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A Survey to Highlight Areas of Focus for Patient Care in Settings Utilizing Medical Interpretation

Azayzel DeRegis

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Thesis submitted in partial fulfillment of Honors

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Azayzel DeRegis, Author

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Felipe Fiuza, Faculty Mentor

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David Korfhagen, Faculty Reader

Abstract

This thesis recounts my personal experience working as a volunteer medical interpreter for the Language and Culture Resource Center at East Tennessee State University. The result of my time spent volunteering as a medical interpreter, shadowing professional medical interpreters, and witnessing patient-provider interactions during interpreted sessions was an inspiration to study medical interpretation further and delve into the challenges faced by patients who require medical interpreters. During my time researching this topic, I found that the United States is severely lacking in Spanish medical interpreters—with some healthcare facilities employing no medical interpreters—even though the size of the Hispanic population is on the rise. I also found that the language and cultural barriers to the Hispanic population receiving quality healthcare are a significant reason why the Hispanic population reports a lower satisfaction with U.S. healthcare. Through years of observation and practice, I developed research questions to help guide one in discovering what areas the Hispanic population is least satisfied with in healthcare. To discern what those areas of the greatest dissatisfaction are exactly, this research study manifests in the creation of a survey designed to improve the quality of healthcare received by the Hispanic population of Northeast Tennessee by identifying some of the principal issues faced by the Hispanic population within the U.S. healthcare system. The goal of this thesis is to highlight these issues as areas of focus for healthcare providers when they care for patients specifically in interpreted appointments.

Definitions

Limited English Proficiency (LEP) Individuals: Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can be limited English proficient, or "LEP." These individuals may be entitled to language assistance with respect to a particular type of service, benefit, or encounter (Office of Economic Impact and Diversity).

Interpretation: The process of oral rendering of one language into a second language and vice versa to facilitate the exchange of communication between two or more persons speaking different languages (Coleman).

Translation: The process of a written rendering of one language into a second language and vice versa. Medical translators often need to deal with paperwork and with the more formal side of the medical world (Language Connections, 2019).

Chapter 1

Introduction

Since my first Spanish class in the seventh grade, I have always been fascinated by the idea of learning a new language. It was comforting to know that if I failed to grasp the nuances of grammar in my own language, I could simply learn another language and have a brand-new chance at mastering the grammar of that one. Aside from comforting, learning a new language was exciting—everything is new, and through learning a new language one begins to learn about other cultures as well. I remember staying after class with my friends to dance salsa with my Spanish teacher in middle school, or when we would make traditional Hispanic meals or play games to identify the flags of different countries in Latin America. The more Spanish classes I took, the more I learned about different countries, cultures, and the complexities of the language that connects all of these places. I also realized early on how difficult it was to speak and understand a language that I had never spoken before, which I believe inspired in me from the start a cultural sensitivity to and a sprouting understanding of the lives of immigrants who move to another country where they do not yet know the language and thus have to learn it. I knew then that I wanted to one day move to a Spanish-speaking country to fully immerse myself in that perspective and become fluent in the language myself.

It was not until my first year of undergraduate school at East Tennessee State University, however, that I experienced the effects of language barriers out in the world. I had come to college to begin my journey to fluency in Spanish while pursuing an education in medicine. After class one day during my second semester at ETSU, one of my Spanish professors recommended that I travel to a Remote Area Medical (RAM) Clinic to gain some first-hand

experience volunteering in medicine. She explained that the clinic was completely free for patients and provided affordable access to dental, vision, hearing, and primary care appointments for anyone in the rural setting. I learned that some of the students in my honors cohort had planned on volunteering at the same clinic, and some of them were Spanish minors or majors like myself. We all decided to sign up as support for Limited English Proficiency (LEP) Spanish-speaking patients. In no way was I fluent, but I thought I could at least help and that I was better than nothing if the clinic needed a last resort when it came to interpreting for the LEP Spanish-speaking patients. If I was not needed, I would help with set up, take down, and general support. As it turns out, however, I was definitely needed. There were too many LEP Spanish-speaking patients for the small number of ad-hoc interpreters in attendance, so the other interpreters and I did our best to help out where we could. I was not experienced, and I did not know most of the medical terminology, so I would talk around the terminology and explain what the doctor was talking about in very minced Spanish words and the patient would correct me or teach me the proper vocabulary as we progressed through the various appointments. Then at the end I would thank the patient for their patience and perseverance, and I would move on to the next patient where I implemented a lot of the new vocabulary I had just learned from the previous patient. Nothing forces a person to learn faster than being under pressure, which I imagine is why total-immersion in a different country is the best way to learn that country's language—you are forced to. That first RAM Clinic was my first time seeing the effects of language barriers in the U.S. healthcare system with my own eyes.

After my first RAM Clinic, I began exploring other ways of learning the language: Spanish round table discussions at the public library every Thursday at 7:00 PM, talking with my Spanish-speaking friends and their families in Spanish, and more RAM Clinics to improve my

medical vocabulary. Now that I had seen the problem of language barriers in healthcare for myself, I decided to pursue a newfound, personal goal to become a great medical interpreter and translator. Around that time was when one of my Spanish professors at ETSU, Liv Detwiler, recommended doing volunteer medical interpretations with the Language and Culture Resource Center (LCRC) on campus. I thought that was a great idea and decided to reach out to them. It was at this time that I was met by my current thesis mentor, Dr. Felipe Fiuza, who invited me to come to the next RAM Clinic with the LCRC and a small team of student interpreters. He also gave me a Spanish-English medical dictionary to study and help with my lack of vocabulary, and while I studied Spanish medical terminology I also researched the need for medical interpreters in the U.S. I was curious to find out more about this issue, and how to get involved. I found that in 2019 the U.S. Hispanic population surpassed 60 million, and accounted for 50% of the nation's growth between 2010 and 2019 even though this group only comprises roughly 18% of the U.S. population (Noe-Bustamante, Lopez, & Krogstad, 2020). That meant the Hispanic population was the fastest growing in the U.S., which is why the need for medical interpreters and culturally competent healthcare was on the rise and still is. There are two reasons for this drastic increase in the Hispanic population in the U.S. The first is because Latinas have the highest birthrate in the country for women of childbearing age, and the second reason is because of the influx of Hispanic immigrants into the U.S. every year (Chong, 2002). With the rapidly growing population becomes ever more pressing the issue of delivering quality healthcare to patients who cannot speak English fluently. After studying up on my vocabulary as well as the statistics of this language barrier issue in healthcare, I was determined to make an impact on at least one patient during the course of this RAM Clinic with the LCRC.

The morning of the clinic in November of 2019, I woke up at 4:00 AM to drive to Gray, Tennessee and find my fellow student interpreters. We gathered together and had a small breakfast inside one of the RAM tents before getting started, then we went to the registration desk where patients checked in to listen for any Spanish-speaking patients that came in. Very soon I was one of the few student interpreters left who had yet to be partnered with a patient and travel with them to their different appointments.

"Hola señora, buenos días. ¿Está Ud. aquí para una cita de ojos, oídos, dental…?" Dr. Fiuza was talking to a woman who had just walked into the RAM clinic. She explained that she was there for a checkup and an eye and ear appointment (for the purpose of this narrative, I will refer to this patient as Ms. Ramirez). Dr. Fuiza then pointed to me and told the patient that I would be directing her to all of her appointments today. I greeted the patient and introduced myself and my level of experience, and she introduced herself as Ms. Ramirez and thanked me for interpreting for her because she said it made things a lot easier. I walked Ms. Ramirez through the registration process, asking her questions like "¿Cuál es su dirección?" ("What is your address?"), "¿Cuál es su nombre y apellido?" ("What is your first and last name?"), or "¿La fecha de nacimiento?" ("Date of birth?). She would answer the questions and I would fill out the information on the check-in form. Thus far, everything had gone smoothly, and I thought "I can do this, no problem." Then, after filling out all of the required materials, we went to the next station where patients were being triaged by nurses, and the nurse asked Ms. Ramirez, "What are your symptoms today?" It was a very simple interpretation for me to do in Spanish, but the problem I knew was going to be interpreting Ms. Ramirez's response to this question. I prepared for the most embarrassing job of my life.

Sure enough, Ms. Ramirez' response was long, fast, and included a lot of medical vocabulary that I had never heard before: *carie, gripe, analgésicos, tos*. I thought, "what did I sign up for?" I had to explain to both the nurse and Ms. Ramirez that I did not know of many of the words Ms. Ramirez had just said, and asked Ms. Ramirez if she could explain the words that I did not know so that I could accurately translate for her. "Already off to a horrible start," I thought. Thankfully, Ms. Ramirez was extremely patient with me and explained everything that I had questions about in detail until I understood. Knowing what I know now, I would have told my younger self that he needed to speak in the first person solely as a facilitator of the conversation, and when pausing the conversation to ask questions for myself to also say "Interpreter question" aloud to make it clear that I was then speaking to the patient solely for my own understanding. I would have also told myself back then that I needed to communicate my "interpreter question" mini-conversations to the provider (Association of American Medical Colleges). All of these are now standards of medical interpretation for me—a part of the pillars of accuracy, cultural competency, etc.—but back then I had a limited amount of interpreting experience, and an even more limited amount of medical terminology in Spanish. As we progressed through the triage, I learned that asking about blood glucose levels and blood pressure were best referred to as "el azúcar" or "la presión" for the patient, even though those words were not literally what the nurse had said. I also learned an immense amount of vocabulary in the course of ten minutes, which I then utilized during later appointments when we went to the eye doctor, ear doctor, and the primary care physician. In between appointments, we had time to discuss how the last appointment went, and Ms. Ramirez was direct about correcting me and helping me to improve—a token of her patience and positive attitude that I very much appreciated.

Throughout the course of the day, I said goodbye to departing patients and hello to others for whom I would also be interpreting and translating. By the end of the day, I had gained almost eight hours of medical interpretation experience. Although I learned a tremendous amount of information that day, I truly felt less prepared than when I began because I realized exactly how much I did not know. It was time for me to study medical interpretation and memorize vocabulary regularly to improve my skills, and then I would put it into practice.

After the RAM Clinic, I began working for the LCRC for my service-learning hours in the medical interpretation and translation classes I was taking at ETSU. The more experience I gained, the more confident in my abilities I became. In the summer of 2021, I shadowed medical interpreters at a local clinic with a patient population of 60% LEP Spanish-speaking patients. I continued to interpret at RAM Clinics and for the LCRC at various appointments all over Johnson City, TN. With the constant support of the medical interpreters at the clinic and the experience from the RAM Clinics and appointments through the LCRC, I slowly became more equipped to handle medical interpretations. As I progressed, I began to notice some patterns of challenges for the patient, provider, or interpreter in my own medical interpretations that seemed to mirror the patterns I was reading about in either my classes or during my free time when I would research medical interpretation.

In the next chapter, I will discuss these patterns of challenges faced by all three parties—providers, LEP Spanish-speaking patients, and the interpreters—pertaining to medical interpretation, and how they can possibly be handled. The challenges I encountered had a great impact on my decision to make the survey that is the result of my experience working in medical interpretation. These challenges were the driving force in the creation of my survey statements and the main reasons why I specifically chose the current survey statements to be included.

Chapter 3 discusses the research methodology that one would employ if they were to conduct the survey, and Chapter 4 will draw connections from the challenges I noticed during my time in medical interpretation to the survey statements directly, and will discuss the statements and recommendations for the research.

Research Questions:

The following research questions were used to guide this study:

Research Question #1: Are LEP Spanish-speaking patients satisfied with the quality of healthcare they are receiving at the healthcare facility where the research is to be conducted?

Research Question #2: What are the areas within healthcare with which LEP Spanish-speaking patients feel dissatisfied and/or satisfied?

Chapter 2

Challenges and Barriers Faced

One of the main challenges that I noticed while shadowing the medical interpreters at the local clinic pertains to the natural flow of medical interpretation. Because interpreters cannot suddenly recall entire paragraphs of information to interpret to the patient or provider, both the patient and the provider must speak in short bursts, a few sentences at most. Then the interpreter interprets what was said, and the speaker can continue with another few sentences. This process of talking back and forth through a medium, the interpreter, forces the provider and the patient to keep their language concise and short, especially when the provider may only have a limited amount of time to devote to all the patients to be seen that day. Naturally, this ordered process of communication through the interpreter can cause some loss of communication or potential miscommunication. For example, when I was working as an interpreter I remember when the provider would spend most of the time explaining the patient's condition and the cause of the condition—interspersed with questions from the patient seeking to understand their condition—that the provider would have to rush towards the end of the appointment, and important questions that normally would have been asked were skipped or overlooked. The prescriber may have told the patient what they were going to prescribe them, but they did not explain what the medication does, its potential side effects, how it may interact with the patient's other current medications, etc. In medical interpretation, speaking concisely is not always what is best for the patient. I realized that soon after starting medical interpretations through the LCRC and when I was shadowing professional medical interpreters at the clinic.

Another challenge I noticed was faced by the interpreter was how the patient and provider view the interpreter. Medical interpreters are extremely useful in situations where the patient

does not speak any English. Not only can they interpret for the patient and provider, allowing for communication that otherwise would prove very difficult, but the interpreter also allows the patient to open up and express how they are feeling. The interpreter can express emotions and use body language to convey what both parties are trying to communicate, and can help to clarify discrepancies in communication or when there is confusion due to a cultural barrier. This allows patients to feel more comfortable and at ease. Then they can ask questions and take control of their health, because the interpreter is actively intervening to achieve ethical, effective, culturally-sensitive care (Hsieh & Kramer, 2012). However, the interpreter's ability to help the patient feel comfortable and open up about their health and any questions they may have is impeded when the interpreter is viewed strictly as a tool for communication. This utilitarian view is accompanied with the ethical standard for interpreters: the interpreter-as-conduit view. The interpreter-as-conduit view can become problematic if a provider expects an interpreter to only provide the literal, word-for-word interpretations of what is said, because tensions may arise if the provider suspects that is not what the interpreter is doing. When the provider views the interpreter solely as a conduit for communication instead of a collaborator to provide quality care, communication can become unidirectional, only going from the provider to the patient because the interpreter can no longer intervene and advise the provider appropriately based on their expertise as the interpreter. When the patient views the interpreter solely as a conduit for communication rather than a welcoming member of the healthcare team, the interpreter can start to be seen as a gate-keeper of information, which can also cause tensions to arise. The view of the interpreter strictly as a tool can also be detrimental to communication because the interpreter then becomes provider-proxy, and the emotional work that the interpreter could potentially be performing becomes a tool as well (Hsieh & Kramer, 2012).

Generally, during interpreted appointments the interpreter cannot advise the provider in their area of expertise during the interpretation, but there are many opportunities that present themselves when the provider and interpreter step out of the room. The provider and interpreter can discuss what was said, and the interpreter can advise the provider on certain questions that the patient may not know they should ask, or areas of confusion and concern due to cultural barriers between the provider and patient. For example, certain countries have social stigmas surrounding C-section births, and patients from those countries may not know much about C-sections and may be afraid to talk about that option. This may be a potential cultural barrier between the provider, who refers or performs C-sections all the time, and the patient, who cannot fathom undergoing this type of operation. The interpreter can step in and help explain where the barrier lies between the provider and the patient, and can help bridge this gap since the interpreter understands both cultures. Explaining the patient's care while remaining culturally sensitive is paramount to offering the most ethical and effective care possible to patients, a service that many times can only be provided by the interpreter. Thus, it is equally as important not to view the interpreter solely as a tool, because doing such hinders the interpreter from offering their own expertise during appointments and ignores the interpreter's important role in the patient's care as part of the healthcare team.

Ultimately, it was these language and cultural barriers that inspired me to create the specific statements included in the survey. The challenges that came with the natural flow of an interpreted session inspired the statements pertaining to making sure the patient obtains all the necessary information about their care. The challenges that came with cultural barriers inspired the statements relating to making sure the patient feels heard and that their needs have been met. Through positing the survey statements, I hope to identify the root of some of the problems that

arise in U.S. healthcare that cause the Hispanic population to feel less satisfied with the quality of healthcare they receive.

Chapter 3

Research Methodology

This single-method descriptive study was designed to be conducted to identify areas of focus for healthcare providers caring specifically for Limited English Proficiency, Spanish-speaking patients within the East Tennessee Hispanic population in hopes of improving the quality of healthcare provided to this population.

Population and Sample

Study participants would be LEP Spanish-speaking patients at a primary care facility in East Tennessee that cares for a large population of LEP Spanish-speakers. Patients would be included in the study whether they are regular patients at this facility or if this is their first appointment. Only patients over the age of eighteen would participate in answering the survey. The researcher conducting the survey would choose dates to go into the clinic and stand at the checkout desk holding the surveys and asking patients if they would like to complete the survey to help with quality improvement of medical care for Spanish-speaking patients at the clinic. When the researcher conducting the survey is not present at the clinic, the survey would be available to take for any patient who had just finished an interpreted appointment. The researcher conducting the survey would then go to the clinic at the end of each week to collect any surveys that patients had completed that week.

Instruments

The main instrument utilized in this survey would be the patient survey, which would be provided in both English and Spanish so that patients could choose which language they were more comfortable using to complete the survey. Eleven statements would evaluate patients' perceptions

of the quality of healthcare they receive, ultimately identifying areas that patients feel were not addressed during their appointments, or were not addressed sufficiently enough for the patient. These statements would be graded on a 4-point Likert scale without a 'neutral' option. This choice was made because not including a 'neutral' option would force participants to provide some answer instead of not answering because they feel they do not have an opinion on the matter. A space is included at the end of the survey as well to allow participants to provide additional clarification, feedback, or anything else that they feel is necessary for the information obtained through the survey.

Data Collection and Analysis

First and foremost, a primary care facility in East TN with a large population of LEP Spanish-speaking patients would need to be identified and approached to inquire about potentially conducting the survey. Then the researcher conducting the survey would need to obtain permission and approval to conduct the survey from the facility and the university's Institutional Review Board. Once these requirements are met, the researcher can then approach the facility to begin conducting the survey and approaching patients checking out after interpreted appointments. The researcher would explain the purpose and the methodology of the research study either in Spanish or English, depending on which language the patient is most comfortable with. The research would be conducted over the course of two months of practice, and the facility staff would distribute these surveys and any accompanying consent forms to all LEP Spanish-speaking patients checking out of interpreted appointments. Interpreters at the facility could also be approached to explain the survey and its purpose, and asked if they could provide their LEP Spanish-speaking patients with the survey after they finish an interpreted appointment. The surveys and consent forms, once

completed, would be kept in a safe location to protect the privacy and anonymity of any patients who elected to take the survey.

Data from the patient surveys would be analyzed utilizing a statistical software to provide descriptive analysis, including but not limited to frequencies of answers, measures of central tendency, standard deviations, variances, and graphs to answer the research questions, “are LEP Spanish-speaking patients satisfied with the quality of healthcare they are receiving at this healthcare facility?” and “what are the main areas of medical practice that need to be emphasized and explicitly asked about during interpreted appointments with LEP Spanish-speaking patients at this healthcare facility?” A chart would be provided to help answer these questions by categorizing individual results for each survey statement, showing the means, standard deviations, frequencies, and central tendencies each in their own respective columns. Then the variance and statistical significance of any significant findings would be discussed underneath the chart.

Chapter 4

Discussion and Recommendations

The ultimate goal of this research would be to understand what exactly are the areas in U.S. healthcare with which LEP Spanish-speaking patients are the most dissatisfied, which would allow us to then understand which areas to focus on during interpreted appointments. These areas could include critical information that is lost due to the natural flow of how an interpreted session is conducted and the limited amount of time available to devote to every patient, or they could be focused on the cultural barriers preventing providers from providing the most ethical and effective care for a patient, for example.

When I am a patient, even as a native English speaker, I sometimes struggle with being informed of all of the potential side effects of my medications by my doctor. Once I go to the pharmacy to pick up my new prescription, the pharmacist will often tell me what some of the side effects are, and at that moment I decide that this specific medication is not for me. The medication also might be very expensive, depending on whether or not I as the patient have insurance, and whether or not my insurance prefers that medication over another similar one. If I struggle to learn all of these important details about my health and the healthcare I am receiving as a native English speaker, "I can only imagine how difficult this process must be for someone who is not a native English speaker and has limited English proficiency," I thought during the beginning stages of this research. This is why many of the statements in the survey pertain to medications—ensuring that patients know the strengths, effects, interactions, and reasons for their medications. These are all areas of information that are critical to patient care yet can be overlooked even during appointments entirely in English. In interpreted sessions, this problem may be exacerbated simply due to the natural flow of how an interpreted session is conducted,

which is why it is important that this survey highlights these issues faced by the Hispanic population. Once these issues are highlighted, they can be focused on specifically during interpreted sessions to make sure Hispanic patients are receiving the same quality of healthcare as any other patient, whether they have limited English proficiency or not.

The other main issue I focused on when creating the survey was cultural barriers impeding the communication process for the patient and provider. This is where statements 9-12 in the survey come into play. They will address concerns or questions that patients often feel are neglected or completely forgotten about. If patients have a specific concern or a cultural barrier that they wish to discuss, statement 12 provides a space where patients can list any clarifying details for other statements, or explain more in depth their questions or concerns.

Patient Survey in English

#	Statement	Strongly Disagree	Disagree	Agree	Strongly Agree
1	I am confident that I know the names of all of my medications.				
2	I am confident that I know the side effects of all of my medications.				
3	I am confident that I know the potential ways that my medications may interact with one another, if any.				
4	I am confident that I can read or have read to me the labels on my medications.				
5	I know exactly when to take each of my medications.				
6	I know exactly how much of each of my medications I need to take.				
7	I know how many times per day I need to be taking each of my medications.				
8	Every time I come into the clinic, I leave with certainty that everything I need to know about my medications and treatments has been explained to me.				
9	Every time I leave the clinic, I feel certain that I was able to ask all of my questions.				
10	Every time I leave the clinic, I feel certain that all of my medical issues have been addressed.				
11	When I come into the clinic for an appointment and an interpreter is present, I feel that the conversation between the healthcare provider and me goes smoothly.				
12	If you have anything else to add to this survey, please write that here. You can use this section to clarify your answers above.				

Patient Survey in Spanish

#	Declaración	Estoy totalmente en desacuerdo	No estoy de acuerdo	Estoy de acuerdo	Estoy totalmente de acuerdo
1	Estoy seguro/a/x de que sé los nombres de todos mis medicamentos.				
2	Estoy seguro/a/x de que conozco los efectos secundarios de todos mis medicamentos.				
3	Confío en que conozco las posibles formas en que mis medicamentos pueden interactuar entre sí, si las hay.				
4	Confío en que puedo leer o me han leído las etiquetas de mis medicamentos.				
5	Sé exactamente cuándo tomar cada uno de mis medicamentos.				
6	Sé exactamente cuánto de cada uno de mis medicamentos debo tomar.				
7	Sé cuántas veces al día debo tomar cada uno de mis medicamentos.				
8	Cada vez que entro a la clínica, salgo con la certeza de que me han explicado todo lo que necesito saber sobre mis medicamentos y tratamientos.				
9	Cada vez que salgo de la clínica, tengo la certeza de que pude hacer todas mis preguntas.				
10	Cada vez que salgo de la clínica, tengo la certeza de que se han discutido todos mis problemas médicos.				
11	Cuando llego a la clínica para una cita y hay un intérprete presente, siento que la conversación entre el proveedor de atención médica y yo transcurre sin problemas.				
12	Si tiene algo más que agregar a esta encuesta, por favor escríbalo aquí. Puede usar esta sección para aclarar sus respuestas anteriores.				

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