objectives. Providers' goals can include identity and relational goals as well. For example, an OB/GYN provider explained, "If I walk in [to the room] and I like my patient's shoes, I'd say, 'OH, I LOVE your shoes! They are so cute [high cheery tone].' […] Some of [the interpreters] go like, 'Yeah, haha.' I'm like, 'NO! Tell her! I like her shoes!!'" (Hsieh & Hong, 2010). Recognizing a provider's effort for relationship-building with the patient as a communicative goal is critical – as providers rely on healthcare interpreters to construct their identities and relationships in clinical encounters.

Another interesting (but also unexpected) issue is how different clinical specialties differ in their attitudes toward interpreters as Patient Ally (Hsieh, Pitaloka, & Johnson, 2013). Patient Ally involves behaviors that are traditionally considered problematic (e.g., advocating for patients, assisting patients outside of medical encounters, and providing emotional support). This is an area where interpreters often disagree on their roles and functions. Many interpreters follow the traditional interpreter-as-conduit model and reject the Patient Ally function, arguing that such practices are necessary to protect patient agency and prioritize provider-patient relationships (Hsieh, 2008). However, others have reported that avoiding expected social norms and acting like a robot is not only awkward but also inappropriate in a place where a foreign patient can feel very alienated and disempowered (Hsieh, 2008).

In our studies, we found that nursing staff appreciate interpreters' functions as Patient Ally; in contrast, mental healthcare providers are often leery, if not resistant, to such practices (Hsieh, Pitaloka, & Johnson, 2013). Rather than viewing such interpreting practices from a normative perspective (e.g., what is expected as an appropriate interaction between interpreters and patients based on social norms), we argue that it is the therapeutic objectives held by providers that create diverging demands and expectations for interpreters. Because nurses' tasks often include providing emotional support, an interpreter who is attentive in providing a human touch to all aspects of care is complementary to a nurse's objectives. In contrast, because mental healthcare providers may treat patients who experience past trauma (e.g., losing family members in wars or violent events), an interpreter's simple greeting (e.g., "Where are you from? Do you have kids?") risk triggering an episode or compromise prior therapeutic improvements.

In summary, the literature suggests that successful interpreter-mediated medical encounters rely on interpreters' ability to be flexible *and* adaptive to the diverging clinical demands (e.g., clinical specialties and therapeutic objectives) and the emergent nature of provider-patient communication (e.g., shifts in tasks, identities, and relationships). Recent studies also suggest that providers do not always react negatively when interpreters disagree with them or challenge their communicative goals, especially when healthcare interpreters do so to protect the quality and equality of care.

Cultural Constructions of Linguistic Functions

Any healthcare interpreter would quickly agree that language barriers are not limited to the differences in providers' and patients' preferred language. This is because different cultures often hold different cultural consciousness and language ideologies, which can also be context-dependent (Hsieh, 2021; Hsieh & Kramer, 2021). For example, Western culture views language as a tool for communication (i.e., an instrumental view of language); as such, having more information is empowering and facilitates decision-making (Hsieh & Kramer, 2012b). As providers strive to optimize healthcare delivery through patient-centered care, information seeking is often viewed as an essential skill for communicative competence for patients (Cegala & Post, 2009). However, not all cultures view the relationship between language and information through such a utilitarian, instrumental approach.

In some cultures, when certain things are uttered, the reality is evoked. Thus, for many cultures, to inform patients about their cancer diagnosis is to (a) invite cancer into their body, (b) put a clock on their life expectancy, or (c) take away hope (Rosenberg et al., 2017; Weaver et al., 2022; Yeung, 2017). Importantly, these "acts" are not understood in a symbolic,

metaphorical sense but are perceived as meaningful actions that transform reality. In American English, some speech acts still hold such reality-transformative power. For example, before an umpire announces, "Play Ball," balls thrown by a pitcher are just part of the practice, not the game. But after the announcement, any ball thrown by the pitcher counts toward the official scores. Imagine a culture that views language that discloses a patient's diagnosis and prognosis (e.g., disclosure of "bad news") can not only inform but also *transform* reality (Hsieh & Kramer, 2021; Kramer, 2013; Smith, 2003).

Importantly, the reality evoked by speech is equally real, powerful, and valid to both patients and providers. For example, when asked to find a way to balance family preferences and truth-telling to a dying patient, a physician responded, "When I was in medical school, it was driven home to us that autonomy was the lynchpin concept. You're destroying my moral compass" (Solomon, 1997, p. 90). To the physician, agreeing to such a compromise is reality-transformative with devastating consequences (e.g., becoming an unethical physician who offers substandard care).

From this perspective, an interpreter-as-conduit model cannot be the only measure of effective and appropriate interpreting in health contexts. Interpreters need to not only manage the meanings conveyed but also the reality evoked.

Conclusion

This is an exciting time for researchers and practitioners of healthcare interpreting. As the field of interpreting studies moves beyond the conduit model, the interdisciplinary and applied nature of healthcare interpreting provides tremendous opportunities to engage in theory-oriented, evidence-based practice. As we recognize and examine the impacts of contexts, including interpersonal, organizational, and sociopolitical dynamics that shape the process of interpreter-mediated interactions, interpreters become more than language and cultural brokers – we become an essential member of a healthcare team, guarding and facilitating the quality and equality of care.


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4

EXPERIENCE FROM THE NAJIT 44TH ANNUAL CONFERENCE IN LAS VEGAS

CARMEN GONZALEZ

Carmen L. Gonzalez, a Certified Court Interpreter in the State of California, and a Medical Certified Interpreter (English>Spanish).

She graduated from the San Francisco State University Legal Court Interpreters Program, and the Paralegal Program. She holds a BS in Industrial Engineer from the Central American University in Nicaragua, and a Business Administrator Degree from the Central American Institute of Business Administration in Nicaragua, her native country.

Carmen has worked as a freelance Spanish Interpreter and Translator in the San Francisco Bay Area for over fifteen years, having professional experience interpreting in different settings in the State of California.

She has been an interpreter trainer for more than five years. She is also certified by the American Translators Association.

She is a Licensed Trainer of The Community Interpreter ©, a program developed by Cross Cultural Communications (CCC).

When I started working as an interpreter, I was mainly dedicated to medical interpretation, as were many of my colleagues. It was a good way to gain experience in interpreting skills, being able to develop and practice the different modes of interpretation.

After working for about ten years as a medical interpreter, I was finally able to become certified as a legal court interpreter, something that took me to other types of assignments. I have been mostly interpreting for depositions on workers compensation and personal injuries, as well as interpreting for civil cases and family law for the past five years.

Continuing education is also required for legal court interpreters, so I became a member of the National Association of Judiciary Interpreters and Translators (NAJIT), a professional association like ATA (American Translators Association) in some ways, but different in other ways. Attending both annual conferences was a very good experience which helped me to complete my CEUs right on time.

This year the 44th Annual Conference (NAJIT 2023) took place in Las Vegas, Nevada, a city that I had visited over ten years ago. The NAJIT Conference was held from Friday June 2nd to Sunday June 4th. The Pre-conference Workshops took place on the first day, Friday.

The main conference is usually one and a half days long. This year it was difficult for me to choose the sessions that I was going to attend. Now that I read the program again, I realize that there are many other sessions that I would have liked to attend, too.

NAJIT is really promoting professional standards in interpreting and translating. It provides continuing education for us, the legal interpreters, and translators, and it is helping us to refine and update our skills.

The NAJIT Conference in Las Vegas was attended by 330 people. There were also exhibitors and sponsors present in the Exhibit Hall for the three days the Conference lasted. There was an evening reception on Saturday June 3, a great chance to network and have a wonderful time enjoying dance and music with our colleagues. The Conference came to an end on Sunday June 4th at noon. Time to say goodbye and go back home to our regular activities, while we wait for next year to meet again for the 45th Conference, next time in Providence, RI. See you there!


https://pixabay.com/photos/event-venue-auditorium-meeting-1597531/

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