TB & CULTURAL COMPETENCY

Notes from the Field

Northeastern Regional Training and Medical Consultation Consortium Issue #9 Winter 2009

My Interpretation

By Lauren Moschetta-Gilbert
Based on interviews with TB control staff

Introduction

Language issues remain a significant challenge when working in cross-cultural situations. Improvements to language access have been made, but are not perfect. For instance, many hospitals now offer medical interpreter training programs for bilingual staff, and telephone interpreter services have expanded, increasing both the number of languages available and the hours of service availability. However, often there is no additional pay for staff members who take on an interpreter role, making specialized training less appealing for some. Telephone interpreter services can be cost prohibitive for smaller organizations, and without the latest hardware, passing a telephone receiver back and forth has been described by some as cumbersome and time consuming. In this edition of our newsletter, we will hear about one healthcare worker's experience as he navigated language barriers with a patient. We will also examine the common pitfalls of using family members or untrained persons as interpreters, as well as provide guidance on how to do this more effectively when it is the only option.

**Names have been changed.*

The Patient

Amina* was diagnosed with TB after being seen in the Emergency Department with prolonged cough, fever, chest pain and weight loss. Her children urged her to go to the Emergency Department after an episode of hemoptysis. She was prescribed the standard four anti-TB drug regimen and referred to the TB clinic for continued care and monitoring. Originally from Pakistan, Amina had been in the US with her husband and children for about two years. Her husband had recently returned to Pakistan for a one year business venture. The family was Muslim and spoke Urdu, and the three children, aged 17-25, spoke English fluently.

Nurse case manager

I had been informed that the patient's first language was Urdu, so I set up the language line interpreter service before she arrived at the clinic to speed things along. When Amina arrived with her English speaking eldest daughter, Yasmin,* I introduced myself, and explained that we would be using a telephone interpreter. I began describing how and why the interpreter language line is used. The patient stated that she preferred to use her adult daughter to interpret for her. I then explained that medically accurate and reliable interpretation of information is critical to her care and treatment, and this is best achieved by using a certified interpreter. Amina seemed to get upset and stated that her daughter "spoke for her" and that she relied on her to know that everything is ok. Yasmin then said that her mother didn't believe in taking medicine and that if she were not involved, her mother would likely not cooperate with her own treatment. At this point I was feeling very conflicted about how to proceed. I knew it was not 100% reliable to communicate through the daughter, but I didn't want to lose the patient's trust and cooperation, so I didn't push the matter any further and decided to use the daughter as the interpreter. This seemed to work out o.k. as we began the contact investigation.

Yasmin then said that her mother didn't believe in taking medicine and that if she were not involved, her mother would likely not cooperate with her own treatment. At this point I was feeling very conflicted about how to proceed.

As the nurse case manager, I also needed to assign an outreach worker to this case for DOT. My personal experience working with Muslim families has led me to believe that both

Continued on page 2

Continued from page 1

male and female Muslim patients prefer to be cared for by female healthcare workers. Unfortunately, I did not have a female worker available for the case. I did, however, have a male worker who happened to be Muslim. I chose him to work with the family, thinking this would be a good cultural match.

Outreach Worker

In hindsight, my first visit to the patient's home didn't go too well. After answering the door, Amina quickly ran upstairs to get her daughter, Yasmin and was followed back downstairs by Yasmin and two sons. I was invited into the living room and hesitantly followed but declined to sit because I still had several DOT visits that afternoon. Yasmin brought plates of food from the kitchen and offered something to drink. I always find this an awkward part of my job. I politely declined, stating that I had just finished lunch and then turned my attention to Amina and the need for her to take her medication. Once Amina had taken her pills, I confirmed the preferred time for DOT going forward. With Yasmin interpreting, I asked Amina if she had any questions, and at that point she spoke in a very animated way, raising her voice a bit. When I looked to Yasmin for the explanation, she said her mother had no questions. I wasn't sure what to do or say, and I'm sure I just stood there for a minute.

I started to point out that her mother had said something but Yasmin quickly interjected, agreeing that she did say something, but that her mother understood what I said and had no questions. Everyone else was quiet and feeling somewhat uncomfortable and anxious about getting behind on appointments, I decided to leave.

DOT visits continued over the next few weeks with no problems. After the first two or so visits the food offerings stopped. It was usually just a very quiet visit. It crossed my mind that I may have offended the family by not accepting food, but I didn't know what to do about it. It's not something I am comfortable with and I thought that I was polite in my refusal. I was new on the job at the time, but still find this a challenge to deal with.

A few weeks later, Yasmin informed me that she would be traveling to Pakistan and would be gone for three weeks. She said that her brother Jafar,* aged 17, would interpret in her absence. I was hesitant about this but then realized that there really hadn't been much need for interpretation and our visits are usually quick and quiet. I agreed to have Jafar interpret if the need arose in the daughter's absence.

Some days later I noticed Amina looking a little tired. She had her head in her hands with her eyes closed. I commented to Jafar about it. He said that his mother was tired because Yasmin was not around to help her with the housework and cooking. I asked if his mother had any questions about the medications, as I always do. Until this day, the answer had been no. But this time Amina spoke and I looked to Jafar for interpretation. He said his mother was complaining about some stomach upset after she took her pills. I asked a few questions about other symptoms and pain, which were all denied, and learned his mother took her pills on an empty stomach. I called the clinic and the nurse case manager spoke with Jafar, suggesting his mother eat a small amount of bread or crackers before I came to give her the medication and that she drink some water over the course of the day. The nurse case manager also suggested Amina come into the clinic for some tests if the stomach upset didn't go away.

When I arrived at work the following Monday, I learned that Amina had been seen in the Emergency Department with nausea and vomiting and was diagnosed with kidney stones. I have to admit, I was stunned by this news. I began to go over the previous home visit details in my head. How did I miss the fact that Amina must have been experiencing a great amount of pain? Thankfully, I knew Yasmin was returning from Pakistan the next day and resolved to figure out the miscommunication then. When I arrived at the home for DOT, Yasmin was waiting with her mother and an older male. Yasmin was angry and wanted to know how her mother ended up in the Emergency Department when I had been coming to the house everyday to oversee her treatment and ensure that everything was ok. She informed me that the family was upset about the situation and that her uncle, the older male, traveled two hours on a bus to be there for the visit, because he felt "my mother is not safe under your care."

When I heard this, I got upset. I felt my face get warm and was not immediately sure how to handle the situation, as I still did not understand exactly what happened. I eventually began trying to reassure Yasmin that her mother's health was very important

Continued on page 4

DID YOU KNOW?

Standard 6 of the National Standards on Culturally and Linguistically Appropriate Services (CLAS) states: "Health care organizations must assure the competence of language assistance provided to limited English proficient patients/ consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services **(except on request by the patient/consumer)**."

Available at: *http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15*

THE CASE AGAINST USING FAMILY, FRIENDS, AND MINORS AS INTERPRETERS IN HEALTH AND MENTAL HEALTH CARE SETTINGS

Family Members and Friends as Interpreters

Sometimes family members/friends are reluctant to ask questions when they do not understand or when they are embarrassed. They may lack medical vocabulary in English and their own language. Family members/friends are often uncomfortable and will not ask for a more qualified interpreter when the situation gets beyond their abilities.

Sometimes family members/friends will not give the patient a provider's full and complete explanations. They may be embarrassed to admit they do not understand or embarrassed by the nature of the conversation. They might not agree with the provider. Conversely, they may miscommunicate the patient's message, preferring that the provider hear their version of the situation.

Family members'/friends' emotional involvement often results in a tendency to protect the patient from bad news; therefore, they edit or change information. Also, sometimes family members/friends will not share with a provider the patient's full message, again because they are embarrassed, do not have what they judge to be the proper vocabulary, or because they make a decision that the provider doesn't need to know "all this extra information."

Finally, aside from interpretation lapses, confidentiality is also a problem when family members/friends serve as the interpreters. Often, the patient does not want to disclose upsetting private information or secret issues in front of a relative. The patient may not feel confident that the family member/friend interpreter will maintain confidentiality and will not disclose private information to others.

Minors or Children as Interpreters

The Office of Civil Rights, U.S. Department of Health and Human Services, expressly discourages the use of minors in health care interpreting. The following tool provides a selected list for the case against using children as interpreters:

Role Reversal

The child ends up having to process information and provide help and support to the parent or other adult.

Editing

The child may interpret messages to suit his/her personal view of what is appropriate, convenient, or proper to say to spare parents from suffering embarrassment.

Mistakes

It is unlikely that children understand all the intended messages, even when they say (and believe) they do.

Guilt

It is easy for children to feel they are the cause of suffering because they said something painful or made a mistake in conveying a message.

Omissions

Adult patients often omit mentioning important information because they do not want the child to know sensitive aspects of their lives.

Confidentiality

Even when cautioned, children do not understand issues of confidentiality and may inadvertently reveal sensitive material learned during interpreting.

In addition to those reasons cited above, there may be religious, spiritual, and moral prohibitions against engaging minor children in adult situations and discussions (e.g., sexual practices, reproductive health, substance use and abuse, and domestic violence).

Gilbert, M.J. (2005) "The Case Against Using Family, Friends, and Minors as Interpreters in Health and Mental Health Care Settings" in Process of Inquiry—Communicating in a Multicultural Environment. From the Curricula Enhancement Module Series. Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development.

Reprinted with Permission

Continued from page 3

to me and express my regret about what happened. Yasmin and I were having this conversation in English without regard for the fact that her mother and uncle could not understand what we were saying.

It was only when Amina and the uncle began to speak in Urdu that I realized I needed to take some kind of control over the language and interpretation situation. I asked Yasmin to please tell her mother and uncle that I wanted to hear what they had to say and to request that they speak one at a time. I then told Yasmin that I wanted to have some "guidelines" for our conversation to help ensure that everyone was heard and understood. I asked her to repeat that information to her mother and uncle and ask if they were in agreement. Once everyone agreed, I asked again for everyone to speak one at a time and for Yasmin to interpret everything that was said fully and completely. I also requested that we try to look at the person we are speaking to rather than at Yasmin, who would be interpreting. This became tricky when Yasmin immediately resumed her questions for me. It was not easy for her to remember to interpret her own questions to me in Urdu so that her mother and uncle would understand, and reminding her added more tension to the exchange. I tried to diffuse the tension by sympathizing with her about how difficult it must be. I reminded her that the only reason I was asking her to translate her questions was so that her mother and uncle were fully aware of what was being said and to perhaps avoid another communication issue. It occurred to me that I should have used these guidelines from the start.

It was interesting to me that I was chosen for this case as a "cultural match" for the patient, but it really played no part in our working relationship. While we did share a religion, culturally, we were very different.

Needless to say, the communication process was slow and somewhat frustrating. But I realized this was my only chance to reconnect with the patient and her family after what was perceived as a breach of trust and it was going to take some time given the language challenges.

We eventually figured out that Jafar had been embarrassed by his mother's description of blood in her urine, so he did not interpret those words into English. Additionally, Amina had her head in her hands during our visit that day, making it hard to detect any pain she may have been experiencing. Jafar admitted that when I asked if his mother was in any pain, he also did not translate that question. To further complicate matters, I learned that Amina was not entirely comfortable having Jafar interpret for her and had wanted Yasmin to postpone her trip for this reason. Once these details were clear, Yasmin apologized to me for her mistrust. I assured her there was no need for an apology, explaining that this sometimes happens when family members are in the interpreter role. For the remainder of my visits with the family we continued to use the guidelines we had agreed to and had no further problems. Amina went on to successfully complete treatment.

Conclusion:

I will admit that I initially thought the fact that the patient and I shared a religion engendered some kind of unspoken trust between us and would help to establish rapport with Amina. This was not the case at all. The fact that we were both Muslim was not acknowledged or discussed in any way. It was interesting to me that I was chosen for this case as a "cultural match" for the patient, but it really played no part in our working relationship. While we did share a religion, culturally, we were very different. We were raised in different countries, spoke different languages, and did not appear to have common family customs or traditions. In fact, I realized that Amina and I had not developed a strong rapport before Jafar took over the interpreting role. At the time, I didn't think this would matter since Amina was an 'uncomplicated' patient. I learned, however, particularly when family members are in an interpreter role, a situation can become complicated very quickly. It can be very difficult to establish trust once misunderstandings and miscommunications have already occurred.

Lessons Learned:

As a new outreach worker, this was one of the first families I had the opportunity to work with. I will be the first to admit that it was quite a learning experience for me.

Some lessons learned:

- Slow down when working in a cross-cultural situation. Additional time may be needed for casual dialogue and cross-cultural communication in general. I have learned to incorporate this into many of my patient relationships.
- When offered food during a home visit, sometimes it is better to accept the offer and not eat it rather than to "politely" refuse the offer.**
- When untrained staff, community members or family members are in the interpreter role, make the effort

***One topic mentioned in this newsletter is how to handle offers of food or drink during home visits. If you would like to share your experiences on this topic, please go to http://www.zoomerang.com/Survey/?p=WEB228UZGSFD4J to anonymously contribute to our survey. We will use the survey information to discuss the topic more thoroughly in an upcoming newsletter.*

Continued on next page

RESOURCE

One invaluable interpretation resource for TB control staff is the Francis J. Curry National Tuberculosis Center's Making the Connection: *An Introduction to Interpretation Skills for TB Control*, 2nd Edition, DVD with viewer's guide.

This 29-minute video serves as an introduction to working with interpreters. Specific skills that can help TB Control staff successfully facilitate interpreted sessions are demonstrated on the video.

The accompanying viewer's guide expands on the content covered in the video and serves as a reference guide by providing additional information and resources.

The tips below and glossary on page 4 are excerpted from the Viewer's Guide. To order this product or to view it online go to http://www.nationaltbcenter.edu/products/product_details.cfm?productID=EDP-09.

10 Tips for Providers When Working with An Untrained Interpreter

1. Make introductions among all participants and establish the grounds for confidentiality.
2. Illustrate the positioning for the interpreter by placing a chair or asking the interpreter to stand/sit in the appropriate place (beside and slightly behind the patient).
3. Establish and describe that interpreting is performed in the first person voice (e.g., I, me) when speaking for the patient or the provider. This promotes the appropriate relationship between you and your patient.
4. Explain that when the interpreter needs to speak for himself/herself, the interpreter must identify himself/herself as the person speaking and asking the question. For example, if the interpreter needs to ask a question regarding a word that is confusing, the interpreter uses the third person, "The interpreter needs clarification about…"
5. Describe and request that the interpreter use the consecutive mode of interpretation.
6. Ask the interpreter to say exactly what you and the patient say – without adding, changing, or omitting anything – even if what the patient says does not make sense.
7. Explain that the provider will speak slowly and will pause often so the interpreter can interpret accurately. Ask the interpreter to ask the patient to speak slowly and pause often so that he/she can interpret accurately for them. Explain that the interpreter may use a raised hand to signal for either the patient or you to stop speaking so that he/she may interpret.
8. If either the provider or patient uses a term or phrase unfamiliar to the interpreter, request that the interpreter seek clarification by using third person voice.
9. Instruct the interpreter to use a pen and paper to take notes about prescriptions, dosages, and other lists or numbers that could be confusing when repeated in the appropriate language.

   Also instruct the interpreter to inform the patient that any notes taken during the interpreting session will be destroyed at the end of the session and before leaving the room.
10. Ask the interpreter not to have side conversations with the patient or with the provider. The interpreter only interprets what he/she hears or asks for clarification when he/she is confused about a term or meaning. He/she never initiates and carries on a conversation in which one party is excluded from the conversation.

Lessons Learned, continued from previous page

to conduct a "pre-session" (see glossary), clarifying roles, expectations for interpretation, medical terms, confidentiality, etc. I believe this has helped me prevent further communication problems when working with patients and families who speak a language other than English. This technique also helps me to be confident about my ability to direct the communication process even though I don't speak the patient's language.

- Ask the patient what is most important to him/her at different times. For instance: the nurse case manager could have asked if there was anything the patient would like her to consider as she selected someone to work with her during her treatment. This may not have affected the communication issues in this case but may have clarified the significance of a Muslim outreach worker of a particular gender.
- Occasionally repeat the offer to use a trained interpreter. When Yasmin told me that she would be away, I could have repeated the offer to use the language line. Amina may have preferred that option to relying on her teen-aged son to speak for her.

INTERPRETATION GLOSSARY

1st person voice – Interpreter uses "I/me/my" statements during interpretation

3rd person voice – When interpreter intervenes for a transparent clarification, interpreter refers to himself/herself in 3rd person voice by using "he/him/his" or "she/her/hers" statements

Accuracy – Interpreter interprets everything the speaker says without changing the meaning and conveying what is said, and how it is said without additions, deletions, or alterations, but with due consideration of the cultural context of both the sender and the receiver of the message

Completeness – Interpreter conveys the meaning of gestures, body language, and tone of voice of the speaker

Consecutive interpretation – When one speaker starts to say a few sentences, then pauses for the interpreter to interpret. This process is repeated with the next speaker, providing continuous interpretation until the dialogue is complete practice skills to fit the cultural content of the client or patient

Cultural competence – A set of practiced skills, knowledge, and attitudes, that must encompass 5 elements: awareness and acceptance of difference; awareness of own cultural values; understanding the dynamics of difference; development of cultural knowledge; ability to adapt

Face-to-face Interpretation – Interpreter is present with both, or at least one of the persons whom interpreting is provided

Hand signal – Interpreter raises hand to patient or provider to request a pause to interpret accurately or for clarification

Interpretation – Involves conversion of SPOKEN words from one language to another and requires the use of an interpreter

Intervention – The process of intervening allows the interpreter to break into the provider/patient dialogue when a specific problem arises

LEP – "Limited English Proficient" is a term used by the Office of Civil Rights to describe patients/clients who have limited English proficiency

Note-taking – Interpreter can take notes on things that can be easily transposed such as numbers, dosages and times. This helps to keep the interpretation accurate

Post-session – An opportunity to learn from interpreter about cultural topics or behavior that can assist in effective interaction between patient and provider

Pre-session – An introduction made to both the provider and patient before the appointment begins. Sets the parameters for how the interpreter will operate and specifies ways that the provider and patient can help the interpreter to be effective. May also be used to alert provider to cultural issues

Proper positioning – To facilitate as much direct communication as possible between patient and provider, the interpreter sits/stands beside and slightly behind the patient during interpreted session

Sight translation – Oral translation of a written document into the target language

Simultaneous interpretation – Occurs when the interpreter interprets at the same time as the speaker is speaking

Transparent clarification – Occurs when the interpreter needs to intervene and stop the conversation with a hand signal, then switches to third person voice, and refers to interpreter as "the interpreter"

Telephone interpreting – Interpreting carried out remotely, with the interpreter connected by telephone to doctor and patient

Translation – Involves conversion of WRITTEN text from one language to another and requires the services of a translator

NEW JERSEY MEDICAL SCHOOL
GLOBAL TUBERCULOSIS INSTITUTE
225 Warren Street, Newark, NJ 07101-1709
(973) 972-3270
www.umdnj.edu/globaltb