AN INTERVIEW WITH DR. ALVARO VERGARA-MERY

An Oral History Conducted by Barbara Tabach

Latinx Voices of Southern Nevada
Oral History Project

Oral History Research Center at UNLV
University Libraries
University of Nevada Las Vegas

University of Nevada Las Vegas, 2018

Produced by: The Oral History Research Center at UNLV – University Libraries
Director: Claytee D. White
Project Manager: Barbara Tabach
Transcribers: Kristin Hicks, Maribel Estrada Calderón, Nathalie Martinez, Rodrigo Vazquez, Elsa Lopez
Editors and Project Assistants: Laurents Bañuelos-Benitez, Maribel Estrada Calderón, Monserrath Hernández, Elsa Lopez, Nathalie Martinez, Marcela Rodriguez-Campo, Rodrigo Vazquez

The recorded interview and transcript have been made possible through the generosity of a National Endowment for Humanities (NEH) Grant. The Oral History Research Center enables students and staff to work together with community members to generate this selection of first-person narratives. The participants in this project thank University of Nevada Las Vegas for the support given that allowed an idea the opportunity to flourish.

The transcript received minimal editing that includes the elimination of fragments, false starts, and repetitions in order to enhance the reader's understanding of the material. All measures have been taken to preserve the style and language of the narrator. In several cases photographic sources accompany the individual interviews with permission of the narrator.

The following interview is part of a series of interviews conducted under the auspices of the *Latinx Voices of Southern Nevada*.

Claytee D. White
Director, Oral History Research Center
University Libraries
University of Nevada Las Vegas

PREFACE

Alvaro Vergara-Mery is a certified medical interpreter who has live in Nevada since 2003. Born in Chile, Alvaro was raised during the dictatorship of Augusto Pinochet, an era of significant human rights violations. His father was Chilean, but his mother was also a citizen of the United Kingdom. Finally in 1989, Pinochet was indicted and his harsh rule of Chile ended.

For Alvaro, this meant he could more freely seek opportunities elsewhere, including his higher education. He received a bachelor's degree from Universidad de La Serena in Chile, a master's in Education and Spanish from Minnesota State University, and his doctorate in Spanish from Arizona State University.

Today, Dr. Vergara-Mery holds a dual citizenship with Chile and the United States. He is a Senior Medical Interpreter at University Medical Center of Southern Nevada in Las Vegas. He shares his philosophy, experiences, thoughts about COVID era relating to interpretation needs, and recalls being called in on 1 October.

TABLE OF CONTENTS

Interview with Dr. Alvaro Vergara-Mery
October 28, 2020
in Las Vegas, Nevada
Conducted by Barbara Tabach

LATINX VOICES
OF SOUTHERN NEVADA
An Initiative of the UNLV University Libraries

Use Agreement

Name of Narrator: Alvaro Vergara-Mery

Name of Interviewer: Barbara Tabach

We, the above named, give to the Oral History Research Center of UNLV, the recorded interview(s) initiated on Oct. 28, 2020 along with typed transcripts as an unrestricted gift, to be used for such scholarly and educational purposes as shall be determined, and transfer to the University of Nevada Las Vegas, legal title and all literary property rights including copyright. This gift does not preclude the right of the interviewer, as a representative of UNLV, nor the narrator to use the recordings and related materials for scholarly pursuits.

I have been provided with the Latin Voices Project Consent Form and understand that my interview will be made available to researchers and may be quoted from, published, distributed, placed on the Internet or broadcast in any medium that the Oral History Research Center and UNLV Libraries deem appropriate including future forms of electronic and digital media.

There will be no compensation for any interviews.

Alvaro Vergara-Mery 10/28/20
Signature of Narrator Date

Barbara Tabach 10/28/2020
Signature of Interviewer Date

This is Barbara Tabach. Today is October 28th, 2020. I am sitting in my office with, please state and spell your name.

My name is Dr. Alvaro Vergara-Mery. First name Alvaro, A-L-V-A-R-O. Last name is hyphenated, Vergara, V-E-R-G-A-R-A, hyphen, M, as in Mary, E-R-Y.

Terrific. Where were you born?

I was born in Chile (1967), in South America.

What was Chile like when you were born?

Chile was an ugly place. I mean, it's a beautiful country, but it was under…four years after I was born, it got into political turmoil, and then it became a dictatorship in 1973. That changed everything, and we were under military oversight for seventeen years.

How did that affect you at your age? How long did you live in Chile?

My mother [Florida Mery] is a UK citizen. At the beginning, she was taking us back and forth. Then when she decided that Chile was too much and we should probably move—my father [Jaime Vergara] is a Chilean citizen, but the government didn't allow him to leave the country. He was told, "If you want to leave the country, you will never be able to come back. If you want to live here, your family has to stay here." Since he couldn't leave, we decided to stay, and so that was a drag, but we made the best out of it. We had land and my father was in the vineyards and pisco-producing business.

But still, my grandfather was a member of, basically here, the House of Representatives. From one day to the next, Congress was suspended, and there was a military junta in charge, and good luck. There was a point that we couldn't leave Chile anymore, and so we would get some permission to go on a study abroad for the summers. We would go to Europe and spend summers there, but we had to come back; otherwise, we were scared that they would do something to my

father. Then there was a point after so many years where they said, "No, this is not going to work."

Your father did what kind of work?

He was in the pisco. Pisco is an alcohol, a spirit that is produced in Chile and grew in that area. It's from grapes. We had vineyards and fruit trees. We would spend some of the summers working on the farm and picking apricots or whatever was needed.

It must have been beautiful.

It's a beautiful country. Chile is beautiful. Now it's doing very well economically and it's very expensive. But the whole country is maybe six thousand miles long and a hundred and twenty kilometers, eighty miles wide, and the mountains are on one side and the ocean, so you probably have forty miles of useable land. But it's beautiful. You go from the driest deserts in the north to lush and Washingtonian-looking forests, wet, Medieval, Antarctica basically, Cape Horn, with penguins and windswept nothing, plains.

How did you finally leave there? How were the circumstances at that time?

We never left. We stayed. Eventually, the U.S. put pressure on the military junta, and they had some sort of…they would ask the people yes or no, were the two options in '87, I believe it was. *Yes* meant that the president, dictator would continue in power forever, and *no* meant that there would be an election in a couple of years after that. Politically I remember that era and the commercials and all that. They would ask people on TV, "Would you vote for Pinochet?" *Oh yes, oh yes, of course, of course*. Everybody thought that he was going to win, but he lost; 62 percent or so voted against him. The *no* was the option, and that meant that he had to call for an election, and we transitioned from a dictatorship into a democracy, until now.

How old were you when that was going on?

That was years ago. I was nineteen years old.

What did you feel and think about what was happening?

It was a momentous occasion because we had lived under curfew, and everything was banned or censored that it was kind of a freeing event. This was in ’87. In ’89, the new president was seated, March of ’89, and I left Chile in ’90, in September of 1990. I could have stayed there to enjoy all this, but I’ve always wanted to explore other options and countries, and I had the option to go to New Zealand, England, but England is always too expensive, and there was a scholarship here in the U.S.—in Arkansas of all places.

Oh wow.

And so, I said, “Well, let’s explore Arkansas and see what it’s like.” And Arkansas, even today, it’s like another country compared to the rest of the U.S. I explored Mississippi, Alabama, Arkansas. That was my first “Welcome to the U.S.” state.

What did you think about the U.S. based on that?

It was going back; nothing that you would see on TV was there. Where is it? On TV, movies, Hollywood movies, we see all this, and there’s nothing here. But it was an interesting experience. From there, I went to New York City, and from New York City to Minneapolis. I arrived in Minneapolis in the middle of January, and it was brutal. I had been in cold places before, but Minneapolis takes the cake.

Yes, it’s very cold there.

I would meet my…and she would become my wife, there in Minneapolis. I was going to come here originally for two years and then go somewhere else, but I met her. Then I decided to go back to Chile, and I was there for two years. She went to visit me, and she stayed for a year and a

half, and then we applied to colleges from there, and we went back to Minnesota. I went to do my master's, and she also went to do her master's, and we went back to Minneapolis.

You're a graduate of the University of Minnesota?

That's my master's. My PhD is from Arizona State.

Excellent. I'm from Iowa…yes. So I know cold, and I know they're cold.

Yes, but I hated the summers the most.

Really?

Because of the bugs. The mosquitos are just…you couldn't do anything outside, and it was just brutal.

We used to say that the mosquitos in Minneapolis were as big as birds.

Yes, it's like the state bird. That's what they say, yes.

Yes, that's crazy.

My wife is originally from Duluth, Minnesota.

What does she do?

She's a licensed social worker, therapist. She works here at the VA with veterans, and she has her own practice. We've been here since 2003.

Here being Las Vegas?

Las Vegas, yes.

That's a number of years. Do you maintain dual citizenship with Chile and U.S., or how does that work?

Yes, Chile allows dual citizenship, and I have two passports. When I go to Chile, I have to enter the country as the Chilean citizen, and when I come back here, I have to enter as an American citizen.

You know the ropes.

Yes. There are some countries that allow that. England didn't. You have to surrender your UK citizenship if you're going to become a citizen of another country if you are not born there.

Your career path: what were your aspirations when you were this young man coming to the U.S.? What did you think you were going to be at that time?

When I came to the U.S., I liked letters and literature, so I knew that I wanted to do something connected to that. I applied to a master's in ESL, actually, in Spanish, and then my PhD, I wanted to do it with a very well renowned professor, and I was published, so I wanted to go to that particular university. I applied to six universities, and I was accepted in five, so I was like, oh wow, but I was accepted at Arizona State with that professor. I said, "I'm going to go there." It was great. My first experience with the desert in Tempe, in the beginning it was bad, but then…and now I love the desert. The summers are horrible, but there are no mosquitos there, no bugs of any kind, and you can do things outside, and this is a beautiful time of the year, and it's great, but there are things to Tempe.

I wanted to go in humanities, too, and linguistics; all that area of language, and that brought me to culture…And then when I became an interpreter, I studied that and I became also a licensed trainer for the cultural competence classes that are mandated now by law. Nevada just passed a law last year in which it will require that every institution that provides health care to patients, they also must train their staff for cultural competence because 80 percent of the problems is not the language. When people start speaking louder because they think that the patient is deaf, it's not that the patient is deaf, it's another language, so they're not going to understand. That also was interesting to me, the concept of culture and how people see the world from a different culture, a different lens. There's nothing wrong with that, but for us it's like, oh

my god, how could you do this? How could you do that? This is how we do it in the U.S. Oh, well. That was also interesting.

I became licensed and trained for cultural competence. Also, I'm a licensed trainer for the class that I mentioned to you about the intro to medical interpreting. I am back to academia, but in my own terms, and I love it. I love it.

Talk a little bit about cultural competency. I really do believe that's critical. If nothing else from what we do in our work, is the cultural differences that exist. What exactly does that entail when you're trying to teach somebody that?

Cultural competence is basically…I divide it into three parts. First, the person, say, you work for whatever company. You have to be aware, and that's the first part, the awareness, that the person in front of you is different from you whether she/he looks different, their demeanor, their tone of voice, their body language; all the paired linguistic features. That's the first part; that being aware. Because if you are not aware and you think you're only going to see people that look like you…that will never work.

Then after that awareness—okay, the person in front of me is different; they're probably from a different culture; they probably were raised differently than I was—it's simple things because we have an African American nurse at the hospital that he was calling a patient, and he said, "A-A-Ron," instead of "Aaron," because *Aaron* is not an African American name. Or the opposite, we have White nurses mutilating names instead of asking, how do you pronounce your name, or how do I call you? We have doctors from Indonesia or Malaysia with names this long: Bangulasimurachirachi. "Can I call you Dr. B? Is that okay with you?" *Oh yes, that's fine*. Then it's asking. The awareness becomes the interest in that you know that there is something, but then you have the willingness to change, to ask, to approach that person and ask questions, listen.

That's our number-one problem: We don't want to listen. Our nurses, for example—and I do cultural competence in health care, but it can be applied to any institution that deals with customers or patients. "I don't have time for this. I have four patients; I have six patients. I'm not going to be talking to everyone." But that's key because when we ask the patient, why are you here? Some cultures will go on a lengthy explanation. "I'm here for a knee pain, but the knee pain started four or five years ago when I was in Rome going up steps and I fell. Then I went to a clinic out there, and it was too long. Then I was fine, and I didn't do anything." The providers are, "I don't want to hear that. I just want to know, why are you here today?" That's the lack of…Okay, if you ask the question, be aware and allow some more time for the answer if you want that connection, and that's the other aspect of cultural competency. Because if there is no connection, a level of trust when you're telling me, you're not going to trust what I'm saying.

Eventually, we will move through all these cultural components until we understand we will value the person in front of you for that difference, not because they look like us, not because they have been Americanized, not because they…In this country, in the U.S., we speak English, and if you want to speak Spanish, you have to go back to your country, learn and come back. We've heard all those kinds of comments. Some people will not have the willingness to change, and that's the problem.

Isn't that the keyword, the *willingness*?

The *willingness* is the keyword in cultural competence; otherwise, it's not going to happen because you say, "No, I'm going to see only patients if they speak English." Well, that's a federal offense, but that's something else. If there is not that willingness, we're not going to reach you, anyway; we're not going to go anywhere.

Let's back up a little bit. Your training, your first job using your skills, where was that and what was that like? How did you get competence yourself, cultural competency?

You are never a hundred percent competent. When they ask me, "Oh, Dr. Vergara, you as an expert, please advise us," I say, "Wait a minute. I'm not an expert. Nobody's an expert. All I can do is I can facilitate." If you just happen to trigger a minimum willingness and you were at zero when you came to the training, and you are like, "Okay, I understand now, and now I'm going to make only the questions that are important," that's something; we have gained something. This is just practice and working with people from different cultures.

When I teach the introduction to medical interpreting and I do it in a language neutral setting, I have people that speak Punjabi, Spanish, Ilocano, Indian…sixty other languages. The training is in English, and then we go into concepts that are untranslatable because culturally there are no words; there is no equivalent of the same, sometimes, feelings. Some languages have nine different words for *rain*. Do we need to know nine different words for *rain*? But for them it's important. Or healing, alternative healing methods; all that kind of stuff.

Yes, I went to the TOT, which is train of trainers, forty hours, but I'll never be an expert. I keep learning from students, and every student has something to say. When we ask the question, for example, relate or narrate or find a partner or find a group of three, and talk about an instance in which you have been discriminated against, many minorities will have examples. But if you're White, male, you'll be like, "Well, I don't think I have ever been discriminated against." Will you say that? Those are the things. The training is more in you than learning stuff because cultural competence, it's not like you're going to go in a book and read about it and memorize steps to become culturally competent. Yes, we learn about valuing the other person, dignity, treating everybody with dignity, and sometimes we forget. We roll our eyes. *Oh, it's you*

again. Because we have patients that come to the hospital every week, and they say, "Oh my god, it's that guy again. Why are you here?" Like it's a burden. "Oh, are you here again for dialysis? Did I tell you to go to a place? We gave you instructions to go to that clinic." But the person is undocumented, and the clinic will not take the person, and the nurse knows that, but they like to…poke at the hole where the bullets went in because they don't know any different.

Those are the things that we go through, examples. When we have a White male that doesn't have an example of discrimination against me, that's when we go, "Well, imagine if you were Black, or imagine if you were Hispanic, or imagine if you were gay, or imagine if you were any of the other categories." Sometimes it's hard for them because they've never experienced it, but they've had a friend; they know of someone, and that's how they can relate because you don't necessarily have to experience something bad to feel about it.

It's an interesting training, and it's never the same. That's what I love about the cultural competence training because it depends on the group. The group makes the training, and sometimes they are more interesting and sometimes we hear stories that are…I had a case, a refugee from Burma, Myanmar, that crossed the border naked with nothing, nothing. Then we're asking him, "Do you have any papers that attest that you went to college or that you were a nurse there?" How can we ask that question when we know that he crossed the border with nothing, not even clothes on? Those are the things. *Oh, but it says there; the question is right here, and I have to ask.*

Let's talk about your blending of cultures because you said your mother was from the UK. My mother is English and Italian. My father…the paternal grandmother side we don't know much about. My grandfather was from the Basque Country in Spain. It's a mix of mixes.

That was the sauce that you were baked in was this variety of backgrounds coming together in your family.

Correct. Unlike many Hispanic or Latino families, we were not a big family. To this day, there are cousins that I don't know. I never saw them as I was growing up. It's not the idea of the big family gatherings and having lasagna on Sundays or pasta or things like that. It was mostly my mother and I were living in the city, and my father was in the country. Every two weeks or so, he would come to the city for four days, or the next weekend we would go to the country, and back and forth.

Did you have siblings?

Yes, I have two, an older brother and a younger sister.

Do they still live in Chile?

Everyone. Nobody left Chile. My grandmother on the English side, she went back to England to die on her homeland. She lost her mind and was there in an institution for ten years, and that was hard on my mother. Now my mother is eighty-two, and my grandmother died ten years ago, and she was ninety-six, but we had lost her ten years earlier. With COVID, now my mother has been alone in Chile since March, and nobody can visit. Chile has their borders closed.

Because of the COVID-19.

Because of COVID. It's a nightmare just to get there. I could go as a Chilean citizen, but there is no guarantee that I'm going to get a flight back. things can change at any moment, and they'll say, "No, no, we're closing the flights, and you have to be here for another three months." That's been hard, especially on her.

In teaching your children—you listed you have three children.

Yes.

How do you, or have you, shared your cultural identity with your kids? How do they identify? Have they learned your multiethnicity?

We're in the process. I'm raising my two sons here. My adult son is in Chile, and he's already married and on his own, and he is Chilean. The other two here, they are Chilean citizens as well, btu they are Americans. They are just starting to, at fourteen and twelve—we've been to Chile, and we've been to Colombia and other Spanish-speaking countries, and one speaks more Spanish than the other—that's probably my fault—but the younger one is very different; he doesn't want to learn Spanish. The older one is like, "I want to learn Spanish." It's been a mix between. They are starting to process the concepts of being bicultural. It has ups and downs. With COVID and with the political situation of this country now, it's adding stuff to the point that who knows what's going to happen? They are seeing that. My wife's father, he has also been an enormous help for us. He is like a third parent. He is from the former Yugoslavia, Montenegro. He adds an extra piece to that. My wife is half-Montenegro and half-German. Her uncle is a redheaded guy. It's like all these colors and varieties. For them, it's super interesting. My older one varies, and sometimes he identifies as Chilean. He says, "Oh, I'm going to play soccer for the Chilean team." Then the next day he says, "Oh no, I'm going to play soccer for the American team." Usually the American team sucks.

He's got a buffet to choose from.

Well, I think you always have the option to choose, and that's the beauty of it, but it's interesting. With online, there is no interaction with anybody else, so it's been interesting.

Are there any Chilean traditions that you've maintained here?

Not necessarily traditions, but the cooking, the way to approach recycling and reusing, that kind of stuff.

What does that mean?

Because in Chile, we reuse stuff; we don't necessarily have a recycling bin outside. But if you buy something and you can reuse it, we will reuse it. We will use a container for something else; things like that. If you're not in the room, do we need the lights on? Do we need the TV on? Do we need the water running while you brush your teeth? All those things are conservancy aspects that here…and sometimes my fourteen-year-old tells the twelve-year-old, "Oh, you're an American; you're wasteful."

That's interesting.

Things like that. Cooking. They're excited to cook and becoming more independent and realizing that, yes, it's not that hard.

What's a Chilean dish? What makes it a Chilean flavor?

Well, the typical Chilean, they could barely make it because they are too complicated. Empanadas are Chilean style.

I love empanadas.

Each country has a variation. The Chilean ones are this big.

Wow, that's big.

Then we have *cazuela*, which is a chicken or beef broth soup with a whole bunch of veggies. The way we cook the rice, for example, is different from the Peruvian rice, many variations. It's an exposure. When my mother was here two years ago, and I think that was her last trip, she taught them a few things, too, and they still remember that. Twice a year I make *milhoja* cake, which is a thousand-layer puffed pastry with *manjar*, which is dulce de leche, but that's a pain in the butt to make.

You only do it for special occasions.

Their birthdays.

That's great. going back to the cultural competency, with what's going on in this country, I always think of it as the scab has been picked off a wound that's been there.

But the thing in this country, for me, it's something that, oh my god, in this day and age, 40 percent of people support hate; that's the keyword here, hate, because it's in Chile I don't like my neighbor, but the hate that you see here, you don't see…I mean, religious freaks, I suppose, in other countries. But that's the aspect that makes a difference, and hate is above culture. Cultural competence will not solve hate. Many people mask it. Even in a position of power, they mask it, they try to, but, in essence, it's there.

Do you see that a lot here?

That's the scary part, and I see that from doctors to nurses to healthcare providers to patients, yes, and that's the aspect that makes hope almost impossible. You have the haters that make their own groups, and we have group A, group B, group C, groups that are going to the mountains of Idaho to create their own community. All those things that are scary, you don't see that in many countries. You see the ethnic wars, Armenians and Azerbaijanis; they hate each other, and they fight for land. That's historic, basically, or the Greeks and the Turks and so on and so forth. But how you see it here as a personal level, masked, it's even more scary. It's scarier than if it were out in the open.

When you first came to the United States and you were in the South, did you observe that kind of cultural thing going on?

No, because I was staying with a teacher family, and we would go to school, and most of the students were Black. One time I was invited to a party on a beautiful plantation-like house. The

owner was making a comment that she was very proud that the house was going to be sold and a Black person could not buy the house. It was written down in some of the…

And this is in nineteen…?

This is in ’94. That was like, oh wow, can you actually put that on the deed of the house? Is it legal? Those are the things that are scary in this country. Or when doctors would say, “Go back to your country.” This is a seventh-generation Hispanic that has been here before you, for five generations before you, and you are telling him or her to go back to his country? Do we tell you to go back to England or France or wherever you came from? Those are the things…Some people just say it because they’ve heard it, but some people actually say it to hurt, and that’s the essence of hate.

Were you ever the recipient of that?

No, I have not been the recipient of that. But when people say, “Oh, you don’t look typical Hispanic,” what is a typical Hispanic? What, five foot two, is that typical Hispanic, short and darker? What is the typical Hispanic? I tell them, “Look on TV. We have Cameron Diaz as an actress and she’s White and she is Hispanic. We have whoever else, Black and also Cuban, Hispanic. Do we call Cubans African Americans? They don’t like to be called African Americans because they’re not Africans and they’re Americans; they’re humans. If you go to England, to France, nobody has those boxes. The boxes are only here. Oh. That is the unwillingness to seek change.

I also had diversity…chartered a committee at my hospital. The previous person was like, “Oh, diversity should be…today is Moroccan Food Day, and the next week is Indian Food Day.” I looked at her and said, “Really? That’s what you think diversity is?” Yes, people don’t know. They hear the word, and they think that, oh yes, we are very diverse; we go to Japanese

restaurants on Fridays and then we have a Mexican restaurant on Thursdays and we have taco Tuesdays.

A time that you might have been called in to do interpretation for a patient, how do you start that conversation?

We interpret and we use the first person and the voice. If a female says, "I'm here because I am pregnant," I will say, "I'm here because I am pregnant." I use the first voice. Normally there is no problem. There are occasions in which the patient doesn't understand what an interpreter is, but that's not language; that's education; they don't know. They look at you like, why is he talking to this guy, and then talking to me? You have to process that as the interpreter. "I'm going to say what you say to the doctor." *Oh*. Sometimes we have to explain what an interpreter is.

We always have to remind providers that whatever they say, we are going to say. If you're going to make a joke or a stupid comment, we will say that. They'll say, "Oh okay, don't say that." I say, "Well, I'm going to give you this one time. But if you say something, by law I have to say it. This is the one warning you get." They normally get it. Some might say, "I'm never going to use you again." I say, "It's up to you, but remember the legal framework of this. You can always use a phone interpreter if you don't want to use an interpreter in person." They have the option to use a phone or a tablet, which is also legally valid.

It's legally valid, but is it as accurate?

If it's a standard, normal interpretation, yes. But if you are an on-the-phone interpreter, for example, and the patient says, "It hurts right here," well, where is right here? Those are sometimes the things…or the patient mumbles and you can't understand, so the phone is not going to work. You need an interpreter in person, and that's why we are there. End of life, we

have a family of four and the patient, and they're all talking. For situations like that a live interpreter would be better.

In this world of communities worrying about undocumented people, what kind of impact has that had on health care and what you've observed and participated in?

From the cultural and linguistical point of view, because the law says that we have to provide care that is culturally and linguistically appropriate, whether the nurse complains, he/she has to communicate with the patient, and if the patient doesn't speak English, he/she will have to use a phone or an interpreter in person. Though they complain, and sometimes they don't call the interpreter, we have a complaint from the patient's family saying, "My mother has been here, and she's been calling an interpreter, and the nurse has refused to call an interpreter." Then we send a team, and they investigate, but that's something else. We do have that unfortunately. We still have cases like that where for some reason the nurse denies the interpreter.

We also have cases in which the patient is older, probably mentally off, and he/she has designated someone that is not an actual interpreter but a family member, and in this case he/she has to sign a declination of interpreter services, so the record says that that's why we did not use an interpreter for that person.

There are all these instances, but in actuality, any person, regardless of who is paying the bill, the undocumented is an insignificant portion of when people say, "Oh, they are taking our money, and we are paying for it, and taxpayers are paying for the illegals." It's probably less than what we are paying for the American citizens that are indigent that we have to see and feed, anyway, so it's not that significant, in my opinion.

What are the hardest languages to find interpreters for?

We have a service that provides interpreters in two hundred and seven languages. Now, we have seven thousand languages in the world, so, every once in a while, we have languages that they don't have an interpreter for. When we do see that, for example, with indigenous languages of Mexico, Mexico alone has seventy-six or seventy-three indigenous languages.

Oh, I didn't realize that.

We have, let's say, a patient that speaks Tzotzil, well, the language line doesn't have a Tzotzil interpreter. What we do, we go there, and the patient talks to a family member in Tzotzil, the family member talks to the interpreter in Spanish, and the interpreter in English to the provider. We have to do a three-way interpretation when we don't have that language. Some of the indigenous languages—and this is the cultural thing—when the doctor explains, "We are going to take your appendix out, and it should be easy, very quick, easy procedure. You'll be out in an hour." Then we say that in Spanish to Tzotzil, and there is no word for *appendix*. How are you going to explain we're going to take something out when you don't have a word for it? We have to explain that this is something that they have, an explanation, and they are going to remove it, but it's a part of the bowel that we don't know what it's for, and nothing is going to happen if we take it out. But there is no word for *appendix* or no word for *organs* because the language doesn't have the word.

Languages that are masculine oriented, in English is neutral; in Spanish it's not. We can have a room with ninety-nine women and one male, and we would use the *adios* pronoun, plural, masculine, because there is no neutral. The nurse, in Spanish you have to say *la enfermera* if it's female, or *el enfermero* if it's male. In English we have nurses that are gender neutral. That doesn't work in Spanish. The language doesn't allow it. You have to say, "Is it okay if I say your name instead of *la* or *el enfermero*, or what do you want me to use, *la* or *el*?" They'll guide you.

They'll tell you. It's not that you're offending them, but the language…When you say, "Oh, my pronouns or he/she or his," well, that doesn't work in Spanish, and many other languages like Spanish that you have to identify male or female, masculine or feminine.

There are always challenges. But in COVID times, we have seen a significant…I don't want to call it unfair, but it is…we see a lot of Hispanic cases because they're exposed more.

Talk about that.

They are exposed more. They are frontline and kitchen, dishwasher, all the jobs that are technically lesser quality, less pay or…but they are extremely important, cleaning, housekeeping. We see a significant number of people that they got the virus from wiping down a toilet in a hotel room, and they don't want to say anything because if they say something, they're going to lose their job and be fourteen days out, and they have to bring food. When we tell patients, "You have to isolate in your home and find your own room," they don't have their own room.

What do you do? How do you advise them?

We tell them, "Try to be isolated and be on your own." They say, "I don't have my own room." "Okay, too bad." I don't know of any resources or anything that is being done for cases like that. It's not like other countries where they put you in a hotel, or they put you in a place that the government is paying for, and you do your fourteen days quarantining there. For example, if I were to go to Chile now, if I fly there, if I don't have a house or means for a hotel, they will put me up for two weeks, for fourteen days in a place with all expenses paid and food until I'm done with my quarantine, and then I go to my house or wherever I'm going. We don't have anything like that here. The hospitals' responsibility ends here; the rest is up to you. That's the reality that they infect everybody else.

It breaks your heart.

Yes. The rest of the family will be then in the hospital four or five days later.

Do most of the families, let's say the primary language that they're living with is Spanish, do they understand what COVID is? Has it changed, maybe, since March versus now?

Yes, now I think everybody understands. In the beginning, it was challenging because the news was in English. Most of the Hispanics that got exposed at the beginning, they were not watching news, or they were not paying attention. One of the aspects is that most of them come here and they don't mingle; they don't explore. They stay with a family, and then they go to work and come home, go to work and come home, or go with somebody to do landscaping or whatever, and they come home. They don't explore beyond, so they never leave their culture. For them, it's like being back in Guatemala or Mexico, whatever country, so they don't assimilate, and it's not because they don't want to, it's because they are scared; they are undocumented; whatever reason. That's safer. It is safer to be part of that group. Why would go out and explore anything else?

It's got to be frightening. You must run into a lot of frightened people.

And we do run into a lot of people that come to the hospital, and they say, "Why didn't you come earlier?" *Because I didn't have a ride. Because I was scared. Because I didn't know where to go. Because they told me that this is not free*. All sorts of…we hear everything.

Do you also deal with…I read something about you…do you also deal with victims of crimes or that type of thing?

Yes. As an interpreter, yes, we deal with…one of the toughest jobs as an interpreter for me has been when I go and interpret for (sane) cases, sexual assault, and those are tough. The questioning alone is tough, raw questions, and you can see that the patient is…sometimes hearing a male asking questions…sometimes we try to send a female, but we are down to a

skeleton crew, one interpreter per shift, and if I'm it, I cannot send a female interpreter. Those are tough.

We see people that don't have the resources to go and seek medical attention. Four months ago, we told them, "You have a spot in the lung, or the liver. Go and see a specialist." Three months later they come to the hospital, and the spot it bigger. "We told you to go see a specialist." *But I don't have the money. They charge three hundred and fifty-five dollars*. "Well, this is growing. This could be cancer." Three months later, they come with full-blown stage-four cancer. They don't have the means. We see the progression. We see patients that need dialysis, and they finally die because they don't qualify for a transplant; they cannot afford the medications. We can only see them under emergency Medicaid, and UMC is the only hospital that accepts emergency Medicaid because the other hospitals will just temporize the patient and say, "For further care, go to UMC." It's hard.

How do you take care of yourself?

Vicarious trauma, I do a presentation on vicarious trauma. To this point, I'm still not affected by what I see. I had an interpreter that after seven years—she was doing the night shift, and after seven years she comes to me and says, "Alvaro, I'm going to be gone in two weeks. This is my two weeks' notice." I said, "Why? You're excellent. What happened?" And she didn't tell me…I said, "That's okay." Then a week later, she comes and says, "You know, that nine-year-old patient that came with a degloving injury in trauma ICU? My daughter is nine, and I saw my daughter there. I'm done." I was like, "Yes." She had a nine-year-old daughter, so she saw her daughter in that patient, and that broke her. Seeing a degloving injury, it's just tough. This was a rollover ejection, so the girl went through and landed, so the legs opened up, and there was a fracture from the coccyx all the way to the back, and it was a degloving injury. It's like a glove,

when you put a glove on, you…so the skin was all peeled off, horrible, and that did it, and she said, "I'm gone. I'm not going to do this anymore."

I have not gotten to that point, but who knows? When we think we've seen it all, something more gruesome or horrible comes, and it's just tough for end of life.

During COVID we hear these stories—I've never personally experienced, fortunately—but with people being in the hospital and isolated and not being able to get visitors and all of that. That has to add a dimension to your work.

Correct, yes, because, "Oh, I can count in *Español*, okay, *bien*. Someone that speaks Spanish; that's great." They only call an interpreter when it's extremely necessary. We have to suit up to go into a COVID patient's room. It's not that they're going to call us for, is it hot; is it cold; you want another blanket; all those. They only call an interpreter when it's an update or something that is important, maybe once a day.

No TLC, no socialization for them.

No, no. Now UMC, I think starting this week, is allowing visitors with restrictions, but we are also seeing a spike in cases.

Do you worry about being exposed yourself, taking it home to your family?

No, no. We wear the masks and we take the precautions. I am probably going through a gallon of cream every…because we wash our hands so many times, it starts peeling off. For me, if it's going to happen, it's going to happen, but I really do take the precautions. If it's going to happen, it's going to happen.

Were your services needed on One October, during the shooting?

We had seven patients that spoke Spanish, and I got there the next morning because I was camping and I got a call from the night interpreter that she needed help. I was camping, so I got

no reception, and I got the message at six the next morning. We were all doing things that is not our job description, but who cares? Because people were coming in bloody, and it wasn't their blood. They thought that they had been shot and were frantic. It was bad even the next morning. What did you do? You were walking around randomly, or did they direct you to certain patients? That day we had a meeting, and then we went to do whatever was needed at the hospital at the time to take care of patients, from moving gurneys to bringing supplies. It's not that we're going to do clinical stuff, no. We're not going to be pushing IVs or anything like that. But stuff that we could do, communications and any ancillary jobs.

All hands on deck to help out.

Basically, yes.

We did a project on that, and I interviewed several of the doctors from UMC. It was eye-opening and fascinating. It was very emotional. It's tough. I admire what you do.

How do you the demand for interpreters growing?

Yes. I've been teaching at Berkeley for three classes, one semester, and we started with fourteen students, then twenty, then twenty-six. I had thirty-two for the class that was cancelled. We're probably going to move to Zoom although it's hard to do the delivery of a class of this nature, sixty hours, on Zoom. I said, "Well, we can take a break and see. But if nobody's going to open…" Some classes you can teach online, but some are hard especially when they're interruptive and somebody has a bad connection and all those other things.

The challenges of our era that we're in. It's interesting. Is there a correlation, would you say, with the change in attitudes in general about a bilingual country? Years ago, when I was young, the discussion would be, well, if you came from Mexico, you should go to school

in English. Then ESL came along and all of that. Is the growth in interpretation services part of the change in that country, do you think?

The growth in interpretation services is mostly driven by a legal framework because nobody wants to get sued over not providing an interpreter. That's one aspect. Then all the other checks and balances, all the other protections state that you should provide an interpreter if that patient is LEP, limited English proficient. Although Joint Commission is not a legal framework—you know what Joint Commission is?

No.

Joint Commission is the commission that oversees hospitals, and they will give you an A-grade, or they will ding you and you're not going to have X number of A's and you're going to be a B hospital, and nobody wants to be a B hospital. Hospital administrations, they are actually more concerned and worried about being dinged by Joint Commission than being legally compliant.

Joint Commission now has updated their regulations, and it says there that you should provide culturally and linguistically appropriate care, which is from HHS. HHS came with those principles. Joint Commission states how it should be implemented. Now that Joint Commission has that "dingable," if we were to create a word, oh, we've got to do something about it.

Interpreters is the same thing. Joint Commission states that you should provide a credentialled interpreter, not anybody. All the forms, if you have a population that you serve that speaks that language, all the forms and hospital's documents must be translated into that language. The law says that if the population of the state, of the area you serve is six percent or more, by law you have to have it in that language. That's why in the Bay Area, if you go to a hospital, they have the forms in fourteen or sixteen languages. Here, we have it in two, now three; Tagalog made the cut. We have English, Spanish, Tagalog, and I think Chinese is coming

with this next census. That's why there is this new interest from the administration. Well, if it says here the Joint Commission, we don't want to be against Joint Commission, and we don't want to be a B hospital, so that's why we've seen this new trend to implement interpreters and cultural competency. But, amazingly enough, here in Nevada, UMC is the only hospital that has staff interpreters.

Really? How do the others not have that?

The others, because they all belong to either the nuns or the health system, they say, "Well, we have a phone service." But in actuality, they're using whoever speaks Spanish. Until something goes wrong. Instead of *liver*, they'll say *kidney*, or something of that nature. People don't get it until they…because they don't want to spend. It's cheaper to get an interpreter than any lawsuit, but people don't see it like that.

When you were talking, before we started the recording, I was mentioning that for this project, we did thirtysomething Spanish language interviews, and the difficulty of transcribing and then trying to translate into English and all of that. Talk a little bit about what you tell people about language.

I am both; I am an interpreter and a translator. Translator is basically everything that is in writing. An interpreter is oral. You can interpret, and if you hear, for example, Spanglish, you can interpret that into English. But if you use Spanglish, which is not the standard, the norm, a person that has not been exposed to Spanglish, because Spanglish works if you are in both cultures, but let's say we have a patient from Peru or Bolivia that is visiting here, has not been exposed to Spanglish, that person will not necessarily, when he/she is going to read a form, will not necessarily understand the form in Spanglish. That's why not everybody should be translating stuff. Some organizations have required that the translator be certified. There are

several areas of certification. You can be a wonderful mechanical translator from engine parts, you can have an extensive knowledge of that, but would you be a good medical translator? Do you have enough medical terminology to do that? That's an ethical aspect. If you are not qualified…I wouldn't do a translation for diesel engines, for example, or boats or motorcycles or engine parts because I don't know anything about engine parts in my own language, much less in English. That's why when we talk about translations—and we have many translations, and I've seen many translations, and, yes, they are not necessarily good because people don't know that they are doing it wrong. We have people that ask me to translate it, and that's the best I could do, oh well.

You have me pondering now.

If you are translating anything official, my recommendation is that you go with a CT, a certified translation, or somebody that has a high degree of both languages, so knowledge in both languages, and can perfectly write in both languages.

Are there stories, unusual stories of episodes in your career that you'd like to share with me that would be fun?

I have many. As an interpreter, I have many stories. Language through the interpreter is when the family in particular, they know what's going on. You have many patients that go to surgery, and the nurse calls the interpreter and says, "Oh, we are ready to sign the consent." And then the interpreter goes to the patient and says, "Did the doctor come and explain to you the consent that you're signing?" *No*. We tell the nurse no. Then they say, "Well, what do you mean? The doctor was right here two hours ago." We ask the patient, but, "No, they didn't explain anything to me. The doctor came and said that I might be going to surgery, but there was nothing else." Sometimes when they use the phone, they document that the consent was obtained, informed

consent. Well, in a court of law that would not be informed consent. In Nevada, only a doctor can explain a consent, not the interpreter, not the nurse. It is through the interpreter that we find all those little details, and then the interpreter will say to the nurse, "I'm sorry I cannot sign the consent unless you call the doctor and the doctor explains to the patient in front of the interpreter all the consent and the risks and benefits and everything else." They say, "Oh, but I'm not going to call the doctor." Well, then we cannot sign the consent.

Many situations like that. Many sad situations. Many great situations. But it's through the interpreter that people realize, oh yes, we can communicate now, and that changes everything. That changes everything for the patient, for the provider. Frustrations are eliminated, not a hundred percent, but many can be reduced. People see, oh okay, why didn't I call the interpreter before?

I assume there's more demand for your services than you have hours in a day.

Correct. At UMC, we have significant. Then we have phone. We have tablet. Interpreters by phone, by tablet, and in person. Since we cannot be in ten places at the same time, we have to favor the ER calls, critical calls, and calls that cannot be done through the phone or a tablet. A simple admission, for example, you can use the phone. If I have an admission and I have an end-of-life and I have a trauma call, I'm going to go to trauma first, then end-of-life, and then the admission. Instead of the admission nurse waiting three hours for the interpreter, she or he can use the phone because it's a simple questionnaire, nothing extraordinary. But the trauma patient we cannot use the phone for. End of life is super hard to use the phone. End-of-life calls, hospice calls, end of life, those are tough, long calls, normally an hour, so you have to be mentally and physically prepared to stand for an hour, to talk for an hour, and to be strong because what is said and goes on there, it's hard. It's hard because most people don't understand. *But the patient is*

still breathing. Yes, the patient is breathing because the patient is connected to a machine, and we can have a patient connected forever. That's why you see the lungs puff up. *Oh. But the patient is warm*. Well, of course, because we have them hooked up to everything. But the moment we turn the machine off and disconnect, sometimes the patient dies almost immediately, and sometimes it takes a while.

A certain percentage of your job is compassionate therapist type of work.

Correct, yes, although the interpreter is present only if there is a provider and a patient. If a family member wants to be alone with a patient, there is no need for an interpreter. It has to be triatic.

In this age where more bilingual people are in our medical field, do sometimes bilingual nurses try to…?

Oh yes.

Can they skip your step?

They think that two weeks in Cancun makes them proficient. At UMC, we have implemented a system in which if you speak Spanish, or any other language for that matter, and you don't want to use an interpreter, you have to prove to us that you are proficient by sending us a pic of your diploma from any university or that you went to college in Algeria and that you speak Arabic, or you can request a proficiency assessment and I will go and test your Spanish. If you're a medical clinician, you will need a four on the international scale to be considered proficient at a professional level. But if you are an admin or somebody that doesn't need any clinical vocabulary or any medical terminology, you only need a three. We will test you, assess your proficiency, and document that you are proficient so that if something happens and they pull the thread and it says here that patient so-and-so and there is no interpreter, so who interpreted?

They go back to the record and say, “Nurse Maria Ortiz. Oh, but she was proficiency tested on 10/28/20, so she’s okay. That’s why there is no interpreter because the nurse was tested. We have the documentation that she’s proficient. All good.” If something happens and that’s not there, then lawsuits.

Have you had to deal with a lot of lawsuits? Have you worked on them?

I’ve been deposed to go to one, and I was there for nine hours talking to lawyers. It’s not that UMC was at fault. We have the system in place. The doctor didn’t want to use an interpreter and used somebody else that was there. Since the doctor is not our employee, it’s a different case. But it is for their protection. “I don’t want to call on the phone. Who speaks Spanish? You come here.” No offense to Maria from cleaning services, but Maria may not necessarily know medical terminology. But the doctor didn’t want to use a phone, didn’t want to wait four minutes for an interpreter, and that’s his problem.

You had to be trained in special medical terminology?

Oh yes, we have to have a minimum of one hundred hours, and we have to maintain our certification. We have to go to conferences and get CEUs and be proactive and keep accruing educational credits to maintain certification, and every four or five years we have to submit to renew your certification or license. That’s what a professional interpreter is.

What is the weirdest thing you have ever encountered?

Human bites. Everything. Human bites is an emergency, actually. Genitals severed. All sorts of things. Foreign objects in rectum. Foreign objects in many places. Then you see, well, humanity is a problem.

You are there for a specific linguistic…and then you’re exposed to all of this other.

Yes, yes. Sometimes we go for lumbar pain, and when the doctor is examining, the doctor notices that there is some hardware in places that normally shouldn't be anything, and the doctor starts asking other questions, and then it takes a whole different route. You always have to be prepared for the unexpected. As an interpreter, you are not going to ever say *oh my god*; you don't react.

You have to have a poker face.

You don't react. If you see things, oh well, that's what people are there for. You may know that they are lying, but you have to interpret what they are saying. We cannot change, edit, embellish or omit anything.

I just flashed on when—and you don't have to answer this—the episodes when the president has had his interpreter with him, and then that interpreter can't share anything that they've listened to because there is no written document and all of that. You really have to be a special personality, too.

Correct. Yes, we cannot share anything that is confidential, either. We cannot identify patients. When I teach and I use examples, they are generic. We have Patient X and Patient B. Maria Ortiz, there is no Maria Ortiz. But we cannot identify anything from a particular patient or doctor. That's confidential.

It's a special thing you do.

I think it is, yes. I love it and I am going to do it until…I'm thinking, also, of retiring in four years, but that's something else.

What would you do?

Exactly. That is the exact question from my wife. “Are you going to be home bothering me all the time? What? No.” But my twelve-year-old will graduate in six years, so maybe I’ll stay until he is out to college.

That’s great, though. Anything else you’d like to share with me about what you do?

No. Thank you. This is an interesting project. I think it was NPR or maybe some other news outlet that they were saying that 34 or 38 percent of frontline responders are Hispanic in this time of crisis, in COVID, and I’m a proud one of those because we are. After I go here, I go to lunch, and then I put my gear on, and then I’m a frontline worker for eight hours.

When you show up at work, you automatically know where you’re going to go?

Yes, we have a system at UMC, which they page us or call us. “I need you in X room. I need you in the ER. We have two patients coming in trauma. We have an end-of-life in Room 356.”

And it’s pretty busy all the time?

Some days are busy, some days are…you never know. You never know what you’re going to walk into, so you have to be prepared for everything. It’s fun. It’s always been fun.

One other thing I was going to ask you because if one of the students were here, they would definitely ask you this question. What do you think of the label *Latinx*?

It works wonderful in English, but in Spanish you will have to say *la Latinx* or *el Latinx* regardless because Spanish does not allow the neutral. I mainly just say *un* is the masculine *Latinx*, and if you are a female, you would say *una Latinx*. It works great in English because it’s language neutral, but in Spanish, unfortunately, the language does not have that neutrality, and it cannot be created because the word *table*, *mesa*, is feminine, and it will always be feminine, and you will have to use *la mesa*.

Not going to change those articles, are you?

Not going to change. Every object in Spanish has a gender. That's the unfortunate part. *Latinx* includes everyone, which is a wonderful cultural concept of the American culture. But some cultures, especially Hispanic, they don't want to include everyone, and that's a fight that has been there all the time. They say, well, Latin Americans and Hispanics are not racists. They are, but it's class. It's more of a class thing than race.

When you were growing up, you were learning English and Spanish simultaneously? How did you acquire your English skill?

Yes, at school. Then I would spend summers in England or in Europe. You can choose any language, but most people would pick English, and even today. Today I think the education in Chile has changed, and it was eliminated if you don't want to pick a language, but still people are trying to in private schools, trying to pick English over…Chinese is actually going up.

That's not surprising. Great. I thank you very much.

Thank you for this opportunity.

This was very enlightening. I really am sorry that one of the kids wasn't here.

[End of recorded interview]