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Image from Austin Zucchini-Fowler

The Essential Workers Issue

Contributors:

Editor's Note

By Maria Baker

As another issue of *Caduceus* shows on my screen, my heart and my mind are filled with this word: gratitude.

We are certainly going through a special year. The way we do our job has changed, as Alcira Salguero describes as an interpreter in her article. The law has (sort of) changed, as Bruce Adelson explains. Translators have had to adapt and explore new fields of specialization with new clients: Tzviya Levin Rifkind addresses some advice when facing technical translation tests. I am incredibly grateful for their contributions.

In the midst of these special times, our greatness, our ability to change, our concern for our fellow human have come to the surface in a unique way. I am indeed grateful, as a healthcare interpreter, to continue to connect patients and providers in person; and as a translator, to assist in making important information available to Spanish speakers.

Another inspiration for gratitude is the amazing work that the ATA staff and volunteers have been doing to make sure that the current circumstances do not deprive members from our long-awaited conference. I will be there as a participant and presenter, and more importantly, at the Medical Division meeting on Tuesday, October 20 at 4 p.m. (Eastern time). You can attend this meeting even if you are not attending the ATA Conference this year. I hope to see many of our readers there!

It is also a great pleasure to continue to work on *Caduceus* with the support of a fantastic team: Santiago Achinelli, Andreea Boscor, and our administrator, Yasha Saebi. We hope you enjoy reading it as much as we have enjoyed assembling it.

What are you grateful for?

María

Maria Baker is a language instructor, medical interpreter, and translator. She obtained her B.A. in TESOL in Santa Fe, Argentina, and her M.A in Spanish and TESOL from West Virginia University. She is currently a freelance medical interpreter and translator, Outreach Coordinator for the IMIA, Vice President of the Interpreters and Translators Association of Alabama, and a volunteer in the ATA's Medical Division.

Letter from the Division Administrator

By Yasha Saebi

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Dear Medical Division members,

The ATA Conference is around the corner and, as you know, we are going to have our first virtual conference. This is an exciting time of the year for ATA members and this year it may very well be the only excitement of the year for many of us. If you are registered to attend the conference, it is time to check the Conference sessions and put together your sessions schedule. Check the continuing education credits that each session offers for your specific certificate.

On that note, the Medical Division's distinguished speaker, Dr. Claudia Salazar, will present two 60-minute sessions on Saturday, October 24th, 12:30 pm- 1:30 pm, and 2:00 pm- 3:00 pm on the subject "No Longer the 'Third Wheel': Overcoming the Challenges of Working with Interpreters in the Mental Health Encounter." The topic of mental health is a highly requested topic among medical translators and interpreters, and we are honored to sponsor this presentation for you with a topic of your choice.

As to the latest news for our Division, our social media presence has been extended to LinkedIn. Please follow your division page at: https://www.linkedin.com/company/ata-medical-division/.

Our Twitter account is also now up and running; please check https://twitter.com/ATA_MedicalDiv. Check the Medical Division website throughout the conference and after, as it is going to be updated regularly.

Please join us at the Medical Division Annual Meeting on **Tuesday, October 20 at 4:00 p.m.-5:00 p.m. EDT**. Conference attendance is not required in order to join this meeting, so all Medical Division members can attend the online meeting this year. Look out for the invitations to sign up that will come from the ATA. I cannot wait to see you all at the Annual Meeting and introduce our new Leadership Council members to you.

The Medical Division, Interpreters Division and Educators Division are going to host a joint networking event. This virtual dinner party is scheduled for Sunday, October 18 from 7:00 p.m. to 9:00 p.m. EDT. For the networking event, conference registration is required to participate. Let's start the well-deserved party and begin the end of 2020 on a positive note.

Yasha Saebi

Yasha Saebi is a linguist with a B.A. in Translation from Tehran, Iran. Her B.S. in Biology/Genetics and M.A. in Forensic Science/DNA are from George Mason University. She is certified by the Certification Commission for Healthcare Interpreters CCHI and Georgetown University. Currently, she is the ATA's Medical Division Administrator, member of IMIA's Medical Terminology Committee and IAI International Association for Identification.

How to Successfully Pass a Translation Test in Technical Fields

By Tzviya Levin Rifkind

All professional translators are occasionally asked to complete a translation test to receive consideration for a job, especially for long-term collaboration. Having been grading such tests for about 10 years, I have seen some cases where translators could have passed the test if they had been aware of some of the points in this article. Therefore, I would like to share my knowledge and experience, draw your attention to some points, and suggest techniques that will improve your tests and your chances to be chosen for an important collaboration.

The LSP perspective. The first and obvious reason for an LSP to ask you to take a sample test is to check the quality of your translation. Furthermore, it ensures quality from the very start of the collaboration and it is mandatory in the ISO 17100 certification of many LSPs. ISO 17100 is an international standard for translation services management systems. One of the tips I found on the ISO Quality Services home page is: "The two most important elements of translation quality are deemed to be technical accuracy and a supplier's willingness to implement feedback."

When an LSP is audited by clients, the auditor expects to see objective evidence that the LSP has qualified translators before they are assigned to the client's highly specialized content. Usually the identities of the partners and associated sample tests are not shared.

A sample test is an option to filter the strongest and most experienced translators for an LSP with a focus on expertise in a specific and specialized subject matter. For this reason, the LSP tests the linguist's knowledge of terminology in a certain domain and suitability to the target audience. If you think the test piece you received might not demonstrate your skills, you can try to discuss it with the LSP. They might explain why they chose this specific test or, sometimes, send you a different piece of text that would better serve this purpose. Also, a test can contain sentences that can be translated differently for different contexts or audiences. Another aspect that is tested is if the translation sounds natural and fluent.

A main point that is important in all tests is to see if the translator is accurate, makes no omissions, additions or mistranslations and avoids spelling errors. The reviewer gives the test a score. Since a score can sometimes be misleading due to the scoring method, usually reviewers are also asked for their general opinion on the sample translation. Sometimes a translator with a test evaluated as "conditional" is still given a chance. However, the best strategy is to avoid basic mistakes and make an amazing impression from the very beginning! LSPs also seek translators that fit into their team in terms of experience, expertise, and CAT tool familiarity, as well as teamwork skills. Introducing an inadequate member can disturb the efficiency of the whole team. Thus, the test not only checks technical elements but also the person's ability to receive, apply, and give criticism, key elements in successful project with long term customers. Consequently, the testing

process involves both translation and discussion of the feedback.
Attitude to improvements. Some improvements of the test piece are welcomed. For example, an improvement to the layout of the text can represent a good sign because it shows the translator looks at the whole picture and is confident enough to make a change when it means improvement. In some tests, issues are deliberately created to evaluate the translator's attention to details.
How far can or should you go? It depends on the LSP and test reviewer and how they perceive such changes. However, normally, this is something you cannot know.

Follow instructions. Part of the test is following instructions. So, make sure to carefully read and understand the instructions before you begin. Read them once more before you deliver the test to ensure you did not miss anything.
Take your time. Make sure to allow at least one day after completing the test before reviewing it again prior to delivery. On the next day there is a higher chance to catch any basic mistake you may have made. Remember that even the most skillful translator can fail due to fatigue or overload.

Thoroughly understand the function of the device you are dealing with. Research the subject matter, for example, for a technical translation, search for a device on YouTube and find a video demonstrating its uses and functions.
Finding information. If the subject of the test, such as a device or medication, is replaced by a placeholder (e.g., XYZ), try doing a web search on a part of a sentence that does not include the name, putting it between double quotation marks. In many cases, this step will lead you to the original text, reveal what "XYZ" stands for and provide you with additional information.

Differentiate the brand name from the company name. Specific product lines frequently have a name. The “Vent-Os System” is not produced by Vent-Os and should not be translated as "the system of Vent-Os". The manufacturer is SinuSys with Vent-Os being the name of the device. You should always confirm the name, conducting a web search to verify the details. This search may take a couple of minutes but the failure to do so may cause you to fail the test.

Terminology. Make sure to use the correct proper names. One wrong term might make you fail.

Capitalization provides useful hints. Sometimes the brand name is all capitalized and followed by first-capitalized words. The latter are descriptive and not part of the brand name. For example, in "The CONTOUR Curved Cutter Stapler", the brand name is "CONTOUR". Now that you know the exact brand name, you can implement the correct syntax in your language.
Different languages have different capitalization rules. For example, family names in French are all capitalized (Jacques BREL) while names of months are written in all small letters (octobre).

Of course, these hints don’t exist in languages that do not use capital letters (e.g., Farsi, Arabic, Amharic and Hebrew).
When leaving text untranslated (many clients require leaving brand names and names of organizations untranslated), make sure not to include the same word twice in both languages. It is a common error when the source and target

language use different scripts, like in translation from language written in Latin script into a language written in Cyrillic, Farsi or Hebrew script. For example, for the word "technology", translation of "DELTAWIND™ Technology" to "Технология DELTAWIND™ Technology" is incorrect. The Russian word "Технология" means "technology", so "Технология DELTAWIND™ Technology" actually means "DELTAWIND™ Technology".

Addressing acronyms. A. Make sure not to repeat a word that is already part of the acronym. The word "system" is a good example. The letter S in ABS (anti-lock braking system) stands for "system". Do not translate it to "ABS system" in your language.

Addressing acronyms. B. If your target language assigns gender to nouns and/or verbs, such as in French, Russian, and Hebrew, read the acronym to yourself word by word. Pronounce the word for every letter in the acronym. Only then determine the gender of the acronym. Once you determine the gender, use it to structure the whole sentence. It is common for translators to incorrectly address an acronym by its sound, which might be different than the sound of the noun in the full expression.

Referring to the names of medication. As we do with acronyms, we tend to address medications by the sound of their name. However, the noun itself, "medication", determines the gender. For some languages the noun "medication" is feminine, as in Hebrew, while in others it is masculine, as in French.

Register and style. Consider the domain and target audience. Don't be poetic in technical texts. Likewise, legal language is inappropriate for a medical device user manual as it is high register for patient-facing materials. So, although the translation may be correct and the syntax proper, the wording may be inappropriate for the target audience of your text. Format, layout and use of CAT tools. Some LSPs specifically include it in grading a test. Make sure to format the translated text in the same manner as the source one. When using a CAT tool, pay attention to tags, understand what each represents and put each one in the correct place. In addition, if dealing with a bi-directional segment, make sure to use directional marks where needed.

Spelling. Apart from running spell check, which is obvious, make sure that all words which spell check cannot verify are spelled correctly. Usually these will be brand names. Search the web for all spelling options of that noun and verify the correct one.

Avoid literal translation. Make sure your text is phrased according to the syntax and grammar rules of your target language.

Consistency. Keep consistency in the terms you use if there is more than one correct translation. For example, "placebo" in Hebrew can be either translated to one of two options (אינבו or תרופת דמה) or transliterated (פלצבו). Choose one option and stick to it throughout the text. Be consistent in structure and flow of sentences. Aim to achieve harmony.

Also, make sure to consistently use parentheses (round, square and curly) and quotes (single or double) for each specific use.

Abbreviations. Don't abbreviate words that are not abbreviated in the source. On the other hand, don’t write in full words that are abbreviated. So, if your source

has "kg", write the equivalent abbreviation in your language, such as "кг" in Russian. On the other hand, if your text has "kilogram", write the full word, such as "килограмм" in Russian.
Prepositions. They are used differently in different phrases among different languages. For example, in English you say, "the difference between XXX and YYY", which, when translated to Hebrew, is (literally) "the difference between XXX to YYY". Make sure to convey the meaning, not the sentence structure.
Read the translation out loud. Read it out loud to yourself or even in your head to make sure it flows, and everything sounds smooth and correct.

The tips listed above will help you avoid losing points unrelated to your knowledge of the language and expertise in the subject matter. After all, the purpose of taking the test is to show the LSP that you are qualified for the job. Now, your attention to details will convince them that you are truly a professional translator.
These tips can also help you in your daily work. Passing a translation test is only the start. Hopefully, it results in a long and fruitful collaboration.

Acknowledgements: I would like to thank my husband, Stephen Rifkind (www.gaguzia-translations.com), for his support, as well as some linguistic corrections.

Tzviya Levin Rifkind has been a medical translator for more than 22 years and worked as a nurse for 23 years, with a BA in nursing (summa cum laude). She is an ATA and ITA (Israeli Translators Association) member. Her certificates include a Recognition certificate by the ITA and an ALTA Certificate of Proficiency. She specializes in English into Hebrew medical translation. Thanks to her practical experience as a nurse, she has mastery of most medical fields and translates all types of medical documents. Her services include proofreading, editing, counseling on terminology, counseling on right-to-left issues and, last but not least, translation test review and grading. For more information, see www.sciencetrans.com.

The New Section 1557 Health Care Civil Rights Rules:

A Different Perspective

By Bruce Adelson, Attorney at Law

The U.S. Department of Health and Human Services (HHS) recently changed health care civil rights rules under Section 1557 of the Affordable Care Act (ACA). The new rules altered those issued in 2016. The new rules also eliminated some parts of the 2016 regulations and made other changes, which include deleting:

The definitions section, eliminating definitions of key terms; Special Note: However, these definitions remain in other federal laws that are part of the ACA as explained below.

Specific nondiscrimination protections based on sex, gender identity, and association; Special Note – In August 2020, a federal judge in New York blocked the new rules about sex discrimination. To be consistent with the U.S. Supreme Court's 2020 decision about sex discrimination, the N.Y. court ordered the restoration of the 2016 rules, which protect against health care discrimination on the basis of sexual orientation and gender identity.

Translated taglines on notices and significant communications to consumers;

Language access or limited English proficiency plans;

Notices about language access rights and non-discrimination at health care provider locations and on their websites; and

Requirement to have a compliance coordinator.

However, despite these and other changes to Section 1557, the hallmark right to free language assistance in health care through qualified interpreters and translators providing effective interpretation and translation for limited English proficient (LEP) people essentially remains the same as it was before these new rules became effective in August 2020. In fact, most other language-related federal legal protections and non-discrimination requirements also did not change.

The 2020 alterations are part of a much bigger legal picture. Section 1557's health care civil rights protections can only be fully comprehended by understanding the "ancestral" laws on which the ACA is based. On July 14, 2020, a federal appeals court reaffirmed this crucial legal reality by ruling: "Applying section 1557 requires an understanding of its relationship to previous civil rights statutes. Section 1557 incorporates by reference the grounds protected by …. earlier nondiscrimination statutes and prohibits discrimination on those grounds in the health care system."

Uniquely among federal laws, Section 1557's mandates originate from six different federal statutes, each with its own regulations, guidance, advisories, directives, jurisprudence, and history:

Americans with Disabilities Act (ADA);

Rehabilitation Act of 1973;

Title VI of the Civil Rights Act of 1964;

Title VII of the Civil Rights Act of 1964;

Title IX of the Educational Amendments of 1972; and

Age Discrimination Act of 1975

What does this all mean?

In short, health care providers must do their research, in addition to reading the new 1557 rules, to understand their federal non-discrimination legal obligations. As the July 2020 Court of Appeals decision advises, the first step is understanding all of the requirements of the ACA's legal ancestors.

While the ACA's requirements have now changed, those of Title VI, the Rehabilitation Act of 1973, and the Americans with Disabilities (ADA) have not. The following three examples help inform the larger point how the Section 1557 language assistance changes do not alter or minimize the federal language access rights established by the ACA's legal ancestors.

Example 1: The new rules eliminated the translated tagline mandates, which do not specifically exist in other federal laws. The ACA now generally does not require non-discrimination and language assistance availability notices. However, Title VI does.

Title VI of the Civil Rights Act of 1964 (45 Code of Federal Regulations (CFR) 80 and 42 U.S. Code § 2000 d) requires federally

subsidized health care providers, state, and local governments to provide effective spoken language assistance to people who are not English proficient.

Title VI requires federally subsidized health care organizations to translate Notices of Non-Discrimination and Language Assistance Availability into applicable non-English languages. For example, in two recent HHS Title VI enforcement agreements, HHS required the investigated provider to give "… notice of the right to free Language Assistance to LEP persons in a language they can understand."

The new 1557 rules incorporate previous HHS guidance into the 2020 regulations. Such guidance requires Title VI non-discrimination notices: "it is important to provide notice in appropriate languages in intake areas or initial points of contact so that LEP persons can learn how to access those language services." And see: "When language assistance is needed to ensure meaningful access to information and services, it is important to provide notice in appropriate languages in intake areas or initial points of contact so that LEP persons can learn how to access those language services."

The ADA and Rehabilitation Act have similar requirements for people with disabilities, such as the ADA's regulation, 28 C.F.R § 35.106: " A public entity shall make available to applicants, participants, beneficiaries, and other interested persons information regarding the [ADA] … and make such information available… to apprise such persons of the protections against discrimination…"

Example 2: The new 1557 rules removed the recommendation that health care providers have Language Access or Limited English Proficiency Plans. However, contrary to many commentators, this Plan requirement remains in federal law, through Title VI court decisions, federal guidance from HHS, the Department of Justice (DOJ), and virtually every other federal agency.

A 2016 federal court ruling is most significant for informing everyone that these Plans are legally required under Title VI. In this case, LEP Spanish-speaking parents sued the School District of Philadelphia alleging various forms of discrimination, including national origin and language.

The federal court held:

"… an effective LEP plan [that] includes the translation of vital written materials into the language of each frequently-encountered LEP group eligible to be served and/or likely to be affected by the recipients' program [is clearly required]"

Example 3: The 1557 rules deleted the requirement for a Civil Rights Coordinator.

However, the ADA and Rehabilitation Act (that prohibits disability discrimination by federally subsidized organizations) clearly require both. For example, under the ADA and Rehabilitation Act, health care organizations must designate at least one individual to coordinate the covered entity's compliance with prohibitions of disability discrimination. 28 CFR 35.107(a) and 45 CFR 84.7(a) Title VI requirements are substantially the same, as seen by the following excerpt from an HHS settlement with a large hospital: "Within fifteen (15) calendar days after the Effective Date of this Agreement, MHS shall complete the designation of a senior staff person to serve as its Language Assistance Coordinator and notify OCR of its designation."

In examining and evaluating the new 1557 rules, it is vitally important to remember that the Affordable Care Act is built on decades worth of laws guaranteeing many rights, including the right to free, effective language assistance through qualified, trained interpreters and translators. These laws, like Title VI, remain unchanged even after HHS altered Section 1557. The

multiple requirements of these laws remain legally binding on all federally subsidized health care organizations.

Remember that The Law is complex, with many twists and turns. The new rules are part of this complexity. They are much more than meet the eye and retain substantial legal requirements against health care discrimination.

I. Bostock v. Clayton County, No. 17-1618, 590 U.S. ___ (2020).
II. Schmitt V. Kaiser Foundation Health Plan, __ F.3D __, No. 18-35846, 2020 WL 3969281 (9TH CIR. JULY 14, 2020)
III. See: U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES and MEE MEMORIAL HOSPITAL Resolution Agreement Transaction Numbers: 12-143846, 13-151016 & 13-153378 (2016) and SETTLEMENT AGREEMENT BETWEEN U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE FOR CIVIL RIGHTS, SOUTHEAST REGION AND ALABAMA DEPARTMENT OF HUMAN RESOURCES (2017)
IV. HHS Guidance, Federal Register /Vol. 68, No. 153/Friday, August 8, 2003
V. T.R. et al v. The School District of Philadelphia, No. 2:15-cv-04782-MSG- Document 30 (E.D. Pa. 2016)
VI. VOLUNTARY RESOLUTION AGREEMENT Between the U.S. Department of Health and Human Services Office for Civil Rights And Memorial Health System. Transaction Number: 08-79513

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How I have navigated the surge and implications of COVID in barely 72 hours

By Alcira Salguero

As I started preparing to write this short article, I stopped to think: what on earth has happened to me and to the rest of the world? Is this real? And here is where my story begins.

I ended 2019 in a reasonably great way! The meaning of "great way" for me was this: ending relatively healthy, no casualties of any kind, nor personally or professionally, gladly and gainfully employed with the same employer since 2009, loving and great friends around me. What more could one ask for? Let's face it, of course, in my dreams I would love a small yacht docked along the Monte Carlo waters, a home in a beautiful European resort, another home in the beautiful sandy beaches of my own country, Mexico; a small Cessna would be nice too, right? A few trips around the world, two three times a year, not bad either! Would I change all that for the love of my family, my life, my friends, and my job? Hmm, tempting, but I would not do it.

Fast forward, to January 14, 2020, off to Mexico for 16 days of a bit of studying, combined with R&R. From January 15 to 19, off I traveled to Cuernavaca, in the state of Morelos. Cuernavaca ,is the City of Eternal Spring, south of Mexico City, about 40

miles away by car or a comfortable motor coach service. Cuernavaca is well known by the locals, tourists, ex-patriates and by Mexico's elites, who maintain manor houses, basically, (beautiful colonial haciendas). Cuernavaca is a great part of Mexico's history dating back to the 16th century. Rich history, gastronomy and arts. It is also known for its silver mining activities:…gorgeous, beautiful silver crafts (highest quality of silver is .925, it is usually engraved in all pieces as a certificate of authenticity) from jewelry to exquisite decorative house art. While in Cuernavaca, I attended an excellent workshop: Desafío Lenguas 2020, organized by Katharine Allen and Barry Olsen from InterpretAmerica,. I attended titled, SimLab: capacitación intensiva para intérpretes en servicios de salud, taught by Liz Essary and Laura Holcomb from Seven Sisters. It was my first time attending this fantastic conference. There were many European language conference interpreters as well as an interesting mix of court interpreters within the indigenous language services from various parts of Mexico. And, of course, medical interpreters from the US. We were only a handful, nevertheless, the content was very ad-hoc, enlightening and rewarding. We were in a beautiful resort with lush botanical gardens, beautiful pools, outdoor patio dining for breakfast, lunch and dinner, a great spa available adjacent to the premises, and a very Zen atmosphere. In addition to all the above, we had a highly talented duo of instructors, pushing us for 7 hours a day. Lunch took place in a beautiful sunny garden, with delicious food, mingling with attendees from other conference workshops. Now, who wouldn't want to work hard during the daytime sessions when you knew the evenings would be man absolute pleasure, strolling in the resort or stepping out to downtown restaurants in the main square, al fresco!

On January 30th, I went back to work, re-energized and charged with a fresh mind and ready to tackle all challenges! My second evening back in the Bay area, I was peacefully still adjusting to being back in my adopted city of33 years and counting, San Francisco. I was not paying attention, but the newscaster caught my attention when I heard the tail end of "Chinese PhD who traveled from China back to Monterrey, Mexico, acknowledged to the immigration agents in Mexico, he was in Wuhan where there was an outbreak of the coronavirus and he acknowledges it is a highly contagious virus that can be transmitted through contact." I jumped out of my seat, thinking to myself, "Oh my God! I wonder what day that man traveled? Did he have any connecting flights in the Mexico City airport, where I was? Yikes!!! I texted one of my siblings, who happens to be a managing director for the Amex VIP lounge at the International Airport in Mexico City.

My brother texted me back with something like "We don't know much YET, but the man traveled on a different path than yours and on a different day". I was somewhat relieved Whew!

February came around, and the coronavirus news were heightened all over the world! As a staff interpreter, I am normally assigned an average of 6 patients a day, depending on the complexity and duration of every case. The first couple of days in February, cancellations were coming through but I was still on the hospital service. By mid-February, my organization's emergency management teams started implementing immediate safety protective protocols for the ENTIRE organization. In less than a week, hospitalists, clinicians, nurses, social workers, and all other support services personnel started wearing all

types of masks, gowns, gloves, and face shields; the emergency management teams initiated daily hospital wide bulletins, implementing strict preventive measures. Inpatient interpreting services were cancelled at once, then the preferred mode of language service at that time became the language interpreting service provider on the screen or by phone. No more in person services.
On the other hand, at the medical office building, which is always a bustling area with people coming and going in and out of elevators, in and out of offices. the emergency management teams halted in person appointments, in less than 72 hours.

All clinicians, nurse coordinators, and administrative staff were sent home immediately. By then, there were still a FEW appointments in the medical office building. But it now had an eerie feeling: lights off in many areas of the floors, only A FEW staff members; masks, gloves, keeping distance, no more tables or chairs at the employee's nice, cushy lounge, a big sign with new protocols: only 2 people can enter the lounge at one time, keeping 6-feet distance; no lunch gatherings anymore; eating is now at the employee's desk. As a staff interpreter, I serve both hospital and medical office building assignments indistinctly. When, I work at the medical office building on lunch break, in-house interpreters are allowed to sit in the lounge room and interact with all the outpatient personnel, which is always most pleasant and it helps us build strong working relations. In-person patients in waiting areas were NOT allowed anymore. In the meantime, ALL CLINICIANS were figuring out how best to continue caring for their patients. Meanwhile, I was overwhelmed just trying to understand the severity of what was happening with this COVID-19. At the same time, I'm wondering how all this will affect our LEP communities with no interpreters in person anymore. In approximately 72 hours, I saw my inpatient and outpatient appointments go from 6 to 1 or 2, and reduced to about 2 hours a day of work After that, I had to go home. I was in shock, thinking, "how can all of us, in house interpreters, support our clinicians and our LEP communities?"

My first challenge occurred when one of our recently operated patients had to be discharged but needed to get all the post-operative standard teaching before going home. This type of post-operative teaching sessions is given in two consecutive days and each session lasts 4-5 hours. Under normal circumstances, these post-operative sessions are given in the patient's room and in the presence of two family members, who take responsibility to assist the patient at home for approximately two-three weeks on a 24 hour basis. By this time, it was already March. State mandates were becoming more stringent day by day as COVID cases surged. Our institution follows all State regulations in addition to AMA, JACHO, OSHA, etc., and all other medical or labor boards. By late February and early March, family members were no longer allowed to come into the patient's rooms. Patient's family members could no longer pick up their loved ones directly in their rooms. Families were instructed to wait in a specially designated area of the lobby.
I believe it was the first Saturday of March when I received that assignment for teaching discharge. I arrived at the designated hospital floor. I met the leading RN coordinator and I was instructed to wear all PPE and follow the newly implemented COVID protocols, so I could interpret the discharge teaching class. The RN in charge looked at me and said, "Thank you for being here, this is 48 hours post op, first day of teaching." Needless, to say this was an LEP patient, still trying to comprehend

what on earth is happening. Of course, no family was allowed to come up to the room; the family hads to wait by the lobby. The little spinning wheels in my head are thinking "Alcira, under general circumstances these teachings are difficult for patients, even when the family is here. There is no way our patient will comprehend all this, even if we give the patient all materials in Spanish." I stopped for a minute, turned around and asked the RN coordinator, "do any of the family members in the lobby have a standard cell phone or an iPhone?" The RN replied "of course, everyone has a cell". I said "great, then; that will give us a chance to visually show them what we are discussing, if they can see it on their phone." She responded, "OK, let's see if this works and let's call them." I informed the RN that I had brought my hospital tablet. Therefore, we could ask the family to participate in the whole teaching from their phone so they could see the medicine names, the logs, the blood pressure cuffs, etc. And VOILA!! Here was my first unplanned and improvised "video interpreting service". From that moment on, there was a "perception" that I was skillful with technology. Little did they know! By this time, the volume of in person assignments came to a halt. In a matter of three days, 80% of the clinician workforce was asked to work from home. Incredibly talented clinicians in highly specialized fields, many baby boomers, just like me.

Meanwhile, at the medical office building, executive management is not sure how the LEP community will be served. Some clinicians working from home had to start using a telephonic interpreting service to speak with the LEP community. At times, the telephonic services worked well, and other times they did not. Some clinicians became a bit frustrated. They wanted to connect with their LEP patients, but it was difficult. Another challenge with the LEP community was that a great majority are not familiar with cell phone technologies.

In the meantime, I was allowed to work from the "ghost" medical office building, assisting LEPs who unexpectedly show up at the clinic because their appointments were made a year ago and they were not informed of the severity of the COVID-19. they still wanted to comply with seeing their surgeons or clinicians. Next, I was collaborating with one of the few medical assistants who worked in person in the medical office building, coordinating telephone appointments for ALL the clinicians. On one of those occasions, a clinician came to work in the medical office building. The medical assistant informed me that the clinician needed to speak with a Spanish speaking patient, but he didn't know how to initiate the call. Once again, I had my tablet. I called IT and asked what platforms or services clinicians were allowed to use when they needed to see a patient. IT informed me that it was only FaceTime or WebEx. I relayed this to the clinician; I could download FaceTime and I could call the patient to see if they have an iPhone. The patient had an iPhone. Woohoo! I interpreted for the clinician and the clinician was able to see how well the patient's incision was doing. The clinician was pleased to see the patient and confirm the well-being of the patient. As I was trying to help clinicians and medical assistants, I realized how much in the dark I was myself about handling technology. And of course, I also saw how much help our LEP communities needed to understand how to have "video health appointments."

By mid or late March, I realized that I was creating a reputation for myself among some clinicians, medical assistants and administrative

personnel that I "knew" how to connect our LEPs and clinicians". However, that was far from the truth. I can be resourceful and brainstorm but I have never been a "techie" at all. From March through May, I went through a fair amount of stress trying to support clinicians and medical staff with all video challenges: LEPs not being able to download their application, bad connectivity, sometimes our medical office building had bad connectivity, sometimes the clinician's location had bad connectivity. I was nervous and "jumpy" because I had to connect several different clinicians for their appointments at different intervals but I had to work with the medical assistants, giving preliminary instructions to our LEP patients to download applications so they could have their VIDEO appointments with their surgeon, clinician, social worker or others.

Even though, I am not a "techie," from April up until August, I have attended an average of 10 different great webinars on Remote Simultaneous Interpreting, the differences between platforms, the different types of remote services available for end users, interpreting on Zoom, Voice Box and others.
What I have learned is to: accept; discern; allow; prepare and train = ADAPT, ADAPT and never stop learning. Even if it is not pertinent to your own interpreting or translating specialty, it is of utmost importance to know the array of differences that are available in our industry.

Alcira Salguero, CMI (Spanish), received a solid bilingual education growing up in Mexico City. Her degree in hotel management led to a career as a purchasing specialist in industries ranging from tourism to engineering to pharmaceuticals. In 2007, Alcira made a career change to medical and legal interpreting. She holds a Certificate in Legal Interpretation (San Francisco State University, 2005). She is a member of ATA/NCTA/NAJIT/IMIA and CHIA. She is currently enrolled in the online certificate program in translation through the University of California in San Diego. She is an avid learner and takes part in many different continuing education programs which allows her to maintain her national certification active as a medical interpreter.

She holds a position as a staff interpreter with California Pacific Medical Center/Sutter Health in Northern California, where she has worked since 2009 up until now. When, she is not studying or interpreting, she enjoys cooking, meeting friends, traveling, and doing a bit of moderate exercise, light Zumba "moves". Her goal in the pursuit of happiness, once she retires, she wants to live in Paris for a whole year and aside from traveling, of course, she wants to improve her French.

Got any cool leads for cool article ideas? Send them to our Copy Editor, Santiago Achinelli at santi@achinelli.com