

WHEN THE LAW MEETS MEDICINE



Translating Written English Texts into American Sign Language for Deaf and Hearing Interpreters

An Independent Study Guide

Worth up to 2.0 CEUs as an Independent Study for RID's CMP/ACET Program.

Using the DVD

WHEN THE LAW MEETS MEDICINE

This DVD and study guide were created by

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&

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for the

CATIE Center



THE COLLEGE OF
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*When the Law Meets Medicine:
Translating Written English Texts from ASL to English*
by Doug Bowen-Bailey and Trudy Suggs.

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Companion DVD information

This packet is designed to accompany the DVD *When the Law Meets Medicine*. If you do need this DVD, visit www.stkate.edu/catie for ordering information.

Earning CEUs through RID's CMP/ACET Program

To earn CEUs, you need to have an independent study plan accepted by a sponsor who deals with independent studies. To find a sponsor, visit: www.rid.org/cmppsp.html. There is a sample Independent Study Plan in Appendix B. You need to have a plan approved before you begin the independent study.



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Meet the Authors

Doug Bowen-Bailey



I live and work in Duluth, Minnesota on the shores of Lake Superior. Where I live means that it is impossible for me to specialize in a way that I could in a larger city. So, I end up wearing many hats. I am hearing and work as an interpreter. I also provide mentoring services and coordinate interpreter education opportunities for Northeast Minnesota. I also create video resources on CD-ROM and DVD. This grew out of my experience as a mentor where I saw the gaps in existing resources for professional development.

I feel fortunate to be involved in so many different aspects of the interpreting process. Both working as an interpreter, thinking about how to effectively guide other interpreters in their own professional development, and how to apply technology to assist in all of that. I am grateful for all the variety that continues to keep me excited about my work.

Trudy Suggs



Hello. I'm Trudy Suggs, from Faribault, Minnesota, where the Minnesota State Academy for the Deaf is. I've worked with interpreters since I was two years old and throughout my life, which translates to over 30 years of working with interpreters. I was mainstreamed in elementary school, attended, and also attended self-contained and mainstreamed classes in public schools. I went to Gallaudet University and graduated, then went back to working with interpreters in graduate school in Chicago. So, my experiences in working with interpreters have been quite diverse and comprehensive.

I'm also a Certified Deaf Interpreter (CDI), and often work with hearing interpreters. I've seen many different things, and the power and importance of collaboration in deaf-hearing interpreting teams. It's truly important in almost every situation. I was delighted to work on this project with Doug, because it's a great opportunity to provide increased training for deaf interpreters - especially nowadays, where there are such limited resources and very few training opportunities for deaf interpreters, unless we participate in workshops for hearing interpreters. So, this DVD is really a great opportunity - not only for deaf interpreters, but for hearing interpreters, too - to study native, first-language American Sign Language users like myself. I've really enjoyed working on this project. I hope you don't become overwhelmed or struggle with the text and jargon like I did; it was a challenge for me. Good luck with this project!



The Goal of this Project

Welcome to the study packet for the DVD, *When the Law Meets Medicine*, which is designed to assist interpreters in developing skills for translating English texts into ASL. A particular focus is English texts which have a combination of medical and legal language. The hope is that this DVD will help you develop skills to create accurate and clear translations for the deaf patients that you might be working with. (DBB)

A Brief Overview

I would like to briefly explain the history of this project. It started with another DVD created for Fairview Health Services. Fairview needed ASL translations of some of the admission documents they give to patients, like the *Patients' Bill of Rights* and *Notice of Privacy Practices*. They contacted me for assistance in this, and I contacted Trudy. We created this DVD with a review process and passed it along to Fairview. They were satisfied with the results, but I wasn't satisfied with just being done with it. It was a good resource for patients, but Trudy and I working together as a Deaf-hearing team was such an educational experience for us, that I thought it would be an opportunity for other interpreters to learn as well. So I asked Fairview if they would be willing to allow it to be used for interpreter education and they said they would. We then approached the College of St. Catherine and received support for it. We have worked almost a year since then developing this DVD which incorporates the texts and translations from Fairview as well as explanations of the approach to translation and a process for going about this work.

This independent study is designed so you have the option to earn CEUs from RID's Certificate Maintenance Program. I'd like to give you a brief description of how it is set up. It's based on the work of Vygotsky, an educational psychologist who studied how people learned, and concluded that there are three steps to the process.

The first is: *Working with Object*. In this step, the learners work with something to the point where they become frustrated or encounter a struggle. It is this frustration that motivates them to want to overcome it and prepares them to take the next step which is: *Working with Other*. The "other" can be a person or another resource like a DVD or book. Learners work with this "other" to find strategies for resolving whatever issues they encountered in working with the object. This makes them ready for the third step which is: *Working with Self* where they can work independently. The learners then work on their own until they encounter frustration or begin to struggle which puts them back in the first step of the learning cycle. So, the independent study format is really designed with those three steps in mind.

All of the original sources for this study packet were actually first produced as video for the DVD version and then translated into written English.

This design is intended to provide for multiple ways to access the information in order to facilitate professional development for both Deaf and hearing interpreters.

At the end of each segment, there are initials to show who was the primary author. It is clear who is signing on the DVD, but not so clear in written form.

*DBB - Doug
TS - Trudy*



One last thing: Trudy will next describe her approach to translation just as I have described the way this independent study is designed. However, the goal of this project is for you to develop skills in translating English texts into ASL and for making your interpretations clear. Don't feel the need to follow what Trudy or I suggest if another way will work more effectively for you. The point is really to improve the services that we deliver as interpreters to the people with whom we work. (DBB)

Explaining Our Translation Process

I'd like to explain how the process worked for translating from the original text to the DVD, how I approached this and what my process was. However, my approach and style may be different from yours, and that's perfectly fine. Each interpreter has an individual approach to translation. I'll explain my approach and how I did it, though.

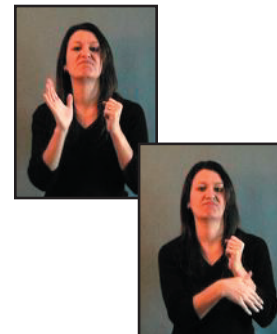
When I got the text from Fairview, I read through it and was daunted by the legal and medical jargon. I didn't quite understand all the jargon, and was a bit apprehensive about the work. As I read through the text, I thought in English rather than ASL. For the words and concepts I wasn't too sure, I made notes and asked Doug, who worked with me, about them. There were some he didn't know, either. Neither of us are lawyers or doctors, after all. For the parts we both couldn't decipher, we contacted the Fairview team who developed the text, and asked for clarification. I wanted to make sure I translated the text correctly. After that, I went back to the original text, and informally translated the text into ASL in my head.

Next, I had to visualize who the viewers of this DVD would be. Fairview facilities are frequented by different people who have diverse cultures, languages and experiences. For example, the deaf patient may not sign and prefer to speak, or maybe the deaf patient signs only, or maybe the deaf person only knows some signs and gestures but isn't fluent – or has additional disabilities hindering ASL fluency. How could we meet all those different needs? Doug and I had a good discussion, and came to the agreement that the ASL translations couldn't possibly be accessible to all individuals, so we decided I would sign for the general public, then those who didn't understand sign could watch captioning. People who are fluent in ASL can use this DVD, and then for those who aren't necessarily fluent in ASL, such as immigrants, or who may need some type of language facilitation, a deaf interpreter, language expert or language facilitator could be brought in. That Deaf Interpreter should be certified and have the necessary training and knowledge for such a situation. So we agreed that a CDI or language facilitator could be present when watching the DVD, and pause the film to facilitate the language or interpret. So those were the options we agreed upon. Besides, the hospital is still responsible for accommodations. That's how we decided who to translate the text for.



The next thing I had to consider was how I could sign all the text. There was no way I could have memorized the text; I'm not quite that adept! I created my own translations to be used with a teleprompter. The translations were written in a manner that most people, even Doug, wouldn't have understood – but that I could understand. For example, when I wanted to use this sign shown at right, I wrote SWAT. Had someone seen that word, s/he would have thought I meant “to swat a fly.” The translations had different words like that, understood only by me. I then gave the translations to Doug, who put it on a teleprompter using a computer located underneath the camera for me to look at.

SWAT



When we taped, a noteworthy thing happened: I found that as I signed, sometimes what I had written didn't feel or translate right. I didn't always follow the script of my translation word-for-word; rather, I expanded upon the information when I felt it was appropriate. Word-for-word translation between ASL and English just can't be done. They're two different languages!

An example of Teleprompter Script for the First Section of The Minnesota Patients' Bill of Rights

LEGISLATIVE INTENT

LEGISLATURE, NARRATE, PURPOSE WHAT? ENCOURAGE KNOWLEDGE/INTEREST, HEALTH OF PATIENTS ANY HEALTH CARE PLACE. HEALTH CARE PLACE LIKE HOSPITAL, DOCTOR, ETC., CAN TELL U THAT RIGHT WAIVE, (SWAT), THEN U CAN ENTER? NO. IF YOU HAVE GUARDIAN OR SOMEONE TAKE CARE OF YOU, OR SOMEONE ELSE, THAT RIGHTS LOST, CAN MAKE SURE PLACE ALLOW GIVE U HAVE RIGHT. ALSO CAN IF FEEL RIGHTS NOT GIVE, CAN THRU (ADMINISTRATIVE AGENCIES) OR COURT RELATE THAT THERE WITH GUARDIAN. IF FIND PROBLEM, TRUE BIZ, THEN INVESTIGATE PROCESS, THAT PLACE CAN TRUST, FOLLOW CARETAKER THEIR DECIDE. THIS PART PURPOSE WHAT – ALL PATIENTS HAVE RIGHTS FREE CIVIL, RELIGIOUS, CAN RIGHT MYSELF DECIDE, KNOW CHOICE HAVE WHAT, CAN'T HOSPITAL OR PLACE NO ME CAN'T. ALSO THAT PLACE SHOULD HELP SUPPORT HELP U DECIDE, RIGHTS.

That brings up another obstacle I encountered. When I work in a real-life situation as a CDI, I rely heavily on consumer feedback, making sure the consumer understands me or making sure the information I sign is clear. But here, there was no feedback from consumers, since I was signing to a camera. So keep that in mind when you work on this DVD or with consumers.

You'd think that by this point, I'd be done with the translation work – not quite! When the filming was done, I still had to translate from the ASL translations into English subtitles, for people who don't sign. We couldn't follow the text-on-paper version, because remember, I sometimes expanded upon concepts – so had



we followed the text exactly, it'd be different from what I signed. I typed out the subtitles of my translations, and gave it to Doug, who then put the subtitles on the DVD. And that's where another situation emerged: we found that we didn't agree on some of the wording for the English subtitles.

Doug is hearing, and I'm deaf. He felt that some of the sentences were "too deaf," he was actually right. I grew up Deaf in a Deaf family, so my cultural identity is as a Deaf person, and my first language is ASL. Doug is hearing, but he's involved in both cultures and is as bilingual as I am. Still, he thinks like a hearing person, and I think like a Deaf person. So when he pointed out that he felt some of my sentences were "too deaf." I realized he was right. The grammar itself was fine, but as a whole, it had strong cultural connotations. Sometimes I agreed with his views, but at other times I didn't. And it was like that for him, too – he was sometimes "too hearing." It was a really fascinating process to see how culture, identity and language influenced our choices.

We worked through these differing views easily to agree upon the grammar or word choices to use. It all worked out to what you see now.

So, for me, my process includes, first, understanding the information and its purpose. Don't assume you know the meaning or purpose – check with the people who developed the text. Next, understand who your audience is or who you're working with, and make sure you have the right audience in mind as you sign the translations. Also, make sure your translations are accurate and clear, working with your team. Finally, create a supportive environment with your team where everyone works together. The goal is to get the best, most accurate message across, and you do that by working together as a team. This process was a really complicated process, and it didn't happen overnight.

Overall, the whole process, starting with getting the text from Fairview, going through the filming, and ultimately creating this packet for you, was a fantastic experience for all parties involved. (TS)

Additional Translation Resources

The following are resources to consider as you develop your own process of translation that will work for you.

Boudreault, Patrick (2005). Deaf interpreters. In Terry Janzen (Ed.) *Topics in Signed Language Interpreting* (p. 323-355). Amsterdam and Philadelphia: John Benjamins Publishing Company.

Collins, Judith M. and John Walker (2005). What is a Deaf Interpreter? In Rachel Locker McKee (Ed.) *Proceedings of the Inaugural Conference of the World Association of Sign Language Interpreters (WASLI)* (p. 79-90). Trowbridge, UK: Douglas McLean Publishing.



Gile, Daniel (1995). *Basic Concepts and Models for Interpreter and Translator Training*. Amsterdam and Philadelphia: John Benjamins Publishing Company.

Kiraly, Don (2000). *A Social Constructivist Approach to Translator Education*. Manchester, UK: St. Jerome Publishing.

Nida, Eugene & Charles R. Taber (2003). *The Theory and Practice of Translation* (4th ed.). Leiden and Boston: Brill.

Explaining Our Review Processes

I want to explain about how these DVDs were reviewed. Note that there were two separate processes. One was for the DVD produced for Fairview that had the actual texts and translations. The other was for this DVD produced for interpreter skill development.

For the Fairview review process, we had three initial reviewers. One was a Deaf woman who was experienced with medical settings having worked as patient advocate. The next was a late-deafened man who knew some signs, but relied more on captioning and so was able to check the accessibility of the English subtitling. The third was an interpreter who was experienced in medical settings and would have full access to both the spoken English and the ASL translations.

The reviewers were all given a draft of the DVD, the original English texts, and a form which had a place for them to comment on each segment of the text. An example is given here which shows they had the choice of marking something as *Acceptable*, *Adequate*, or *Unacceptable*. *Acceptable* meant no reason not to proceed. *Adequate* meant that there were things that could be improved, but the problem could also be lived with. *Unacceptable* meant that the project couldn't go forward without it being fixed.

Example of Review Sheet

<p>Fairview Health Services Welcome Materials Review Process</p>		
<p>ASL TRANSLATIONS</p>		
<p>Notice to Patients</p>		
<p><input type="checkbox"/> Acceptable</p>	<p><input type="checkbox"/> Adequate (but could be improved)</p>	<p><input type="checkbox"/> Unacceptable (Needs to be fixed)</p>
<p>Comments/Suggestions:</p>		



Most of the feedback was that things were acceptable. A few segments were just adequate, and none of what the feedback we received suggested that we needed to re-film. We did bring the comments about what could be improved to Fairview. One particularly common comments was on the original backdrop used for filming. Visually, the blue and white backdrop was too distracting. This made the DVD unusable for DeafBlind individuals. This feedback gave added weight to Trudy's and my feeling that this DVD could not be for everyone, and that sometimes to make sure the information was clear, Fairview would need to provide a language facilitator or CDI, as Trudy suggested before. So, the review process was really helpful in giving us more strength in making suggestions to Fairview for future practices as well.

For the review process for this DVD, *When the Law Meets Medicine*, we had a different process in place. We asked several Deaf interpreters, as well as one hearing interpreter, to check the DVD to make sure that the process made sense and the signing was clear. We received the same feedback about the visually distracting background as we did in the Fairview process. I hope on those texts that you watch them in shorter segments so that you don't end up with a headache and that you are able to get through the imperfections to find the benefit that is there.

We also received feedback on the approach to translation. Trudy talked about how we worked together as a Deaf-hearing team and then collaborated with the staff of Fairview Health Services. There are other models such as a Deaf-Deaf team where there is a Deaf person who does the translation in discussion and review with another Deaf person. A future project may be to try to model how this can be an effective approach. (You can also check the additional resources on translation listed on page 8-9.)

Overall, the reviews showed that we could move forward with these projects. We know that they are not perfect, but we didn't have the time and resources to make all the necessary revisions to bring them to perfection. However, the review did show that this DVD help to meet the goal of supporting interpreter skill development just as the Fairview DVD helped to improve patient access.

In doing that, the review process for both projects were very important, both in improving the quality and in deepening our understanding of effective translation practices. (DBB)



The First Text: Notice to Patients

With this background, it is now time for you to start your own work on translating these texts. The first text is the *Notice to Patients* which discusses Fairview's commitment to provide access to all of its patients. This is the shortest of the documents – only one page – but you do not have to work on it in its entirety.

The text is on the following page. It is separated into three sections, so if you choose, you can go through this process working on only one section at a time. That may be helpful for you to find out what works best for your own learning style without taking on too much of the text.

Notice to Patients: Translation in Sections

Section 1: Lines 3-8

Section 2: Lines 10-27

Section 3: Lines 30-32

Working with Object

At this point, you should begin your translation process – reading the text and deciding how you would translate it into ASL. It is vital that you do not skip this step in order to watch Trudy right away. Creating your own translation first will help you observe Trudy's work with increased focus.



Also, it is helpful to videotape your own translation so you can go back and look at it, instead of working from memory about what you think you did. Videotaping your own work is crucial to this process and will be very helpful as you compare and evaluate your own professional growth.

Following the text is a form for analysis. Watch your first translation on video and write down the parts that you noted as clear and the ones you struggled with. This analysis will help you to observe Trudy's translations more carefully to see how she managed those passages. (DBB)

Step 1:

Working with Object

Translate Notice to Patients (p. 12) into ASL

Step 2:

Working with Other

Watch Trudy's translations and reflections

Step 3:

Working with Self

Translate Notice to Patients one more time



1 **Notice to patients**

2
3 It is Fairview Health Services' policy to provide equal opportunities for deaf and hard
4 of hearing patients to benefit from health care services available at the hospital and its
5 associated facilities. This is to include family/responsible party of a minor. The services
6 of a qualified sign language interpreter and/or other auxiliary aids (TTY's, Pocket
7 Talkers, Phone Amplifiers and Phone Signalers) will be provided at no cost to the
8 patient/family/responsible party.

9
10 Those situations in which the presence of a qualified sign language interpreter is
11 important to ensure thorough and accurate communication to include, but are not
12 limited to, explaining:

- 13 • The hospital's intake or admission procedure, and obtaining the patient's medical
14 history;
- 15 • The patient's diagnosis, treatment program or schedule, care conferences, social
16 service or spiritual counseling, and obtaining informed consent or permission for
17 treatment.
- 18 • The patient's prognosis during hospitalization, including when conveying or
19 asking information about medical procedures, medications prescribed, and
20 possible side effects; Changes in the treatment program and the need for
21 continued or future hospitalization; Discussions on legal and financial obligation;
22 Discharge planning; and participation in Health education programs.
- 23 • Upon request of patient or family member for addressing and answering
24 questions and/or concerns that patient/family may have about their care at
25 Fairview.
26
27

28
29
30 Fairview Health Services strongly encourages the feedback of our Deaf and Hard-of-
31 Hearing patients. Please complete the feedback form included in the Welcome Packet,
32 and return it to us before your discharge or mail it to the address on the form.

A Vygotskyan Framework for Observation: Notice to Patients

Working with Object: Challenge from Original Translation	Working with Other: Observation of Trudy's Translations	Working with Self: Insight for Future Application

This framework is driven by your first translation of the text. What you identify as challenges from your own translation should guide what to look for in Trudy's translations.



Step 2: Working with Other

Now that you have gone through the first step and analyzed your own translation, you are ready to watch Trudy's translation. Continue using the analysis form to note how Trudy handled sections you noted as difficult or areas of concern. You can use the "Translation in Sections" option if you chose to work with only one section at a time.

After you watch Trudy, go back to the *Notice to Patients* page on the DVD that has her reflections. Watch what she has to say about her work. (They are also included here in written English.) (DBB)

Trudy's Reflections on "Notice to Patients"

In these reflections, I will discuss some of the terms and concepts I had difficulty with. First, I'll discuss the *Notice to Patients* text. The text with this study packet has each line numbered, so if I refer to text on a particular line, you can find it easily by number rather than having to search through the entire text.

Health: Version 1



The first word I found to be an obstacle was *health*. I always signed it as shown in Version 1 at left. However, an ASL teacher told me that the sign I used might not be the best choice. She suggested that it would be better to use Version 2 (shown at left), because the first version implies recovering, while the second sign is more general and refers to the body. It also could mean going to the doctor for a check-up or things of that nature – but not necessarily recovering as the first sign indicates. That was a new line of thinking for me. I actually used both signs in the video; it may not be such a major deal, but overall, the signs do hold different meanings. When I recognized the different meaning of both signs, I realized that I could have used the latter sign instead. Even if I've used ASL as my first language for all of my life, I continue to learn from other people about what the appropriate signs are to this day.

Health: Version 2



Another word that I struggled with – and I actually had to think about this word a bit – was the word *facilities*. Fairview itself is actually made up of many buildings and facilities. I had to decide if I really wanted to sign different words like "hospital and buildings" every time I signed this concept, or if I should fingerspell the word. Or should I have signed *building*? However, a facility doesn't always mean it's a building; it may be there is a clinic inside a building that isn't affiliated with Fairview, but just happens to have the clinic there. Or it may refer to a meeting like Alcoholics Anonymous, which is a program, but not necessarily a building. I decided to expand upon the word each time I signed, by saying "doctors, hospitals, different buildings." You will see me repeating that string of words each time the word *facilities* appears. That may be somewhat cumbersome and time-consuming, but conveys a better translation.

Lines 9-12 or 13 are a good example of how Fairview's language, or rather, its legal jargon, is quite vague. In fact, the text is very complicated and includes a



lot of jargon. When I looked at that part, I wondered, “How do I sign this?” After I thought about it, I decided to come at it a certain way. Here’s an example of a sentence that says, “...ensure thorough and accurate communication to include, but are not limited to, explaining...” For that specific part, I didn’t worry about signing every word. What I did instead was signed, “I will list...” It’s important to note how I used the word “I.” The text here is written in the third person, but here, I made the translations in the first person because when signing in ASL, it’s important to establish a cultural and linguistic link with the viewer, I said, “I will explain those,” and then I ticked them off using my fingers. This is key. Oftentimes, hearing interpreters will list things without delineating it in a spatial sense. That’s a significant gap in ASL. Using my fingers to list items, so that the consumer or deaf person will be able to visualize what’s to come and how much will be coming, is a spatial and important linguistic element of ASL.

The next thing is “at no charge.” This is a minor example, but some people will say that word-for-word. I said “cost-none” – the reason I mention that is because of the conceptual meaning. I’m signing as if I’m holding a casual conversation, rather than formal interpreting for this situation; those little things make for better translations. The *Notice to Patients* wasn’t a major struggle, given its simplicity, but the next one is more challenging! (TS)

Shadowing the Translation

Before moving on to the next step, try copy-signing while you watch Trudy’s work again. Shadowing a signer can be an excellent way to begin to incorporate new ideas into your own work.

Step 3: Working with Self

Now that you have had the opportunity to view Trudy’s work and her reflections, return to the text and develop a revised translation. Using the analysis form, you may want to write down new ideas that emerged in this process for incorporation into your next translation.

Videotape your new translation and compare it to your original translation to see your areas of professional growth. (DBB)



The Second Text: Advance Health Care Directives

Now that you have worked through this process with one text, you are ready to move on to the next text, *Advance Health Care Directives*.

Working with Object

The first step in the process is to translate the written text into ASL as best you can. The text is on pages 17 and 18. Remember that you can do it in sections if desired.

Step 1:

Working with Object

Translate Advance Health Care Directives (p. 17-18) into ASL

Step 2:

Working with Other

Watch Trudy's translations and reflections

Step 3:

Working with Self

Translate Advance Health Care Directives one more time

Advance Health Care Directives: Translation in Sections

Page 17

Definitions: Lines 16-21 (Recommended Order: See Trudy's reflections)

Introduction: Lines 2-14

Health Care Directive: Lines 23-27

Living Will: Lines 29-33

Page 18

Durable Power of Attorney for Health Care: Lines 1-7

Mental Health Advance Directive: Lines 9-14

Following the text is a form for analysis. Watch your first translation on video. Write down the parts that you noted as clear and ones you struggled with. This analysis will help you to watch Trudy's translations more carefully to see how she managed those passages.

Advance Health Care Directives

Fairview will comply with state and federal laws to assure patient rights regarding health care decision-making. Fairview will honor the advance health care directive to the fullest extent possible, consistent with reasonable medical practice, availability of treatments requested and applicable law. Fairview will not discriminate against, nor require any conditions for care, based on whether or not the patient has chosen to execute an advance health care directive.

Patients may revoke their advance health care directive in part or in whole at any time and in any manner. This right is not extended to a proxy decision-maker. Any staff member who receives a revocation will inform the patient's primary care physician immediately and document the revocation in the medical record. Note: As a general rule, a mental health advance directive cannot be revoked during a period of acute mental health crisis.

Fairview will provide ongoing staff and community education programs about advance directives and related issues and maintain a record of such programs.

Definitions:

"Advance Health Care Directives" are written instructions recognized under state law relating to the provision of health care when adult individuals are unable to communicate their wishes regarding medical treatment. For the purposes of this policy, advance health care directive refers to the health care directive, living will, durable power of attorney for health care, or mental health advance directive.

Forms of Advance Health Care Directives:

1. Health Care Directive - Effective August 1, 1998, Minnesota law combined the living will and durable power of attorney for health care into one form called the health care directive. A health care directive is a form of authorization given in advance by any capable adult, regarding the kinds of health care the person would or would not want, if for any reason, the person was unable to, or chose not to, communicate for himself. In it, the person may name an agent(s), communicate specific health care decisions, or do both.

2. Living Will - Prior to August 1, 1998, any competent adult could write a living will stating what the person's health care preferences were in the event the person became terminally ill and unable to make informed health care decisions. The living will may also include the designation of a proxy to make health care decisions on behalf of the person. Current Minnesota law continues to recognize living wills that were completed prior to August 1, 1998.

Advanced Health Care Directives (cont.)

1 **3.** Durable Power of Attorney for Health Care - Prior to August 1, 1998, any competent adult could
2 complete a durable power of attorney for health care to designate an agent to make health care decisions
3 for the person, in the event the person is unable, in the judgment of the attending physician, to make or
4 communicate health care decisions. The durable power of attorney for health care may also include a
5 statement of health care preferences and special instructions for limitations to the agent. Current Minnesota
6 law continues to recognize durable power of attorney for health care forms that were completed prior to
7 August 1, 1998.

8
9 **4.** Mental Health Advance Directive - Any competent adult may write a mental health advance directive
10 which states that the person's mental health care preferences are regarding electroshock therapy and
11 neuroleptic medication (intrusive mental health treatments) in the event the person is admitted or committed
12 to a treatment facility. The mental health advance directive may also include the designation of a proxy
13 to make decisions about intrusive mental health treatments. This information may also be included in an
14 advance directive.

A Vygotskyan Framework for Observation: Advance Health Care Directives

Working with Object: Challenge from Original Translation	Working with Other: Observation of Trudy's Translations	Working with Self: Insight for Future Application

This framework is driven by your first translation of the text. What you identify as challenges from your own translation should guide what to look for in Trudy's translations.



Step 2: Working with Other

Now that you have gone through the first step and analyzed your own translation, you are ready to watch Trudy's translation. Continue using the analysis form to note how Trudy handled sections you noted as difficult or areas of concern. You can use the "Translation in Sections" option if you chose to work with only one section at a time.

After you watch Trudy, go back to the *Advance Health Care Directives* page on the DVD that has Trudy's reflections. Watch what she has to say about her work. (They are also included here in written English.)

Trudy's Reflections on "Advance Health Care Directives"

Now we'll discuss AHCD, or *Advance Health Care Directives*. This part was interesting because the English language tends to be ambiguous until the point is made at the end of a sentence or statement. In ASL, you generally make the point first, then expand upon each point. In this situation, if you look at lines 16-20, you will see that it first explains Fairview's viewpoint, then defines what AHCD is, then gives more information on these things. I looked at that and determined, after I discussed this with Doug, that it'd be better to explain what AHCD was right away, so that people who watch this DVD would know immediately what we're discussing, rather than being turned off by the policy and technical language. If viewers can initially understand what AHCD is, what the policy is, and what it does, then they'd understand the rest of the translations. That's why we've transposed the text and explained the AHCD part first.

That text was challenging and there were several words that I had to really envision the meaning of, what the underlying goals were, and understand before I could translate them appropriately. I'll share a few examples, although I won't list all of the instances because I want you to analyze the text on your own. Some of the words may be easy to you, and others may be not that hard for me but difficult for you. It all really depends on individual language skills. I will give just a few examples. First up is *terminally ill*, in line 30. When I came across that, I immediately knew I'd sign "will die" (note facial expression). Hearing people, or rather English speakers, again, are often ambiguous, since they typically prefer to not be so direct. They tend to be indirect when sharing information like this, while in ASL it would be stated in specific terms. It's not necessarily being blunt; I think it's more of a language-specific nuance to conjure up the visualized meaning. I could have signed vaguely, "the person will die." (Example 1). Rather, I signed, "will die." (Example 2) *Terminally* indicates that it's a given that the person will pass away. However, I, of course, encourage using sensitivity through facial expressions when saying things like that.

Another word I had to think about how to sign was *proxy*. That's a word not often used in English anyway – and when it is, it often refers to voting – but for this situation, I had to think about what it really meant. I knew it meant asking or

Example 1: Ambiguous Expression



Example 2: Direct Expression



appointing someone else to take my place for me. As a result, I signed it on the DVD by showing that a person was brought in to take the place of someone else.

Another example was *competent adult*. I had to once again try to figure out what this meant. In different situations, it means different things. So I visualized that, in this situation, it meant someone who could make decisions for himself. I decided that it meant a person's mental state is okay, and he or she understands the proceedings, so that's how I signed it. Still excerpts of the first part of this description are shown on the right. You'll see that I use this expansion upon the term's meaning time after time on this DVD.

Again, these are just a few examples. See what words give you difficulty, think about their intended meanings, and maybe even make a list of those words. The list will continue to be useful to you, making you aware of the words you struggle with.

Shadowing the Translation

Before moving on to the next step, try copy-signing while you watch Trudy's work again. Shadowing a signer can be an excellent way to begin to incorporate new ideas into your own work.

Step 3: Working with Self

Now that you have had the opportunity to view Trudy's work and her reflections, return to the text and develop a revised translation. Using the analysis form, you may want to write down new ideas that emerged in this process for incorporation into your next translation.



Videotape your new translation and compare it to your original translation to see your areas of professional growth.

Mental Competency





The Third Text: Minnesota Patients' Bill of Rights

The *Minnesota Patients' Bill of Rights* is the most complex of the four texts. We contemplated having it come last, but in terms of the actual filming process for the Fairview DVD, we worked on the *Notice of Privacy Practices* last. Trudy's reflections were created in this order, so we decided to keep it the same for this project. You may, however, decide that you'd prefer to work with the *Notice of Privacy Practices* before you spend too much time on this text.

Working with Long Texts

Spend some time skimming through the entire Bill of Rights. Choose sections that you feel fit with your own specific professional development goals.

Do NOT feel that you have to work with all of the sections or in the order that they are in the text. The Translation in Sections option of the DVD lets you work with whatever portion you choose to.

Working with Object

The first step in the process is to translate the written text into ASL as best you can. The text is on pages 24-29. This text is definitely too long to do other than in sections. So, take portions of it and translate it. The sections are defined below.

Minnesota Patients' Bill of Rights: Translation in Sections

Page 24

Legislative Intent: Lines 1-10

Definition: Lines 12-17

Public Policy Declaration: Lines 19-21

1. Information about Rights: Lines 23-34

2. Courteous Treatment: Lines 36-38

Page 25

3. Appropriate Health Care: Lines 1-3

4. Physician's Identity: Lines 5-9

5. Relationship with Other Health Services: Lines 11-15

6. Information about Treatment: Lines 17 - 27

7. Participation in Planning Treatment: Lines 29 - 39; p. 26: Lines 1-24

Page 26

8. Continuity of Care: Lines 26-28

9. Right to Refuse Care: Lines 30-34

10. Experimental Research: Lines 36-38

Page 27

11. Freedom from Maltreatment: Lines 1-7

12. Treatment Privacy: Lines 9-13

13. Confidentiality of Records: Lines 15-19

14. Disclosure of Services Available: Lines 21-25

15. Responsive Service: Lines 27-28

16. Personal Privacy: Lines 30-32

17. Grievances: Lines 34-39, p. 24: Lines 1-9

Translation in Sections (continued)

Page 28

- 18. *Communication Privacy: Lines 11-20*
- 19. *Personal Property: Lines 22-26*
- 20. *Services for the Facility: Lines 28-30*
- 21. *Protection and Advocacy Services: Lines 32-36*
- 22. *Right to Communication Disclosure and Right to Associate:
Lines 38-39; p. 29, lines 1-4*

Page 29

- 23. *Isolation and Restraints: Lines 10-15*
- 24. *Treatment Plan: Lines 17-22*

Analysis Form

Two copies of the analysis form follow the text. Because of the length of this text, you may need several forms. You can create your own tables or print out more copies of the ones included.



Be sure to videotape your translation and then review it. Write down the parts that you noted as clear and ones you struggled with. This analysis will help you to watch Trudy's translations more carefully to see how she managed those passages.

Minnesota Patients' Bill of Rights

1 **Legislative Intent**

2 It is the intent of the Legislature and the purpose of this statement to promote the interests and wellbeing of the patients of
3 health care facilities. No health care facility may require a patient to waive these rights as a condition of admission to the
4 facility. Any guardian or conservator of a patient or, in the absence of a guardian or conservator, an interested person, may
5 seek enforcement of these rights on behalf of a patient. An interested person may also seek enforcement of these rights on
6 behalf of a patient who has a guardian or conservator through administrative agencies or in probate court or county court
7 having jurisdiction over guardianships and conservatorships. Pending the outcome of an enforcement proceeding the health
8 care facility may, in good faith, comply with the instructions of a guardian or conservator. It is the intent of this section that
9 every patient's civil and religious liberties, including the right to independent personal decisions and knowledge of available
10 choices, shall not be infringed and that the facility shall encourage and assist in the fullest possible exercise of these rights.
11

12 **Definitions**

13 For the purposes of this statement, "patient" means a person who is admitted to an acute care inpatient facility for a continuous
14 period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of that person.
15 "Patient" also means a minor who is admitted to a residential program as defined in Section 7, Laws of Minnesota 1986,
16 Chapter 326. For purposes of this statement, "patient" also means any person who is receiving mental health treatment on
17 an outpatient basis or in a community support program or other community-based program.
18

19 **Public Policy Declaration**

20 It is declared to be the public policy of this state that the interests of each patient be protected by a declaration of a patient's
21 bill of rights which shall include but not be limited to the rights specified in this statement.
22

23 **1. Information About Rights**

24 Patients shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout
25 their course of treatment and maintenance in the community and that these are described in an accompanying written statement
26 of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as
27 defined in Section 7, the written statement shall also describe the right of a person 16 years old or older to request release as
28 provided in Section 253B.04, Subdivision 2, and shall list the names and telephone numbers of individuals and organizations
29 that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made
30 for those with communication impairments, and those who speak a language other than English. Current facilities policies,
31 inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be
32 available to patients, their guardians or their chosen representatives upon reasonable request to the administrator or other
33 designated staff person, consistent with chapter 13, the Data Practices Act, and Section 626.557, relating to vulnerable
34 adults.
35

36 **2. Courteous Treatment**

37 Patients have the right to be treated with courtesy and respect for their individuality by employees of or persons providing
38 service in a health care facility.

1 3. Appropriate Health Care

2 Patients shall have the right to appropriate medical and personal care based on individual needs. This right is limited where
3 the service is not reimbursable by public or private resources.

4

5 4. Physician's Identity

6 Patients shall have or be given, in writing, the name, business address, telephone number, and specialty, of any, of the
7 physician responsible for coordination of their care. In cases where it is medically inadvisable, as documented by the attending
8 physician in a patient's care record, the information shall be given to the patient's guardian or other person designated by the
9 patient as his or her representative.

10

11 5. Relationship With Other Health Services

12 Patients who receive services from an outside provider are entitled, upon request, to be told the identity of the provider.
13 Information shall include the name of the outside provider, the address, and a description of the service which may be
14 rendered. In cases where it is medically inadvisable, as documented by the attending physician in a patient's care record, the
15 information shall be given to the patient's guardian or other person designated by the patient as his or her representative.

16

17 6. Information about Treatment

18 Patients shall be given by their physicians complete and current information concerning their diagnosis, treatment,
19 alternatives, risks and prognosis as required by the physician's legal duty to disclose. This information shall be in terms
20 and language the patients can reasonably be expected to understand. Patients may be accompanied by a family member or
21 other chosen representative. This information shall include the likely medical or major psychological results of the treatment
22 and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician in a patient's
23 medical record, the information shall be given to the patient's guardian or other person designated by the patient as his or
24 her representative. Individuals have the right to refuse this information. Every patient suffering from any form of breast
25 cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of
26 treatment of which the treating physician is knowledgeable, including surgical, radiological, or chemotherapeutic treatments
27 or combinations of treatments and the risks associated with each of those methods.

28

29 7. Participation in Planning Treatment

30 Notification of Family Members:

31 (a) Patients shall have the right to participate in the planning of their health care. This right includes the opportunity to
32 discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal
33 care conferences, and the right to include a family member or other chosen representative. In the event that the
34 patient cannot be present, a family member or other representative chosen by the patient may be included in such
35 conferences.

36 (b) If a patient who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make
37 reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing
38 by the patient as the person to contact in an emergency that the patient has been admitted to the facility. The facility
39 shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe

1 the patient has an effective advance directive to the contrary or knows the patient has specified in writing that they
2 do not want a family member included in treatment planning. After notifying a family member but prior to allowing
3 a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with
4 reasonable medical practice, to determine if the patient has executed an advance directive relative to the patient's
5 health care decisions. For purposes of this paragraph, "reasonable efforts" include:

- 6 (1) examining the personal effects of the patient;
- 7 (2) examining the medical records of the patient in the possession of the facility;
- 8 (3) inquiring of any emergency contact or family member contacted whether the patient has executed an advance directive
9 and whether the patient has a physician to whom the patient normally goes for care; and
- 10 (4) inquiring of the physician to whom the patient normally goes for care, if known, whether the patient has executed an
11 advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to
12 participate in treatment planning in accordance with this paragraph, the facility is not liable to the patient for damages on
13 the grounds that the notification of the family member or emergency contact or the participation of the family member was
14 improper or violated the patient's privacy rights.

15 (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to
16 identify family members or a designated emergency contact by examining the personal effects of the patient and the medical
17 records of the patient in the possession of the facility. If the facility is unable to notify a family member or designated
18 emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local
19 law enforcement agency that the patient has been admitted and the facility has been unable to notify a family member or
20 designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility
21 in identifying and notifying a family member or designated emergency contact. A county social service agency or local
22 law enforcement agency that assists a facility is not liable to the patient for damages on the grounds that the notification of
23 the family member or emergency contact or the participation of the family member was improper or violated the patient's
24 privacy rights.

25
26 **8. Continuity of Care**
27 Patients shall have the right to be cared for with reasonable regularity and continuity of staff assignment as far as facility
28 policy allows.

29
30 **9. Right to Refuse Care**
31 Competent patients shall have the right to refuse treatment based on the information required in Right No. 6. In cases
32 where a patient is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal
33 requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending
34 physician in the patient's medical record.

35
36 **10. Experimental Research**
37 Written, informed consent must be obtained prior to patient's participation in experimental research. Patients have the right
38 to refuse participation. Both consent and refusal shall be documented in the individual care record.

1 11. Freedom From Maltreatment

2 Patients shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. “Maltreatment” means conduct
3 described in Section 626.5572, Subdivision 15, or the intentional and nontherapeutic infliction of physical pain or injury,
4 or any persistent course of conduct intended to produce mental or emotional distress. Every patient shall also be free from
5 nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after
6 examination by a patients’ physician for a specified and limited period of time, and only when necessary to protect the patient
7 from self-injury or injury to others.

8

9 12. Treatment Privacy

10 Patients shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case
11 discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall
12 be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient safety or
13 assistance.

14

15 13. Confidentiality of Records

16 Patients shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release
17 to any individual outside the facility. Copies of records and written information from the records shall be made available in
18 accordance with this subdivision and Section 144.335. This right does not apply to complaint investigations and inspections
19 by the department of health, where required by third party payment contracts, or where otherwise provided by law.

20

21 14. Disclosure of Services Available

22 Patients shall be informed, prior to or at the time of admission and during their stay, of services which are included in the
23 facility’s basic per diem or daily room rate and that other services are available at additional charges. Facilities shall make
24 every effort to assist patients in obtaining information regarding whether the Medicare or Medical Assistance program will
25 pay for any or all of the aforementioned services.

26

27 15. Responsive Service

28 Patients shall have the right to a prompt and reasonable response to their questions and requests.

29

30 16. Personal Privacy

31 Patients shall have the right to every consideration of their privacy, individuality, and cultural identity as related to their
32 social, religious, and psychological well-being.

33

34 17. Grievances

35 Patients shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and
36 exercise their rights as patients and citizens. Patients may voice grievances and recommend changes in policies and services
37 to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including
38 threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers
39 for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act,

1 Section 307 (a)(12) shall be posted in a conspicuous place. Every acute care in-patient facility, every residential program
2 as defined in Section 7, and every facility employing more than two people that provides out-patient mental health services
3 shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time
4 limits, including time limits for facility response; provides for the patient to have the assistance of an advocate; requires a
5 written response to written grievances; and provides for a timely decision by an impartial decision-maker if the grievance
6 is not otherwise resolved. Compliance by hospitals, residential programs as defined in Section 7 which are hospital-based
7 primary treatment programs, and outpatient surgery centers with Section 144.691 and compliance by health maintenance
8 organizations with Section 62D.11 is deemed to be in compliance with the requirement for a written internal grievance
9 procedure.

10

11 **18. Communication Privacy**

12 Patients may associate and communicate privately with persons of their choice and enter and, except as provided by the
13 Minnesota Commitment Act, leave the facility as they choose. Patients shall have access, at their expense, to writing
14 instruments, stationery, and postage. Personal mail shall be sent without interference and received unopened unless medically
15 or programmatically contraindicated and documented by the physician in the medical record. There shall be access to a
16 telephone where patients can make and receive calls as well as speak privately. Facilities which are unable to provide a
17 private area shall make reasonable arrangements to accommodate the privacy of patients' calls. This right is limited where
18 medically inadvisable, as documented by the attending physician in a patient's care record. Where programmatically limited
19 by a facility abuse prevention plan pursuant to the Vulnerable Adults Protection Act, Section 626.557, Subdivision 14,
20 Paragraph (b), this right shall also be limited accordingly.

21

22 **19. Personal Property**

23 Patients may retain and use their personal clothing and possessions as space permits, unless to do so would infringe upon
24 rights of other patients, and unless medically or programmatically contraindicated for documented medical, safety, or
25 programmatic reasons. The facility may, but is not required to, provide compensation for or replacement of lost or stolen
26 items.

27

28 **20. Services for the Facility**

29 Patients shall not perform labor or services for the facility unless those activities are included for therapeutic purposes and
30 appropriately goal-related in their individual medical record.

31

32 **21. Protection and Advocacy Services**

33 Patients shall have the right of reasonable access at reasonable times to any available rights protection services and advocacy
34 services so that the patient may receive assistance in understanding, exercising, and protecting the rights described in this
35 Section and in other law. This right shall include the opportunity for private communication between the patient and a
36 representative of the rights protection service or advocacy service.

37

38 **22. Right to Communication Disclosure and Right to Associate**

39 Upon admission to a facility, where federal law prohibits unauthorized disclosure of patient identifying information to

1 callers and visitors, the patient, or the legal guardian or conservator of the patient, shall be given the opportunity to authorize
2 disclosure of the patient's presence in the facility to callers and visitors who may seek to communicate with the patient. To
3 the extent possible, the legal guardian or conservator of the patient shall consider the opinions of the patient regarding the
4 disclosure of the patient's presence in the facility.

5
6 **ADDITIONAL RIGHTS IN RESIDENTIAL PROGRAMS THAT PROVIDE TREATMENT TO CHEMICALLY**
7 **DEPENDENT OR MENTALLY ILL MINORS OR IN FACILITIES PROVIDING SERVICES FOR EMOTIONALLY**
8 **DISTURBED MINORS ON A 24-HOUR BASIS:**

9
10 **23. Isolation and Restraints**

11 A minor patient who has been admitted to a residential program as defined in Section 7 has the right to be free from physical
12 restraint and isolation except in emergency situations involving a likelihood that the patient will physically harm the patient's
13 self or others. These procedures may not be used for disciplinary purposes, to enforce program rules, or for the convenience
14 of staff. Isolation or restraint may be used only upon the prior authorization of a physician, psychiatrist, or licensed consulting
15 psychologist, only when less restrictive measures are ineffective or not feasible and only for the shortest time necessary.

16
17 **24. Treatment Plan**

18 A minor patient who has been admitted to a residential program as defined in Section 7 has the right to a written treatment
19 plan that describes in behavioral terms the case problems, the precise goals of the plan, and the procedures that will be
20 utilized to minimize the length of time that the minor requires inpatient treatment. The plan shall also state goals for release
21 to a less restrictive facility and follow-up treatment measures and services, if appropriate. To the degree possible, the minor
22 patient and his or her parents or guardian shall be involved in the development of the treatment and discharge plan.

23
24 **Inquiries or complaints regarding medical treatment or the Patients' Bill of Rights may be directed to:**

25 Minnesota Board of Medical Practice

26 2829 University Ave. SE, Suite 400

27 Minneapolis, MN 55414-3246

28 Tel:(612) 617-2130

29 (800) 657-3709

30 Office of Health Facility Complaints

31 P.O. Box 64970

32 St. Paul, MN 55164-0970

33 Tel:(651) 215-8702

34 (800) 369-7994

35 **Inquiries regarding access to care or possible premature discharge may be directed to:**

36 Ombudsman for Older Minnesotans

37 121 East Seventh Place , Suite 410 (Metro Square Building)

38 St. Paul, MN 55101

39 Tel. (800) 657-3591 or (651) 296-0382 (metro)

A Vygotskyan Framework for Observation: Minnesota Patients' Bill of Rights

Working with Object: Challenge from Original Translation	Working with Other: Observation of Trudy's Translations	Working with Self: Insight for Future Application

This framework is driven by your first translation of the text. What you identify as challenges from your own translation should guide what to look for in Trudy's translations.

A Vygotskyan Framework for Observation: Minnesota Patients' Bill of Rights

Working with Object: Challenge from Original Translation	Working with Other: Observation of Trudy's Translations	Working with Self: Insight for Future Application

This framework is driven by your first translation of the text. What you identify as challenges from your own translation should guide what to look for in Trudy's translations.



Step 2: Working with Other

Now that you have gone through the first step and analyzed your own translation, you are ready to watch Trudy's translation. Continue using the analysis form to note how Trudy handled sections you noted as difficult or areas of concern.

After you watch Trudy, go back to the *Minnesota Patients' Bill of Rights* page on the DVD that has Trudy's reflections. Watch what she has to say about her work. (They are also included here in written English.)

Trudy's Reflections on "Minnesota Patients' Bill of Rights"

In regards to the *Minnesota Patients' Bill of Rights*, the biggest challenge was how extremely long it was! When you work with this text, I don't recommend trying to do it all at once. Do it a little at a time. When I developed the notes for the teleprompter, it actually took me a few hours to type out the translations. I would sit and think, and I actually tested the sign to see if it made sense and was clear. In fact, I practiced this part a little. It wasn't like I did all this immediately and easily. After all, this text is about the law and policies and procedures – and there was no way I would have been able to do this off the top of my head. It was challenging, and I wanted to do what I could and the best I could.

Another challenge was how I didn't feel comfortable fingerspelling the different laws in this part. There were so many different laws, like the Minnesota Commitment Act, and the numbers of laws like "Section B, 253.05," and so on. I didn't feel right at all signing them because they were so awkward to sign. It wasn't so bad when I read the information, but to actually sign it was uncomfortable. The things I had to fingerspell were things I knew many people wouldn't remember. They probably would just skim over those parts, but I couldn't just do a half-finished job on the translations because there could be people who do want to know the specific laws. I had to maintain consistency and clarity for that part, even as uncomfortable as it was for me.

One benefit of ASL that English does not have is a spatial representation of time. In ASL, it's easy to distinguish between the past, present and future, given the language's grammatical properties. That was a wonderful asset in doing the translations, because there was one section where I had to read the text a few times to figure out the meaning. The language was so confusing in English although it was easy to sign. An example of this is on page 22, section 7, part B, lines 1-5. There's a line – actually, I won't try to sign it now, but when you watch the translations on the DVD, keep that part in mind. It says something like, "After notifying a family member but prior to allowing a family member to participate in the planning..." I had to take a moment to figure that one out. When this part is signed in ASL, it's easy and clear to understand. But if you had to listen to the spoken version, you'd have to really listen carefully and figure out what was said. The temporal aspect of ASL is a great feature, because it conveys a very clear idea – which, fortunately, is due largely to the spatial and temporal

properties of ASL.

Again, do not try to do all of the text at once. Do it a little at a time. That's what I did, and it worked. Good luck with that part!

Shadowing the Translation

Before moving on to the next step, try copy-signing while you watch Trudy's work again. Shadowing a signer can be an excellent way to begin to incorporate new ideas into your own work.

Step 3: Working with Self

Now that you have had the opportunity to view Trudy's work and her reflections, return to the text and develop a revised translation. This analysis will help you to watch Trudy's translations more carefully to see how she managed those passages.



Videotape your new translation and compare it to your original translation to see your areas of professional growth.



The Fourth Text: Notice of Privacy Practices

Fairview's *Notice of Privacy Practices* spells out the procedures Fairview Health Services goes through in using patients' information and how they protect people's privacy.

Working with Object

The first step in the process is to translate the written text into ASL as best you can. The text is on pages 36 through 44. This text is definitely too long to do other than in sections. So, take portions of it and translate it. The sections are defined below.

Working with Long Texts

Spend some time skimming through the entire Notice of Privacy Practices. Choose sections which you feel fit with your own specific professional development goals.

Do NOT feel that you have to work with all of the sections or in the order that they are in the text. The Translation in Sections option of the DVD lets you work with whatever portion you choose to.

Notice of Privacy Practices: Translation in Sections

Page 36

Introduction: Lines 8-16

Our Pledge: Lines 18-39; p. 37: Lines 1-16

Page 37

Protecting Your Health Info: Lines 18-31

How We May Use It: Lines 33-37

For Treatment: Line 39; p. 38: Lines 1-12

Page 38

For Payment: Lines 14-18

For Health Care Operations: Lines 20-28

Appt Reminders: Lines 30-31

Treatment Alternatives: Lines 33-34

Health-Related Benefits: Lines 36-37

Fundraising: Line 39, p. 39: Lines 1-21

Page 39

Patient Directory: Lines 23-34

Those Involved in Your Care: Lines 36-39; p. 40: Lines 1-5

Page 40

Research: Lines 7-26

As Required by Law: Lines 28-29

To Avert a Serious Threat: Lines 33-35

Organ/Tissue Donation: Lines 37-39

Page 41

Military and Veterans: Lines 2-4

Workers' Compensation: Lines 6-8

Public Health Risks: Lines 10-21

Health Oversight Activities: Lines 23-26

Lawsuits and Disputes: Lines 28-31

Law Enforcement: Lines 33-39; p. 42: lines 1-5

Translation in Sections (continued)**Page 42**

Coroners/Funeral Directors: Lines 7-10

National Security: Lines 12-15

Inmates: Lines 17-21

Right to Inspect/Copy: Lines 26-33

Right to Amend: Lines 35-39; p. 43: Lines 1-11

Page 43

Accounting Disclosures: Lines 13-22

Request Restrictions: Lines 24-32

Confidential Communication: Lines 34-39

Page 44

Paper Copy of Notice: Lines 2-6

Changes to Notice: Lines 8-12

Complaints: Lines 14-20

Other Uses of Health Info: Lines 22-28

Analysis Form

Two copies of the analysis form follow the text. Because of the length of this text, you may need several forms. You can create your own tables or print out more copies of the ones included.



Be sure to videotape your translation and then review it. Write down the parts that you noted as clear and ones you struggled with.

This analysis will help you to watch Trudy's translations more carefully to see how she managed those passages.

1 between Fairview entities, if appropriate. For example, for one health problem, a patient may first be seen at
2 a Fairview clinic, admitted to a Fairview hospital, discharged to a nursing home that is part of the system and
3 then get home care services from a Fairview home care agency. We share information with the different parts
4 of the system to help ensure better and more convenient care for the patient. All of our employees, volunteers
5 and agents will follow this notice.

6
7 This notice applies to all of the records of your care provided at a Fairview facility, created by us, your
8 physician(s), other health care providers or an employee of a company we have contracted with to help us
9 provide services.

10
11 When your physicians, including, but not limited to, anesthesiologists, pathologists, radiologists or other
12 non-Fairview employed health care providers such as advanced practice nurses, technicians and physician
13 assistants are treating you at a Fairview facility, they will follow the terms of this notice. We share health
14 information with these providers to help them provide treatment and for payment and health care operations.
15 Your physician or other health care provider may have different policies or notices about their use and
16 disclosure of your health information used in their office or clinic.

17

18 **PROTECTING THE SECURITY OF YOUR HEALTH INFORMATION**

19

20 Fairview works hard to protect the privacy and security of your health information while you are treated
21 and after your treatment has ended. Fairview uses electronic record systems and believes that they are an
22 important part of improving the quality and safety of the care we give. Physicians, authorized practitioners
23 and authorized members of our workforce use these systems so that they have the information needed to treat
24 you. Fairview has policies, processes and technical protections in place to keep your information from being
25 seen by anyone that should not see it.

26

27 While our internal information systems are secure from access by unauthorized people, e-mail communication
28 between you and Fairview is not secure because it is sent without being encrypted (coded) through public
29 communication lines (the Internet). There is a possibility that e-mail sent using the Internet could be received
30 by an unauthorized person. Physicians and staff will not communicate with you using e-mail unless you
31 want us to do so.

32

33 **HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.**

34

35 The following sections list different ways that we use and disclose health information. For each category
36 of uses or disclosures, we explain what we mean and give an example. Not every use or disclosure will be
37 listed; however, all of the ways we use and disclose information will fall into one of the categories.

38

39 **For Treatment.** We use health information about you to provide your health care. We may disclose

1 health information about you to physicians, nurses, technicians, medical students, or other staff who are
2 involved in taking care of you. For example, a physician treating you for a broken leg may need to know if
3 you have diabetes because diabetes may slow the healing process. In addition, the physician may need to
4 tell the dietitian if you have diabetes so that we can arrange for special meals. Different departments of this
5 facility also may share health information about you to coordinate the different things you need, such as
6 prescriptions, lab work and x-rays. We also may disclose health information about you to a specialist who is
7 asked to help with your treatment or care. It is our practice to give information about your care and treatment
8 to your regular physician so that they have information for your future care. Also, in order to provide better
9 continuity of care for our patients, Fairview is implementing an electronic medical record with certain
10 physician groups that practice at Fairview hospitals but are not a Fairview-owned clinic. We have policies
11 and procedures in place to protect the confidentiality of your health information as it is shared with these
12 physician groups.

13
14 **For Payment.** We use and disclose health information about you so that we can bill you, the
15 responsible party (guarantor), Medicare or other governmental programs, insurance companies or a third
16 party for the services provided. For example, we may need to send information about a surgery you had to
17 your health plan so they will pay us for the surgery. We may also tell your health plan about a treatment you
18 are going to have to determine whether your plan will pay for the treatment.

19
20 **For Health Care Operations.** We may use and disclose health information about you for health
21 care operations. These uses and disclosures are necessary to run our facility and make sure that all of our
22 patients get quality care. For example, we may use health information to review our services and the staff
23 caring for you. We may also combine health information about many patients to decide if additional services
24 are needed, what services are not needed, and whether new treatments are effective. We may also disclose
25 information to physicians, nurses, technicians, medical students, and other caregivers for review and learning
26 purposes. Sometimes we need to hire other companies such as consultants and accountants to help us with
27 some health care operations. If we do, we only provide them with health information when it is needed and
28 only after they have signed an agreement to follow our Notice of Privacy Practices and the law.

29
30 **Appointment Reminders.** We may use and disclose health information to remind you of an
31 appointment.

32
33 **Treatment Alternatives.** We may use and disclose health information to tell you about treatment
34 options that you may be interested in.

35
36 **Health-Related Benefits and Services.** We may use and disclose health information to tell you
37 about health-related benefits or services that you may be interested in.

38
39 **Fundraising Activities.** We may use some of your information to contact you to raise money for

1 Fairview. We may give demographic information to the Fairview Foundation, which is part of the Fairview
2 system, so that the Fairview Foundation may ask you for a donation. We will only release “contact information”,
3 such as your name, address and phone number and the dates you received services. If the Fairview Foundation
4 or we contact you for a donation, you can choose not to be contacted for future fundraising. If you do not
5 want to be contacted, send your request to the Fairview Foundation, 2450 Riverside Ave, Minneapolis, MN,
6 55454.

7
8 In some cases, more than one organization may provide you care at the same time. In these cases, this
9 Notice of Privacy Practices describes your rights and how all of the organizations providing you care will
10 treat your medical or health information. This usually occurs when you receive care at a Fairview facility
11 from a physician not employed by Fairview. If your physician is employed by University of Minnesota
12 Physicians (usually limited to certain patients at Fairview-University Medical Center), University of
13 Minnesota Physicians may use, or provide your contact information to the University of Minnesota
14 Medical School or the Minnesota Medical Foundation, to contact you about fundraising for University of
15 Minnesota Physicians or the University of Minnesota Medical School. You can choose not to be contacted
16 for future fundraising. If you do not want to be contacted, send your request to University of Minnesota
17 Physicians Privacy Administration, 2550 University Ave. W., Suite 401S, St. Paul, MN 55114.

18
19 In certain other limited circumstances, your physician may be employed by a tax-exempt entity and may use
20 your contact information generated from care he or she provides to you at Fairview for fundraising purposes.
21 If you have questions or do not want to be contacted, contact your physician’s office.

22
23 **Patient Directory.** When you are a patient at one of our facilities, friends, family and others may
24 call us to ask if you are in the facility. Limited information about you is considered “directory” information.
25 This information includes your location and your general condition (such as fair, good, etc.). You may also
26 choose to list your faith community (religious affiliation). The directory information, except for your faith
27 community, may be released to people who ask for you by name. This is so your family and friends can
28 call or visit you and generally know how you are doing. You have the right to request we do not give out
29 any directory information. If you have requested not to be listed in the directory, we will not provide any
30 information to persons who ask if you are in the facility, including family and friends. If you have asked to
31 have your faith community listed in the directory, then your name, general condition and location could be
32 given to a community faith leader (clergy), such as a priest, minister, or other spiritual advisor, even if they
33 don’t ask for you by name. Your information would only be given to community faith leaders of the faith
34 community you listed.

35
36 **Individuals Involved in Your Care or Payment for Your Care.** When you allow us to, we may
37 release health information about you to a family member or friend who is involved in your health care while
38 you are a patient at one of our facilities. If you aren’t able to give your permission for these communications,
39 we will use our professional judgment to decide with whom we should communicate. We may also give a

1 limited amount of information to someone who helps pay for your care so they can help with the payment
2 of a claim. You may limit the health information we disclose about you to someone who is involved in your
3 care or the payment for your care, like a family member or friend. In the event of a natural disaster or other
4 disaster, we may disclose health information about you to an entity helping with a disaster relief effort so
5 that your family can be notified about your condition and location.

6
7 **Research.** By performing research, we learn new or better ways to diagnose and treat illnesses.
8 Fairview employees, medical and allied health staff and University of Minnesota Academic Health Center
9 faculty are considered internal researchers. In most cases, use of your health information for research
10 purposes will be reviewed and approved by an Institutional Review Board (IRB). An IRB is a federally
11 mandated board that makes sure that human research subjects are protected. Fairview generally uses the
12 IRB at the University of Minnesota. Fairview's internal researchers will not use your health information for
13 research unless you authorize the use in writing or the IRB decides that the authorization requirement is not
14 necessary. Before the IRB will decide that the authorization is not necessary, the researchers must prove that
15 the project is important enough and show they have a plan to protect the information from any improper use
16 or disclosure. Fairview will not disclose your health information to external researchers unless you authorize
17 the disclosure in writing.

18
19 In some cases, Fairview may permit access to your health information by individuals that are preparing to
20 conduct research. Unless you have consented, Fairview will allow only internal researchers (not external
21 researchers) to access your health information for preparing a research protocol and we will not permit the
22 information to be removed from Fairview or disclosed to a third party.

23
24 If you participate in a research project that involves treatment, your right to access health information
25 pertaining to that treatment may be delayed during the research project so that the research can remain intact.
26 When the research is done, you will have full access to your information.

27
28 **As Required By Law.** We will disclose health information about you when required to do so by
29 federal, state or local law.

30 31 **SPECIAL SITUATIONS**

32
33 **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about
34 you when necessary to prevent a serious threat to your health and safety or the health and safety of the public
35 or another person. Any disclosure would only be to someone able to help prevent the threat.

36
37 **Organ and Tissue Donation.** If you are an organ donor, we may release health information to
38 organizations that handle organ procurement, or organ, eye or tissue transplantation, or to an organ donation
39 bank so that the organ or tissue can be donated or transplanted.

1
2 **Military and Veterans.** If you are a member of the armed forces, we may release health information
3 about you as required by military command authorities. We may also release health information about
4 foreign military personnel to the appropriate foreign military authority.

5
6 **Workers' Compensation.** If you are being treated for a work-related injury or condition, we may
7 release health information about you for workers' compensation or similar programs. These programs
8 provide benefits for work-related injuries or illness.

9
10 **Public Health Risks.** We may disclose health information about you to public health authorities for
11 certain public health activities. These include:

- 12 • to prevent or control disease, injury or disability;
- 13 • to report births and deaths;
- 14 • to report child abuse or neglect;
- 15 • to report reactions to medications or problems with products;
- 16 • to notify people of recalls of products they may be using;
- 17 • to notify a person who may have been exposed to a disease or may be at risk for getting or spreading
18 a disease or condition;
- 19 • to notify the appropriate government authority if we believe a patient has been the victim of abuse,
20 neglect or domestic violence. We will only make this disclosure if you agree or when required or
21 authorized by law.

22
23 **Health Oversight Activities.** We may disclose health information to a health oversight agency for
24 activities authorized by law. Examples of oversight activities include audits, investigations, inspections and
25 licensing. These activities are necessary for the government to monitor the health care system, government
26 programs and compliance with civil rights laws.

27
28 **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information
29 about you if we get a court or administrative order. We may also disclose health information about you in
30 response to a subpoena, discovery request or other lawful process by someone else involved in the dispute,
31 but generally only if your consent is obtained.

32
33 **Law Enforcement.** We may release health information if asked to do so by a law enforcement official:

- 34 • In response to a court order, grand jury subpoena, warrant, summons or similar process;
- 35 • To identify a deceased person, or locate a missing child under age 18; or
- 36 • About the victim of a crime if, under certain limited circumstances, we are unable to obtain the
37 person's agreement.

38
39 We may also disclose health information to a law enforcement official:

- 1 • About a death we believe may be the result of criminal conduct;
- 2 • About criminal conduct at the hospital;
- 3 • In emergency circumstances to report a crime; the location of the crime or victims; or the identity,
- 4 description or location of the person who committed the crime; and
- 5 • In other situations as required by law.

6

7 **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner
8 or medical examiner. This may be necessary, for example, to identify someone who has died or determine
9 the cause of death. We may also release health information about patients of the hospital to funeral directors
10 as necessary to carry out their duties.

11

12 **National Security and Intelligence Activities.** We may release health information about you to
13 authorized federal officials for activities authorized by law. We may disclose health information about you
14 to authorized federal officials so they may provide protection to the President, other authorized persons or
15 foreign heads of state or conduct special investigations.

16

17 **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement
18 official, we may release health information about you to the correctional institution or law enforcement
19 official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect
20 your health and safety or the health and safety of others; or (3) for the safety and security of the correctional
21 institution.

22

23 **YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU**

24 You have the following rights regarding health information we maintain about you:

25

26 **Right to Inspect and Copy.** You have the right to inspect and copy your health information. You
27 must submit your request in writing to the address listed on the form you signed when you received this
28 notice or to the facility where your records are maintained. If you request a copy of the information, we may
29 charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny
30 your request to inspect and copy in certain very limited circumstances. If you are denied access to health
31 information, you may request that the denial be reviewed. Another licensed health care professional chosen
32 by us will review your request and the denial. The person conducting the review will not be the person who
33 denied your request. We will comply with the decision of the reviewer.

34

35 **Right to Amend.** If you feel that health information we have about you is incorrect or incomplete,
36 you may ask us to amend the information. You have the right to request an amendment for as long as the
37 information is kept by or for us. To request an amendment, submit a written request to the address listed on
38 the form you signed when you received this notice or to the facility where your records are maintained. You
39 must provide a reason that supports your request. We may deny your request for an amendment if it is not

1 in writing or does not include a reason to support the request. In addition, we may deny your request if you
2 ask us to amend information that:

- 3 • Was not created by us, unless the person or entity that created the information is no longer
4 available to make the amendment;
- 5 • Is not part of the health information kept by or for us;
- 6 • Is not part of the information which you would be permitted to inspect and copy; or
- 7 • Is accurate and complete.

8
9 We will notify you in writing if we deny your request. If the request is denied, you have the right to submit
10 a written statement disagreeing with the denial, which will be added or linked to the health information in
11 question.

12
13 **Right to an Accounting of Disclosures.** You have the right to request a list of the disclosures of your
14 health information, if any, we have made without your written authorization to third parties for purposes other
15 than for treatment, payment, health care operations and certain other limited purposes. These disclosures
16 are usually those required by law for reasons like disease management, protection of vulnerable adults and
17 children, and birth and death reporting. To request this list, you must send your request in writing to the
18 address listed on the form you signed when you received this notice or to the facility where your records are
19 maintained. Your request must give a time period that you want the list to include, which may not be longer
20 than six years and may not include dates before April 14, 2003. The first list you request within a 12-month
21 period will be free. For additional lists, we may charge you for the costs of making the list. We will notify
22 you of the cost estimate before providing the accounting.

23
24 **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health
25 information we use or disclose about you for treatment, payment or health care operations. Federal law
26 states that we are not required to agree to your request. If you restrict us from providing information to
27 your insurer, you need to explain how you will pay for your treatment. If we agree to the restriction, we
28 will restrict the information unless the information is needed to provide you with emergency treatment. To
29 request restrictions, make your request in writing to the address listed on the form you signed when you
30 received this notice or to the facility where your records are maintained. In your request, you must tell us
31 (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to
32 whom you want the limits to apply.

33
34 **Right to Request Confidential Communications.** You have the right to request that we communicate
35 with you about health matters in a certain way or at a certain location. For example, you can ask that we
36 only contact you at work or by mail. To request confidential communications, you must make your request
37 in writing to the address listed on the form you signed when you received this notice or to the facility where
38 your records are maintained. We will not ask you the reason for your request. We will allow all reasonable
39 requests. Your request must specify how or where you wish to be contacted.

1
2 **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You
3 may ask us to give you a copy of this notice at any time. You may obtain a copy of this notice at our
4 website, www.fairview.org, or to obtain a paper copy of this notice, you may request a copy via an e-mail
5 to privacy1@Fairview.org, or in writing to Fairview Privacy Office, 2450 Riverside Ave, Minneapolis, MN
6 55454.

7
8 **CHANGES TO THIS NOTICE**

9 We must follow the terms of this Notice of Privacy Practices. We can change this Notice of Privacy Practices,
10 however, and reserve the right to make the new notice effective for health information we already have about
11 you as well as any information we receive in the future. We will post a copy of the current notice in this
12 facility and on our website at www.Fairview.org. The effective date of this notice is listed on the first page.

13
14 **COMPLAINTS**

15 If you believe your privacy rights have been violated, you may file a complaint with us or with the
16 Secretary of the Department of Health and Human Services. You may call the Fairview Privacy Office
17 at 612-672-5647 to discuss your complaint, ask questions or to get the contact information for the
18 Department of Health and Human Services. To file a complaint with us, contact the Fairview Privacy
19 Office, 2450 Riverside Ave, Minneapolis, MN 55454. All complaints must be submitted in writing. You
20 will not be penalized for filing a complaint.

21
22 **OTHER USES OF HEALTH INFORMATION**

23 Other uses and disclosures of health information not covered by this notice or the laws that apply to us will
24 be made only with your written permission. If you have given us written permission to use or disclose health
25 information about you, you may take back that permission, in writing, at any time. If you take back your
26 permission, we will no longer use or disclose health information about you for the reasons covered by your
27 written authorization. You understand that we are unable to take back any disclosures we have already made
28 with your permission, and that we are required to keep our records of the care that we provided to you.

A Vygotskyan Framework for Observation: Notice of Privacy Practices

Working with Object: Challenge from Original Translation	Working with Other: Observation of Trudy's Translations	Working with Self: Insight for Future Application

This framework is driven by your first translation of the text. What you identify as challenges from your own translation should guide what to look for in Trudy's translations.

A Vygotskyan Framework for Observation: Notice of Privacy Practices

Working with Object: Challenge from Original Translation	Working with Other: Observation of Trudy's Translations	Working with Self: Insight for Future Application

This framework is driven by your first translation of the text. What you identify as challenges from your own translation should guide what to look for in Trudy's translations.

Step 2: Working with Other

Now that you have gone through the first step and analyzed your own translation, you are ready to watch Trudy's translation. Continue using the analysis form to note how Trudy handled sections you noted as difficult or areas of concern.

After you watch Trudy, go back to the *Notice of Privacy Practices* page on the DVD that has Trudy's reflections. Watch what she has to say about her work. (They are also included here in written English.)

Trudy's Reflections on "Notice of Privacy Practices"

The text for Fairview's policies and procedures about privacy was incredibly long! Again, don't try to translate the entire text in one sitting. Do it a little at a time. If you keep going without stopping, you will be worn out. This really exercises you mentally. So I suggest that if you feel tired, stop and take a break for a while, then come back and work on the translations. This one was particularly interesting for me because the previous text was quite vague with some specific language. But none of the text was vague and specific at the same time. With this particular text, it had text that was both vague and specific at the same time. Some of the text started out a bit general, then suddenly became specific with example after example. So that was a challenge for me. I had to decide how I would sign something, which took some work. It was a nice, challenging task for me because it really made me reflect and helped me expand my lexical thinking.

Also, in this part, I actually signed one word wrong. Was it a major mistake? No, because I think most people would probably have signed it the same way. The word was *electronic*. It's under "Protecting the Security of Your Health Information," in lines 18-25. (Editor's note: page 37 in this packet.) The text discussed files being stored electronically and where it was being stored. For that part, I signed the word *electronic* as shown in example 1. That wasn't the best choice. The word in that situation meant the information was stored as data in a computer. I kept on signing *electronic* the wrong way, not as shown in example 2. I discussed this with the reviewers, and we decided to leave it because the concept was accurate and the sign didn't greatly alter the meaning. Besides, I did sign "typing, computer," and I also mentioned "file" later. Plus, the sign for electronic could also signify electric, so we decided it was okay. If I had messed up in real life, I would have stopped and clarified. If I were in an actual interpreting situation, I would have stopped, notified the parties that I made an interpreting error and made things clear. It's better to stop rather than to leave and later realize you said the wrong thing; this could have serious consequences. It's just better to stop and clarify. In this situation, because I had already been filmed and had no way of clarifying it, and nobody caught this mistake until much later, we decided to just leave it. The reviewers did not think the mistake was serious enough to require re-filming.

Example 1



Example 2





There are a lot of terminology and concepts that you have to really visualize. Again, I advise that you read through the text, understand the intention or meaning, figure out what the goal of the message is, and then go back and actually translate.

Shadowing the Translation

Before moving on to the next step, try copy-signing while you watch Trudy's work again. Shadowing a signer can be an excellent way to begin to incorporate new ideas into your own work.

Step 3: Working with Self

Now that you have had the opportunity to view Trudy's work and her reflections, return to the text and develop a revised translation. This analysis will help you to watch Trudy's translations more carefully to see how she managed those passages.



Videotape your new translation and compare it to your original translation to see your areas of professional growth.

The Final Step: Reflection

Congratulations on making it through all the texts. It is a lot of work to go through the three step process of translation, observation, and re-translation. We hope that this was as educational for you as it was for us as we created the original DVD for Fairview Health Services.

Now is the time for you to reflect on your own journey of professional development. Create a reflection, whether written or signed on video, that shows the insight you gained through this process.

- *What did you learn in this process?*
- *What did you find to be particularly challenging?*
- *What were your strongest areas of professional growth?*
- *Where do you need to continue to focus energy for skill development?*

Taking the time to do this reflection is an important part of integrating what you have worked on into your own interpreting practice.

Credits for the Project

ASL Translations and Reflections

Trudy Suggs
T.S. Writing Services

Video Production and Project Design

Doug Bowen-Bailey
Digiterp Communications

Reviewers

Juan Bernal
Priscilla Moyers
Amanda Gilderman

Staff of the CATIE Center at the College of St. Catherine

Rosa Ramirez
Laurie Swabey
Richard Laurion

Appendix B: Independent Study Plan for RID's CMP/ACET Program



Independent Study Plan



Note: All Independent Study Activity Plans must be approved by a RID Approved Sponsor *prior* to the onset of the activity.

CMP Participant Name: _____		
Address: _____		
City: _____	State: _____	Zip: _____
Phone: _____	RID Member # _____	
Fax: _____	E-mail: _____	

1. What do I want to do? *Briefly describe the activity you will complete for CEUs.*

Using the DVD, *When the Law Meets Medicine* and its accompanying study packet, I plan to practice the process of translating written English texts into American Sign Language.

2. Why do I want to do it? *Personal needs? Professional growth? Skill enhancement in a specific area? Increased general knowledge? Remaining current in the field?*

I wish to develop my skills for interpreting in situations in which both medical and legal terminology is present. I also want to increase my understanding of how to translate written texts.

3. What are my specific goals? *Keep your goals measurable, observable and tangible!*

- ◆ Translate 4 written English source texts into American Sign Language
- ◆ Identify 3 areas of focus for professional development
- ◆ Engage in 3 step process for translation, including original translation, observation of translations done by Trudy Suggs, and re-translation
- ◆ Shadow/copy translation done by native signer
- ◆ Compare and contrast translations
- ◆ Familiarize myself with documents given to patients upon admission to a health care facility

4. How will I accomplish my goals? *Briefly describe your action plan.*

Using this study guide, I will go through the process of translating 4 texts used by Fairview Health Services: *Notice to Patients; Advance Health Care Directives; the Minnesota Patients' Bill of Rights; and Notice of Privacy Practices*. After first translating the text (or portions of the text), I will observe Trudy Suggs' translation and her reflections, then will re-translate the text.

5. How will I show my sponsor what I learned? *Describe your evaluation process.*

I will document the time spent on this study guide using the Time Documentation Sheet; share worksheets completed as a part of this process, and share final reflections.

(Be sure to confirm with your sponsor what evaluation procedure will fulfill their requirements for processing the CEUs.)

6. How many CEUs is it worth? *Remember, in an educational setting, 10 contact hours = 1 CEU. Consider how much time you will devote to this study. A maximum of 2.0 CEUs can be earned for each project. (Larger projects may be broken into components and each component filed as a separate independent study project earning up to 2.0 CEUs each.)*

Working with this study packet has a value of up to 2.0 CEUs, depending on the amount of time spent studying and learning in this process.

Please Note: It will be up to the individual RID Approved Sponsors to determine the amount of time necessary to complete your Independent Study and the CEU value that should be assigned to your efforts. Some sponsors may require that you document 1.5 or more hours of study for each .1 CEU earned. Negotiate this with your sponsor prior to initiating your independent study plan.

I agree to implement the Independent Study Activity as outlined in this plan and to submit all the necessary documentation of successful completion to my Sponsor. I certify that this activity for CEU credit toward the RID CMP requirements represents a valid and verifiable Continuing Education Experience that exceeds routine employment responsibilities.

Participant's Name

Date

Participant's Signature

I will insure that this Independent Study Activity will be overseen and evaluated by individual(s) with the relevant expertise. I, or my designee, have discussed the Independent Study Activity outlined in this plan with the participant and agree that it represents a valid and verifiable Continuing Education Experience. Further, I or my designee, agree to assess the documentation submitted to me by the participant upon completion of the Independent Study Activity and award the appropriate CEUs if completion is satisfactory.

Sponsor's Name (please print)

Code

Date

Sponsor's Signature