

## IV. Key Deaf Fundamentals

I offer the following section on fundamental issues pertaining to deaf persons prior to discussing specifics about XXXXXX. I believe it is imperative that the reader of this report be familiar with these fundamentals because they provide necessary context in which to properly understand the XXXXX and the specific subject matter of this litigation.

### A. *The Language and Cultural Minority Perspective*

Deafness is a unique human condition in that a great many deaf individuals who use sign language to communicate do not view themselves primarily as members of a disability group but, rather, identify primarily as members of a language and cultural minority group.<sup>1</sup> Some deny they have a medical disability at all. In fact the terms “Deafhood” and “Deaf-gain” have recently come into vogue, meant to convey the attitude that life in the Deaf community is a offers cherished and unique bonds, and is even perceived as an *enriched* life, compared to life as experienced by persons who can hear normally (a.k.a. “hearing people”). Characterizations of deafness from a purely medical perspective are anathema to most Deaf persons. There is even a derogatory American Sign Language (ASL) sign that conveys this derided attitude. It is a sign made by forming a “box” around one’s ear – as if that is all they are to some hearing people – a pair of broken ears.

Since the late 1980s, there has been an explosion of scholarship, literature, and art describing Deaf culture (e.g., Dolnick, 1994; Lane, Hoffmeister, & Bahan, 1996; Padden & Humphries, 1988; Solomon, 1994). Deaf culture is a complex mosaic of Deaf history knowledge, values and attitudes about sign language, the Deaf community, hearing loss, and hearing people, and unique social conventions and behaviors that are often quite different from those of hearing persons. Deaf-hearing cross-cultural relations, misunderstandings, conflicts, and “cultural competence” regarding Deaf people are as important in this field as such parallel topics are when referring to racial and ethnic differences between people.

### B. *American Sign Language*

All languages have a vocabulary, a grammar (vocabulary alterations based on a word’s function), a syntax (word order), and a pattern of discourse. All four of these characteristics differ markedly when contrasting ASL with English (Baker & Padden, 1978; Valli, Lucas, & Mulrooney, 2005). I find it useful to compare some of the linguistic features of ASL to non-English spoken languages that happen to share those same linguistic properties.

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<sup>1</sup> There are many subgroups of deaf persons. The major differences between them pertain to when their hearing loss occurred, how severe it is, and how the person prefers to communicate. Socialization preference is another factor. Clearly, a sign language user who was born deaf, attended a school for the deaf, and socializes frequently within the Deaf community has little in common with a person who may be just as deaf, in the audiological sense, but lost their hearing in late adulthood, knows no sign, nor any signing Deaf people. The capitalization of the word “Deaf” is an accepted convention in the field, when specifically referring to that subgroup of deaf individuals who communicate via sign language and identify themselves as members of the Deaf community and its culture. When not capitalized, the term “deaf” is used in general reference to persons with severe to profound degrees of hearing loss, without regard to their communication preferences or sociocultural affiliation.

ASL vocabulary, of course, consists of signs, not spoken words.<sup>2</sup> Another vocabulary difference is that ASL, like the Hebrew language, does not express the concepts of *be*, *is*, *are*, *was* and *were* through specific signs. Both Hebrew and ASL accomplish the linguistic tasks performed by these English words but they do so in ways that do not require a distinct word (or sign) for these terms. A unique category of ASL vocabulary, one that does not have an equivalent in English, are “classifiers.” Classifiers are handshapes that can take on a wide variety of flexible, highly visual meanings (e.g., vehicles, humans, or objects of many different shapes). One can depict the movement and interaction of classifiers in space with amazing specificity and speed in ASL. It would take *much* longer in English to translate what is being expressed in ASL by a skilled signer using classifiers and, even then, the translation would never convey the information in such a visually specific manner as one can literally “see” in ASL.

ASL grammar is also very different than English. Tense is a good example, though there are many others. English is strict, and often redundant, about how tense is expressed through grammar. The proper grammatical form of a verb must be used to express past, present, or future tense. In English, the short sentence, “He has gone to the store” provides two indicators of past tense (“has” and “gone”), with “gone” being a grammatical change from the present tense of “go.” In contrast, ASL establishes tense once, using a vocabulary sign rather than grammar (e.g., a sign like “recently,” “a long time ago,” or “next week”) and then does not indicate what the tense is any further unless tense needs to be changed. Thus the signs for “go” and “went” are identical – the difference in meaning is understood by whatever sign has *already* been used to establish tense in that sentence or conversation. In ASL, tense is understood as remaining the same – perhaps all through a lengthy conversation – until it is deliberately changed by the use of another tense sign.

Turning now to syntax (word order), in both Spanish and ASL, a noun must be mentioned before that noun can be modified by an adjective. Therefore, it is a “car red” in both Spanish and ASL, not a “red car” as in English. ASL shares the German language’s tendency to express verbs at the end of a sentence, not in the middle as English usually does.

The most dramatic difference between ASL and *any* spoken language is how the space around one’s body is used to convey many linguistic concepts. In ASL, physical space(s) around one’s body are frequently assigned linguistic meaning by the signer. These spaces then “hold” or retain that linguistic meaning, even for long periods of time, without their meaning needing to be repeated. It is as if those concepts are “suspended in the air” and remain visually present during a conversation unless the linguistic meaning of that particular space is assigned a new meaning by the signer. Thus, the linguistic meaning of a defined space can be referred to (and thus, its meaning is “repeated”) simply by pointing to that pre-defined space, forming a related sign (often a verb) within that pre-defined space, or even just by glancing at that space as a reference to its pre-defined meaning. The other participants in a signed conversation already know

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<sup>2</sup> At an even more complex level, sign vocabulary contains unique morpheme and phoneme structures, just as spoken languages do. For example, to fully define any given sign, one must know four elements of its production – the handshape, the orientation of the palm, the physical location where the handshape is placed, and the pattern of any movement of that handshape. Changing any one of these elements will create a different sign (or be non-sensical).

who/what that particular space “is,” so they can immediately comprehend the meaning when that space is referred to with a glance, or by pointing, or via a “directional verb” (see below).

Suppose I mention two different people (by fingerspelling their names or using their “sign names”),<sup>3</sup> and then “assign” those people to spaces on the left and right sides of my body, respectively, after I name them. From then on, when I point or glance to either of those locations, it is the same thing as repeating the person’s name, or saying “he” or “she,” as the case may be. I can even use “directional verbs” within those spaces to very efficiently express an entire sentence with one sign. For example, by using the two-handed sign for “argue” but placing one hand in the spot to the left of my body that had been previously defined as person “A” and placing the other hand to the right side of my body, previously defined as person “B,” and then making the “argue” sign, I have – with only *one* sign – conveyed the entire sentence: “[person A] argued with [person B].” Furthermore, by moving this directional verb a bit, where one hand is now close to the center of my body (which indicates me, the signer) but the other hand is in the space previously defined as person “B,” and signing the single term “argue” again, I have expressed the entire sentence. “I argued with [person B]” or “Bob argued with Tony” (if that’s who person “B” is) or “I argued with him” or “We argued.” These all would be correct translations of this remarkably efficient ASL sentence.

Finally, languages have unique discourse patterns, or expected ways that discourse unfolds in that language. In ASL, a commonly expected discourse pattern is to make the point of what you want to say *first*, then explain information that leads to or supports that point, then close by repeating the point. This is often taught in ASL classes by drawing a vertically-oriented diamond on the board – with the “point” at the top and bottom of the diamond being the “point” one is expected to state first, and last, in ASL discourse, with the wider middle part of the diamond reflecting the “explanation” of the point. A typical English discourse pattern looks like an upside-down triangle. English users will typically begin with an introduction (the wide “base” of the triangle which is at the top of the drawing) and finally *lead to* the point (at the bottom of the upside-down triangle). This particular discourse pattern difference between ASL and English often frustrates ASL-users who expect the point to be made first, all the while wondering: “What is this hearing person trying to convey to me?” (because English users typically “lead the listener” toward the point which is saved for last).

ASL shares a certain discourse pattern similar to Japanese. In both languages, there are subtle “feedback signals” expected from the *listener* in a conversation that function to indicate comprehension and encourage the speaker to continue. In ASL, these include certain facial expressions, nods, and a particular sign that means “I see.” In English, we sometimes say “uh-huh,” “mmm-hmm,” etc., for the same purpose but these feedback signals are much more formal and “required” in an ASL or Japanese conversation.

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<sup>3</sup> Sign names are single signs that represent someone’s entire name or a proper noun, such as the name of a city, state, company, college, etc. Sign names are “bestowed” upon people (or proper nouns) by the Deaf community. Often, sign names consist of a person’s first initial (using one of the 26 handshapes of the ASL fingerspelling alphabet), produced at some location on the body that is a unique reference to a characteristic of that person. For example “Rachel” with curly hair may be given a sign name that uses the letter “R” made in “curly” motion near the head. This sign name applies exclusively to that particular person. Another individual named Rachel would have a different sign name, perhaps an “R” formed on her cheek to reflect a dimple someone liked when they “named” her.

All the information above regarding ASL is offered to underscore a few simple points. First, ASL is a remarkably rich and complex language. In no way is it merely a gesture system or “English on the hands.” Nor is it an easy language to learn and especially to master. Second, working between ASL and English is a challenging task requiring a great deal of cognitive energy and bilingual ability. This is certainly true for sign language interpreters but also for a deaf person who is “thinking in ASL” while trying to comprehend English writing or speech (*an issue directly relevant to the present litigation*). Third, appreciation of and respect for ASL is the “coin of the realm” in earning cross-cultural legitimacy from the Deaf community. If one does not comprehend the complexity of the language, understand its marked differences from English, understand the importance of sign language interpreters (or gain fluency in ASL oneself), one’s effectiveness in relating to and earning the trust of Deaf people will be severely compromised.

### ***C. Speechreading (a.k.a. “lipreading”)***

The question, “Do you read lips?” is so familiar but often aggravating to deaf people because it incorporates a number of serious misunderstandings. First, is the erroneous presumption that “lipreading” is a skill that somehow comes easily to many deaf people. One’s ability to fill in the gaps between what is accurately perceived via lip movements, facial expressions, and gestures is strongly dependent on one’s innate fluency in the English language (which is often limited in the deaf population, as explained further below). The less fluent one is in English, the more difficult the “guesswork” portion of speechreading will be. Only about 30% of English speech sounds appear as lip movements. The majority of English speech sounds emanate from tongue, throat, breath, and other physiological functions invisible on the lips. Thus, approximately 70% of speechreading involves guesswork apart from the “data” gained from watching lip movements.

Second, the “Do you read lips?” question presumes that speechreading success is a function of the deaf person’s abilities alone. In actuality, it is the *hearing* person and the *situation* that are primarily responsible for the ease or difficulty of a speechreading encounter. Among the many factors pertaining to the hearing person are: facial hair, mouth and teeth structure, mouth obstructions (gum, cigarettes), enunciation and voice volume, eye contact, accents, use of gestures (very beneficial), lighting on the face (light sources or glare behind the head are particularly problematic), whether or not the topic is clearly established before proceeding and any topic changes are clearly communicated (very beneficial), the vocabulary and syntax chosen, use of idioms or expressions (often problematic), rephrasing rather than repeating words or phrases that are difficult to speechread (very helpful), and other factors.

Still other contributions to the ease or difficulty of a speechreading situation arise from psychophysiological factors that may be affecting the deaf individual. Among the many factors that would impede one’s speechreading abilities are: fatigue, anxiety, worry, concentration difficulties, cognitive limitations, visual difficulties, pain, hunger or other distracting physiological stimuli.

Perhaps the most crucial aspect of the ease or difficulty of speechreading is the communication *situation* one is in. The more constrained the topic is, and the more familiar and

predictable the language is likely to be, the less guesswork the deaf individual will have to do when attempting to speechread. Compare the situations outlined in the table below.

<b>Setting</b>	<b>Easier</b>	<b>Much More Difficult</b>
At a restaurant...	McDonald's, where there are limited choices, discussion is not likely, and pointing is effective	Upscale restaurant with numerous "specials" being described by the waiter and certain foods, ingredients, or terms are unfamiliar to you
At the dentist's office...	A routine teeth cleaning, where limited conversation is expected and no problems are found that need to be discussed	A consultation with the dentist where various treatment decisions and consequences are being discussed
At your child's school...	Attending a holiday pageant where limited, purely social interaction is taking place	A parent-teacher conference where your child's difficulties with academics or behavior are being discussed
At the hospital...	Obtaining enough information to find out where your friend's room is, so you can pay a supportive, social visit	Where you or a family member are the patient and, ipso facto, the situation is "higher stakes"

Inherent in the comparisons above, and other such comparisons that could be made, is the significance of the relative *import* of the speechreading situation, that is, the consequences that could arise if communication is less than ideal in one situation versus another. The higher the import or "stakes" of the situation, the greater the risks are when depending on speechreading to communicate. It is typical (and wise) for deaf individuals to gauge their willingness to speechread in a given situation in relation to the perceived import of that situation.

For example, there are deaf persons with good expressive spoken language abilities (i.e., their voice is readily understood by hearing people) who will refuse to use their voices in higher-stakes situations because it is so common for hearing people to presume that a deaf person's vocal skills are reflective of their ability to hear or successfully speechread, which is not the case.<sup>4</sup> The perceived import of a communication situation may well lead a deaf person who is willing to engage in speechreading in situation "A," but not in situation "B," to request sign language interpreter services in situation "B."

A useful analogy can be made to a hearing person traveling in a foreign country where they are not very familiar with the language. Communication with non-English speaking persons in that country may be acceptable (even fun) while shopping or at a restaurant (even if you don't get the dish you thought you ordered) but not if one was hospitalized or arrested, in which case requesting an interpreter would be the wise course of action.

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<sup>4</sup> A great many factors affect the quality of a deaf person's voice, as well as their speechreading ability in a given situation. The correlation between a deaf person's vocal abilities and their hearing and/or speechreading abilities is exiguous.

#### ***D. English Literacy***

Imagine that you were born inside a glass booth in Russia. You cannot escape the glass booth; you are in it wherever you go. Your challenge in learning the Russian language is to watch people who pass by, or come up to your glass booth, moving their lips. You cannot hear them through the glass – you only see their lip movements, facial expressions, and gestures. How well will you learn the Russian language this way? That is analogous to the difficult task of learning English, or any spoken language, when you are born deaf. The assistance provided by hearing aids or even cochlear implants aside, it is still an apt analogy.

Let's now combine the Russian glass booth analogy with the speechreading information above and imagine a deaf child from a hearing, non-signing family (the norm) arriving at school for the first time. As should be clear, the child likely has no effective language base at this point, given the difficulty of acquiring a spoken language via speechreading alone. The challenge for the educational program, then, is to provide that child with his or her very first language foundation, a situation totally unlike a similar-aged hearing child who arrives at school with extensive familiarity and ability in whatever language they acquired in the home environment, including hundreds, perhaps thousands, of words and a “gut” understanding of grammar and syntax based on four, five, or six years of language use and feedback from their family and others around them. Hearing children arrive at school ready to learn *information* through the language base they already possess and (usually) share in common with their teacher. Most deaf children arrive needing to acquire the language base itself. For them, learning information comes later, or in “fits and starts” as language itself is being learned.

At this critical juncture – the deaf child's arrival at school – certain choices become critical. Will the child be exposed to sign language, through which a *first* language base might be constructed? Or will that school require the child to attempt to learn English as their first language via auditory input, speech and speechreading practice, etc.? Either way, the establishment of the child's *first* language base is a serious challenge. Without an innate first language base, it is extremely difficult to learn how to read and write because literacy skills are normally *built upon* one's first language base.

Again, consider the typical English-speaking hearing child. Arriving at school with a fluent *usage* base of the English language, the teacher's job is “simply” to make the connections between this language the child speaks and hears so often and so well, and the language's written form, usually via a phonetic approach to acquiring literacy. Now consider the typical congenitally deaf child arriving at school for the first time: no solid language base to begin with, no innate knowledge of English usage, expressively or receptively, and no useful ability to benefit from phonetic approaches to acquiring English literacy. The struggle to attain fluency in English, and, after that (or simultaneously) literacy as well, is daunting and very rarely as successful as it is for their hearing peers.

Acquiring English literacy is a lifelong learning curve for most deaf persons. That is not to say there are not deaf people extremely literate in the English language – there are. But they are the exception rather than the rule. The *average* reading ability of deaf high school *graduates* in the U.S. is roughly at the 4<sup>th</sup> grade level.

## ***E. Fund of Information***

Acquiring information is perhaps the greatest overall challenge that deaf persons face. The “information overload” that hearing people sometimes complain of is the antithesis of the average deaf person’s experience. Many pathways to information access are unavailable or less accessible for deaf individuals (e.g., information from the radio, movie and television soundtracks, public address systems, hearing family members’ conversation, any typically “overheard” conversation in the general public, and reading material above the modest literacy skill levels typical of many deaf individuals). As noted, speechreading is unreliable, tiring, and no easy way to acquire clear, detailed information, especially complex information. Only a limited number of persons in most deaf individuals’ lives are fluent sign language users, thus the number of people who offer ready information access is limited in comparison to a hearing person’s life experience. Also as noted, literacy is typically limited in the deaf population, in comparison to hearing persons.

I use the term “fund of information” to refer to the entire collection of knowledge any person has acquired. Only a limited portion of one’s fund of information comes from formal education. Most information comes from other sources in our daily lives. To illustrate the challenge of information access for the average deaf person, and the often serious consequences of a compromised fund of information, engage in the following thought exercise (if you are a hearing person). From the entire “fund” of things you know, imagine removing everything you ever learned from the radio or over a loudspeaker. Now remove everything you ever learned from a television or movie soundtrack (unless you were reading captions or subtitles at the time). Now remove everything you ever read that was above a 4<sup>th</sup> grade reading level. Now remove the majority of conversation your family had at the dinner table or was otherwise not directed at you specifically. Finally, remove everything that you learned, or decided to investigate, because you *overheard* people discussing something of interest.

The average deaf individual will have a notable gap in fund of information in comparison to the average hearing individual, even when the two party’s IQ and educational attainment are similar, although, as with literacy, fund of information varies widely in the deaf population. Fund of information gaps have profound implications in many settings and situations but, in particular, in high-stakes settings and situations, such as medical and legal ones. The usual presumptions about factual knowledge that is common among hearing people cannot be made in regard to deaf persons. It is very common in my experience that I must address fund of information gaps in medical and legal conversations with deaf persons that I would not have to address with hearing persons. This need is also a very common aspect of an interpreter’s work. Interpreters use the term “expansion” to refer to how they address fund of information gaps in their translations, that is, by adding information they judge necessary to fill a given fund of information gap (which often goes unrecognized by the hearing interlocutor). In fact, there is a particular ASL sign for “expansion” that is exclusively used to convey this explanatory behavior in the face of a fund of information gaps.

## ***F. Health Literacy***

The U.S. Department of Health and Human Services (HHS) defines *health literacy* as, “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” Low health literacy is one type of fund of information problem affecting many deaf persons. Low *English* literacy is one contributing factor, as are the many other factors noted above that can contribute to health-related fund of information gaps. I once led a research study (Pollard & Barnett, 2009) examining the comprehension of health-related English words in a sample of 57 deaf adults which found that 30% of those who had completed high school scored “below 9<sup>th</sup> grade” (compared to hearing norms) on a health vocabulary comprehension measure – a score level suggesting low health literacy. More concerning, 22% of the deaf participants *who held college degrees* (81% of the total sample) also scored in the “below 9<sup>th</sup> grade” level.

## ***G. Sign Language Interpreting in Medical Settings***

Numerous federal laws, state laws and health codes, and the standards of the Joint Commission, which accredits hospitals in the U.S., set forth requirements for effective communication in settings where health care services are provided, including in regard to the provision of qualified sign language (and foreign language) interpreter services (Joint Commission, 2010; Schyve, Wilson-Stronks, & Slade, 2010; and *ADA Business BRIEF: Communicating with People Who Are Deaf or Hard of Hearing in Hospital Settings* from the U.S. Department of Justice, 2011). The seriousness of inadequate communication or miscommunication in health care settings underlies the proliferation of such statutes and standards (Barnett, 1999; Dean & Pollard, 2005; National Center for Law and Deafness, undated; Steinberg, et al., 2006).

The Registry of Interpreters for the Deaf (RID) is the main professional body of sign language interpreters in the U.S. The RID’s 2007 Standard Practice Paper, *Interpreting in Health Care Settings* provides examples of medical situations in which the presence of a sign language interpreter would be particularly important. Their *non-inclusive* list cites:

- Taking a patient’s medical history
- Giving diagnoses
- Performing medical procedures
- Explaining treatment planning
- Explaining medicine prescription and regimen
- Providing patient education or counseling
- Describing discharge and follow up plans
- Admitting to emergency departments/urgent care

It is increasingly recognized that interpreting in medical settings requires unique skills and training beyond that expected of interpreters who work in other settings, and certainly beyond persons who might be able to sign but are not professional interpreters (Dean & Pollard, 2005, 2009, 2011, 2013; Earhart & Hauser, 2008; Swabey & Malcolm, 2012). In addition to a plethora of literature and workshops focused specifically on sign language interpreting in medical settings, the National Technical Institute for the Deaf has established a *Certificate in*



*Healthcare Interpreting* program and is working toward establishing a master's degree program in that specific field. Certification standards to interpret in mental health settings also have been established in several U.S. states and special training programs instituted in that topic area, for example in Alabama and Missouri.

In sum, in addition to the profession of interpreting requiring training and skills beyond bilingualism itself, interpreting in medical settings is hyper-specialized – in recognition of the “high stakes” of medical communication as well as the unique knowledge, judgment skills, and other expertise demanded of interpreters who work in health care environments. Not only are the professionals involved in interpreter training recognizing this, those who promulgate laws and regulations regarding safe and effective communication in health care settings also are recognizing this.

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