

# Interpreting in Palliative Care

A continuing education workshop  
for interpreters in health care

by

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with funding from



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## ***Interpreting in Palliative Care***

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The complete curriculum, including documents and video, is available at [www.chcf.org/interpreting](http://www.chcf.org/interpreting).

This document includes blank pages to encourage double-sided printing.

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## **Preface**

### **Why palliative care?**

Of all the possible topics for continuing education for interpreters, why pick palliative care? There are two reasons for this choice of topic, each related to the other.

Palliative care is a relatively new field in medicine, but it is growing quickly. As more technologies and treatments become available to prolong life, patients and families must now consider not only the length of life, but what quality of life is important to them. Palliative care focuses on just that question, leading more hospitals to provide support for palliative care, and more physicians to practice in this field.

Popular wisdom has held that palliative care services are more widely accepted among the mainstream English-speaking population than among ethnic minorities. However, when the California HealthCare Foundation, as part of its multi-million dollar initiative to improve palliative care services in public hospitals in California, did a survey in 2010 of patients receiving palliative care in the state, it found that an incredible 40% spoke limited English. Since palliative care depends heavily on regular, clear communication between patients, providers, and families, it was evident that interpreters would be key members of any palliative care team serving limited-English-speaking patients. For interpreters, palliative care conversations – especially those occurring at the end of life – can be among the most difficult to interpret, not only linguistically and culturally, but personally as well. Yet there has been little training for interpreters in this field. The CHCF understood that training for interpreters would have to be an integral part of its wider palliative care program if services were to improve. This curriculum is the result.

### **Who is the course for, and what is it trying to accomplish?**

This seven-hour workshop is designed for working interpreters who have already received basic training in healthcare interpreting. As such, this curriculum does not set out to specifically teach basic concepts in interpreting such as role, ethics, conversation skills, or standard interpreter protocols. Rather, the curriculum is designed to help interpreters learn more about palliative care as a field and apply their knowledge and skills about interpreting to these difficult conversations. At the same time, Lesson 2 on Interpreting Skills in Palliative Care can also serve as an opportunity to reinforce basic interpreting skills with participants who may need a review. Overall, there are three major messages that we want students to take home.

1. Palliative care is a distinct and rapidly expanding area of medicine with which all interpreters should be familiar.
2. Palliative care conversations present unique challenges for interpreters that require specific knowledge and skills to overcome.
3. Through study and reflective practice, interpreters can expand their knowledge and improve both their interpreting skills and comfort level related to interpreting in palliative care settings.

## **What's in the curriculum?**

This curriculum comprises four “pieces”: the lessons, the handouts (including the interpreting practice dialogues), the video, and the PowerPoint presentation.

### **1. The lessons**

You will notice that the lessons are all structured in the same way.

#### **a. Time**

This tells you how much time is scheduled for this lesson. Although you are free to adjust the time, you should know that this is a fast-paced workshop, and adding time to one lesson will make it difficult to complete other lessons.

#### **b. Introduction**

The introduction gives you a general sense of why this topic is important in the overall scheme of the workshop.

#### **c. Learning Objectives**

Each lesson includes specific skills that participants should be able to demonstrate at the end of the workshop. The learning objectives served as the basis for the development of the post-test, although there are interpreting skills that could not be tested in the short scope of this workshop.

#### **d. Preparation**

These are the tasks that you must complete before the workshop in order to be ready to teach.

#### **e. Lesson Plan**

The lesson plans in this workshop are designed to be both participatory and to fit in the time allotted. As a trainer, you may decide to adjust the lesson plans to better fit the particular group of participants or your own teaching style. We recommend, however, that you choose teaching techniques that are as participatory as possible, recognizing that participants will internalize the content better if they are given the opportunity to interact with the content and each other.

#### **f. Content**

This section includes the material you will be teaching, which you must learn yourself before you can present it effectively. In addition to the content included here, you may wish to do additional research on the web to learn more in order to be prepared for questions. Two excellent sites with information on palliative care are <http://www.getpalliativecare.org/> and <http://nhpco.org>.



g. Teaching tools

These materials are not for distribution; they are meant to assist you in preparing and teaching the material in the lesson.

**Trainer's Note**

*Scattered through the lessons you will find Trainer's Notes like this one. These are designed to give you tips about how to best prepare for a particular class, pitfalls to avoid when teaching certain material, or strategies for addressing challenges in teaching a particular lesson.*

2. The handouts

The handouts are included at the end of the curriculum for easy photocopying. The interpreting practice dialogues, the glossaries and the documents for sight translation are available in traditional Chinese (often read by speakers of Cantonese), simplified Chinese (often read by speakers of Mandarin), Korean, Russian, Spanish, Tagalog, and Vietnamese. These languages were chosen because they are the most common non-English languages spoken in California. Please feel free to have the handouts translated into other languages as needed, acknowledging the California HealthCare Foundation as the source.

3. The video

The video accompanying this course shows participants examples of a few brief conversations that might take place in a palliative care environment: in this case, one dealing with end-of-life decision-making. The conversations have been designed however, not to focus on the patient and provider's decision-making process, but to highlight the decisions that an interpreter must make in facilitating the communication among the speakers. It is important that, as a trainer, you familiarize yourself with the video carefully and with the decision points that the short scenes illustrate.

4. The PowerPoint presentation

While lectures (at their worst) can send participants to sleep, an interactive lecture with clear teaching points, accompanied by interesting graphics in a PowerPoint format, can be interesting and effective. As with the video, it is important to learn the content yourself and practice with the presentation before attempting to use this tool to teach; you will notice that it does not consist of the typical bulleted list but depends more on pictures to reinforce the spoken message. As always, preparation will be key to successful teaching.

## **How should the curriculum be used?**

Every trainer prepares differently for the classes he or she teaches. Here are some suggestions, though, that may help you prepare effectively to teach this fast-paced and emotionally intense workshop.

1. **Read everything first** to get an overall sense of how the course is laid out. Watch the video. Run through the PowerPoint. Don't worry about mastering the content or the materials yet; just get familiar with the layout of the workshop.
2. **Find out who your participants will be.** We include here an example of a survey you could have participants fill out before the class that will give you an idea of the languages, previous training and interpreting experience of your students, allowing you to adjust the workshop to the needs of the students.
3. **Go back and prepare for each particular class.** Start by reading the lesson plan through first to give yourself an idea of how the class is supposed to work.
4. **Study the content section** to learn the material you are going to teach. Note down questions you have as you read; if a question occurs to you, it will certainly occur to your students! Research those questions online to find the answers.
5. **Prepare a class outline.** Not even the most experienced trainers can teach directly from a document with dense text, like this curriculum. A class outline contains instead your own bulleted notes to remind yourself quickly and easily of what you want to teach, how you want to teach it, and how much time you have allotted yourself. Also, the act of creating the outline will help you internalize the content and your chosen methods. Attached here you will find an example of what the class outline for the first lesson might look like.
6. **Prepare your materials.** Make sure your computer works with the data projector. Check that the markers haven't dried up. Get the handouts photocopied. Learn how to use the video player on your computer, or order a DVD player and monitor for the class. Think of everything that could go wrong, and plan your back-up!
7. **Practice.** Some trainers rehearse their presentations, especially if they are teaching a class for the first time. At the very least, practice with the PowerPoint presentation and the video, as the integration of the technology with the oral presentation can be a bit tricky at first. As a matter of fact, practice several times.
8. **Take a deep breath,** and
9. **Enjoy your class!** Your students will appreciate this opportunity to learn new information and vocabulary, practice their skills, and interact with colleagues.

**Interpreting in Palliative Care  
A Continuing Education Workshop for Interpreters in Health Care**

**Date:** \_\_\_\_\_

**Trainer's Name:** \_\_\_\_\_

**Student Survey**

*Please complete the following questionnaire and return it to the trainer listed below no later than the indicated date. The information you provide will be used by the course instructor to prepare course materials and activities.*

**Name:** \_\_\_\_\_

**Language combinations:** \_\_\_\_\_

**Job Title:** \_\_\_\_\_

**Please describe your professional experience in interpreting, including any training courses or academic programs.**

**Please describe how you learn best.**

**Please state what you would like to gain from this course. List any specific knowledge, skills and/or subject matter related to interpreting in palliative care settings that you would like this course to address.**

*Please return to:*

*Please return by:* \_\_\_\_\_

*Survey designed by Katherine Allen, MA*

## Sample Class Outline

**Title: Lesson 1: Introduction to Palliative Care (PC)**

**Date:** \_\_\_\_\_

Time	Topic	Key Content	Teaching Method	Materials
	Student definitions of PC	<ul style="list-style-type: none"><li>• Student stories</li></ul>	<ul style="list-style-type: none"><li>• “Who has interpreted for a palliative care encounter?” 2 stories</li></ul>	<ul style="list-style-type: none"><li>• Flip chart</li><li>• Markers</li><li>• Computer</li><li>• Internet access</li></ul>
	Why PC?	<ul style="list-style-type: none"><li>• Student definitions</li><li>• PC is needed because of the changing face of illness in the U.S.: moving from acute to chronic, from curing to managing.</li></ul>	<ul style="list-style-type: none"><li>• Elicit definitions of PC based on stories.</li><li>• Audio of Dr. Meier's interview</li></ul>	<ul style="list-style-type: none"><li>• Speakers for computer</li><li>• PP presentation cued</li><li>• Note cards on PP presentation</li></ul>
	What is PC?	<ul style="list-style-type: none"><li>• PC manages symptoms but doesn't cure.</li><li>• PC focus on quality of life for patient and family.</li><li>• Compare PC, hospice, pain management.</li><li>• PC provided by teams</li><li>• Implications for interpreters</li></ul>	<ul style="list-style-type: none"><li>• PP</li></ul>	
	Summary and review		<ul style="list-style-type: none"><li>• Review definitions on flipchart; ask for revisions.</li></ul>	
	Break		<ul style="list-style-type: none"><li>• Give 15-minute break</li></ul>	

## Class Outline Template

**Title:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Time	Topic	Key Content	Teaching Method	Materials

## **Workshop Schedule**

<b>Time</b>	<b>Topic</b>
8:30 – 9:00	Arrival and Sign-in
9:00 – 9:20	Getting Started
9:20 – 10:15	Introduction to Palliative Care
10:15 – 10:30	<i>Break</i>
10:30 – 12:00	Interpreting Skills Applied to Palliative Care
12:00 – 12:30	<i>Lunch</i>
12:30 – 1:30	The Vocabulary of Palliative Care
1:30 – 2:45	Practice Interpreting
2:45 – 3:00	<i>Break</i>
3:00 – 3:45	Sight Translation in Palliative Care
3:45 – 4:30	Belief and Emotion in Interpreting
4:30 – 5:00	Post-test and Final Evaluation

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**SIGN-IN SHEET**

*(Please print)*

Name	Job Title / Institution	Language Combination(s)	Email
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			





## **Activity: Getting Started**

**Time:** 9:00 – 9:30 (sign-in at 8:30, with the class starting promptly at 9:00)

### **Introduction**

The beginning of any training sets the tone for the rest of the day, establishing a safe and friendly learning environment, and providing key information about the logistics of the course. In a short and intensive workshop such as this one, the opening must also be done as quickly as possible, in order to cover all the material in the time allotted.

### **Learning objectives**

At the conclusion of this activity, students will have:

1. Met their colleagues.
2. Learned what the workshop will cover.
3. Taken a pre-test.

### **Preparation**

1. Survey students before the day of the workshop.
2. Review content and lesson plan.
3. Develop a class outline based on the content and lesson plan.
4. Secure flipchart and markers
5. Write the course objectives and the agenda on large pieces of flipchart paper to post on the wall.
6. Make sufficient copies of Handout #1 (What Do You Know Already?).
7. Create a sign-in sheet on which you ask participants to print their name and contact information. Include a bolded note that the certificates will bear the names as they appear on the sheet. A suggested template is included on page 15 of this curriculum.
8. For each student, provide a name tag (which moves with the student into small group work), and a name card in the form of a table tent (which is easier for the trainer to see).
9. Prepare a logistics handout, including information on
  - a. the location of the restrooms
  - b. how lunch will be handled

- c. when you will mail certificates to those who pass the final test
  - d. how continuing education credit will be assigned.
10. Provide a resource table with bilingual medical dictionaries, practice materials, and any other resources you deem appropriate.
11. Set up the room with the tables in an open “U” shape if possible. This configuration leads to more class interaction. Avoid the classroom style of desks in rows if at all possible.

## **Lesson Plan**

### Sign in (8:30 – 9:00)

For some reason, people have a tendency to arrive late to morning trainings. For this reason, it's a good idea to publicize the start of this training as 8:30 a.m. This provides some wiggle room for the participants to get lost, find the facility, park, find the training room, sign in, get a name tag, and find a seat, all with lots of time so that you can start precisely at 9:00.

Place the sign-in sheet, the name tags, the name tents and the logistics handout on a table at the entrance for students to pick up as they enter. Give a ten-minute warning and a five-minute warning, and be prepared to start right at 9:00.

### Welcome and introductions (9:00 – 9:10)

Welcome the participants and introduce yourself.

Ask the participants to introduce themselves by stating:

- a. their names,
- b. their language pairs,
- c. where they interpret, and
- d. what they hope to learn.

Write these on the flipchart as a reference. Allow 30 seconds/student.

If the group has more than ten participants, use a different activity for group introductions.

#### **Trainer's Note**

*It is not unusual for participants to want to tell long stories when presenting themselves. While in-depth introductions can serve to build trust, in a one-day workshop you simply don't have the time. Limit participants to answering the four questions you asked. If you can find a way to do this with humor, so much the better. Some trainers use an egg-timer so that students hear a buzz when their 30 seconds are up.*

### Outline of course and logistics (9:10 – 9:15)

Referring to the course agenda on the flipchart paper, review the overall goals of the workshop and the specific topics that you will cover.

### Pre-test (9:15 – 9:30)

Pass out the pre-test (Handout #1: What Do You Know Already?). At 9:30, collect the pre-test and go on.

## Lesson 1: Introduction to Palliative Care

**Time:** 9:30 – 10:15

### **Introduction**

Palliative care is a relatively new field of medicine that is being increasingly incorporated into healthcare systems across the country. As a result, interpreters in healthcare settings will be more and more likely to be interpreting for encounters discussing palliative care. The better they understand the goals, techniques and challenges involved in this type of care, the better they will be able to facilitate clear communication among providers, patients and caregivers.

### **Learning Objectives**

At the conclusion of this lesson, students will be able to:

1. Choose the correct definition of palliative care from among four choices.
2. Identify one common reason why a provider might request a palliative care consultation.
3. Explain in general terms the relationship between curative care, palliative care, hospice care, and pain management.

### **Preparation**

1. Review content and lesson plan.
2. Develop a class outline based on the content and lesson plan.
3. Practice the PowerPoint presentation. Practice it again. And again.

#### **Trainer's Note**

*This slide presentation uses images and the occasional bulleted text to emphasize the spoken word. As a result, it is both more interesting to watch and more difficult to present than most slide shows. Instead of reading from the slides that appear; you will want to present coherently and use the images to support your talk. While a text is provided under Content, complete with notes about when to advance the PowerPoint animation, you will sound more natural if you learn the material and present from note cards instead of trying to read the sample text. This will require preparation and practice! You may even want to try audiotaping yourself to see how you sound.*

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4. Secure audiovisual equipment:
  - PowerPoint presentation
  - Laptop and data projector
  - Screen
5. Make sufficient copies of Handout #2 (Why Do We Need Palliative Care?) **OR** prepare to use the audio version at <http://www.thirteen.org/openmind/health/palliative-medicine-care-versus-cure/2038/>, (minutes 18:20 – 20:58).
6. Make handouts of the PowerPoint slides **with the notes page**, in landscape orientation.

### **Lesson Plan**

1. Ask the group who has interpreted for a palliative care conversation. Ask for a few brief descriptions.
2. Ask the group, “So, based on these stories, how would you define palliative care?” Entertain 3 or 4 responses and write them on the flipchart. Do not comment on them.
3. Pass out Handout #2 to three students. Have each read one paragraph aloud to the group. **OR** play the audio version of this section of the interview with Dr. Meier. At <http://www.thirteen.org/openmind/health/palliative-medicine-care-versus-cure/2038/>, minutes 18:20 – 20:58.
4. Show the PowerPoint presentation attached to this curriculum. A sample script is provided under Content to give you an idea of how it might be done.
5. Return to the definitions that you collected at the beginning of the class; review them one by one, and ask the group to add to or correct them.
6. Review the key points.
7. At 10:15 give a 15-minute break.

### **Content**

#### Slide #1

Advances in medicine have transformed our society. (*advance*) Fewer people today (*advance*) die of infectious disease, and (*advance*) more people are living longer. (*advance*) But in addition, (*advance*) more people are living longer with serious and chronic illnesses. Many of these patients live with the ongoing physical, functional, mental, and emotional effects of their health conditions. To improve their care, a new field of medicine has emerged. It is called palliative care. (*advance*)

Slide #2

Even interpreters with professional training and solid experience will find that interpreting in palliative care requires some special techniques and vocabulary. That's why the California HealthCare Foundation has created this program: to help interpreters be better prepared to interpret in palliative care and end-of-life encounters. *(advance)*

Slide #3

But what is palliative care? Palliative care, as described by the [Center to Advance Palliative Care](#), **is the medical specialty focused on improving the overall quality of life for people facing serious or life-threatening illness.** Palliative care emphasizes pain and symptom control, intensive communication (including family support and shared decision making), and coordination of care. Palliative care focuses not only on physical comfort, but on emotional and spiritual well-being as well.

Palliative care is a relatively new field of medicine. The name comes from the term *(advance)* "palliate," which means, *(advance)* to make less severe or intense. *(advance)* In medicine, "palliate" means to lessen the severity of pain or disease without curing or removing the underlying cause. So, for example, palliative chemotherapy usually aims to shrink or slow the growth of a cancer, not to cure the cancer. Palliative radiation therapy usually helps lessen symptoms like shortness of breath, confusion or pain, but will not make the tumor go away. And palliative care in general focuses on **improving the overall quality of life for people facing serious or life-threatening illness, not on curing the cause of the illness.** *(advance)*

Slide #4

So this is this first important point. Palliative care *(advance)* treats, *(advance)* prevents or *(advance)* relieves the symptoms of a serious or chronic illness, but *(advance)* it does not cure it. *(advance)*

Slide #5

The second important thing to remember about palliative care is that it can be delivered at any time in a patient's illness. It can be delivered at the same time as curative treatment, or it can be delivered by itself, when further curative treatment wouldn't be useful. The ultimate goal is to improve quality of life for patients who are facing serious illness, as well as for their family and friends. *(advance)*

Slide #6

So, in a nutshell, palliative care improves the quality of life for patients who are facing serious illness as well as for their family and friends. *(advance)*

Slide #7

*(advance)* When a patient is approaching the end of life, you may hear various terms to describe the patient's options for care. In addition to "palliative care," you may hear terms like *(advance)* "hospice care", *(advance)* "pain management", and *(advance)* "comfort care." *(advance)* How are these related? *(advance)*

Slide #8

These various types of medical care have a lot in common. Both palliative care and hospice emphasize *(advance)* comfort and quality of life for patients who have serious illnesses. *(advance)* Both seek to provide comprehensive, holistic care, addressing spiritual and psychosocial issues in addition to physical symptoms. *(advance)* Both are provided by multi-disciplinary teams, and *(advance)* both address patients together with their families. *(advance)*

Slide #9

However, hospice care is a specialized form of palliative care, offered to patients who are expected to die within six months *(advance seven times)* and who no longer desire life-sustaining treatments. Unlike hospice patients, patients receiving palliative care may still be getting treatments whose main purpose is to prolong life. *(advance)*

Slide #10

There are other differences as well. Hospice care can be provided at home *(advance)*, in a nursing or assisted living facility *(advance)*, or in an inpatient hospice, *(advance twice)*, but it is NOT usually provided in the hospital. Also, hospice has its own payment structure and regulations under Medicare and Medicaid. *(advance)*

Pain management is a more focused type of care, limited to keeping the patient as free of pain as possible. Experts in pain management have found many techniques –based in pharmacology, in psychology, and even in medical technology – for helping patients live with pain. Pain management is an integral part of both palliative care and hospice care. It can also be used together with curative therapies, or independent of all three as part of treatment for chronic pain.

Slide #11

This graphic can help explain the relationship between the various forms of care. Usually life-prolonging therapy and hospice care do not overlap. Hospice is a specialized form of palliative care. Pain management can be part of all three of these, but each does more than just manage pain. And the management of chronic pain is usually different than all of them. *(advance)*

Slide #12

You may hear the term “comfort care.” This term can be confusing. Some people use this term to mean the same thing as palliative care. Sometimes it means “comfort measures only” and is closer to the meaning of hospice care. *(advance)*

Slide #13

So, let’s look at what palliative care services include. According to the Center to Advance Palliative Care, “Palliative care programs support the primary physician and the patient by *(advance)* providing time to devote to intensive family meetings and patient/family counseling; *(advance)* expertise in managing complex physical and emotional symptoms such as pain, shortness of breath, depression and nausea; *(advance)* support for resolving questions and conflicts between families/patients and

physicians concerning care goals, DNR orders and treatment requests, and (advance) coordination of care across health care settings.” (advance)

Slide #14

Clearly, providing all these services requires a range of knowledge and skills that spans various disciplines. This is why palliative care is delivered in teams. While teams differ by facility, a palliative care team often includes (advance) one or more physicians who specialize in palliative care, (advance) nurses, (advance) social workers and (advance) chaplains. (advance) Palliative care is definitely (advance) a team effort. (advance)

Slide #15

Doctors may call for a palliative care consult for a variety of reasons. (advance) Perhaps they want to clarify the patient’s “goals of care.” This means that they want to understand better what a patient is hoping will be the outcome from a course of treatment. Or they may need help in (advance) managing a patient’s pain or other symptoms. A palliative care team can also help a physician in (advance) planning for a patient discharge. The team is often called to help with (advance) difficult communication situations such as breaking bad news or discussing withdrawal of life-prolonging treatments. (advance)

Slide #16

So what does all this mean for an interpreter? First of all, a palliative care consult will involve interpreting for a patient who may feel quite ill. The patient may or may not be nearing the end of life. (advance) There may be difficult issues discussed, and difficult decisions may have to be made. (advance) Certainly, the encounter will be longer than usual and may include family members or multiple caregivers. (advance)

Slide #17

One important thing to remember is that palliative care teams are not just concerned with what the patient or family says, but about (advance) the underlying meaning – what we call “the subtext.” (advance) Are there messages that are not being communicated through words? (advance) Are there cultural issues that are impacting the communication? It is especially important that providers be made aware of these things so that they can inquire more deeply into patients’ and families’ beliefs, values and wishes.(advance)

Slide #18

As I mentioned, palliative care conversations can be difficult. (advance) You may be surprised to hear that physicians often have very limited training in communication and end-of-life care and may themselves have difficulty with sharing bad news or shifting the conversation from curing a disease to reducing its symptoms. Add cultural and linguistic differences to the mix, and providers may not be as skillful at these conversations as we might wish. When clinicians feel uncomfortable, (advance) and when patients and families get upset too, (advance) the interpreter may often feel caught in the middle. It is normal to want to escape from things that are painful or difficult – doctors, nurses, social workers, patients, families, and interpreters as well. But the more you know, the better

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you will be at helping these difficult discussions go more smoothly for everyone involved. (advance)

### Slide #19

So, here's a quick review.

Palliative care is an approach to treatment that focuses on helping patients with serious or life-limiting illnesses to (advance) maximize their quality of life. It emphasizes (advance) management of pain and other symptoms, (advance) communication among the treating physicians, (advance) coordination of medical and supportive services, (advance) assistance with patient decision-making about care, and (advance) support for caregivers. (advance) It is delivered by a team, and, for patients and families with limited English proficiency, interpreters are a key part of that team.(advance)

### Slide #20

Questions, anyone?



## **Lesson 2: Interpreting Skills Applied to Palliative Care**

**Time:** 10:30 – 12:00

### **Introduction**

This lesson will serve both as a review of good interpreting practice for trained interpreters, and as an introduction to good practice for those who may be lacking adequate basic training. It will also introduce some interpreting challenges specific to palliative care and provide interpreters with practice in identifying and evaluating response options.

### **Learning Objectives**

At the conclusion of lesson, students will be able to:

1. Provide three examples of situations in which it would be appropriate to ask for, or suggest, clarification in communication between the patient/family and provider.
2. Discuss options to address interpreting challenges and select the option that best represents appropriate interpreting techniques.
3. Describe three cultural considerations common in palliative care conversations between providers and patients from cultural groups for whom the participant is likely to interpret; propose at least two possible actions that the interpreter could take if these cultural issues seem likely to create a misunderstanding.

### **Preparation**

1. Watch the video.
2. Review the content and lesson plan.
3. Develop a class outline based on the content and the lesson plan.
4. Practice pausing the video at the correct places.
5. Secure audiovisual equipment:
  - Video: *Interpreting Challenges in Palliative Care*
  - Laptop and data projector
  - External speakers
  - Screen

## **Lesson Plan**

This lesson uses a video to reinforce good interpreting practice, introduce new techniques and highlight challenges common to interpreting in palliative care. As the class watches the video, pause the video where indicated and pose the questions suggested. (The script is included after the chapter, with the pauses indicated in red).

The goal here is twofold; first we want the students to remember what they've learned in basic training. Secondly, however, we want to get students thinking in terms of options and consequences. In many cases, there is not just one acceptable course of action. There could be several, some more appropriate to this particular situation and some less so. Students may even suggest creative answers not illustrated here, which is just fine if they can show how their response effectively facilitates understanding in communication. Once you have elicited feedback from the class as to Carmen's options for each discussion point, refer to the options provided for each dilemma and add anything the class missed. Be sure to include the "best option" solution for each dilemma.

### Scene 1

1. Introduce Scene 1 of the video

The class is going to follow one interpreter through a series of assignments related to palliative care. Coming up are three videos clips about Carmen de la Vega, a fictional freelance Spanish interpreter. Carmen is going to interpret for several encounters related to Mrs. Jacinta Loreto, a 50-year old woman of Mexican origin who speaks limited English. Interpreters constantly make decisions about how best to handle the varied situations they run into. As you follow Carmen through these assignments, you will be stopping at key points when Carmen has to make a practice decision so the class can evaluate her options and decide which would be best.

2. Play video, scene 1, lines 1.1 – 1.7. Pause video. Elicit from the group the good interpreter practices they noticed in this first scene.
3. Play video, scene 1, lines 1.8-1.9. Pause video. Point out that the doctor has started speaking Spanish and that he didn't let Carmen do her pre-session. Elicit from the group what they think Carmen could do.
4. Play video, scene 1, lines 1.10 – 1.23. Pause video. Suggest that Carmen doesn't know what "metastasized" means. She thinks it means that the cancer is now in Mrs. Loreto's liver, but she's not sure. Elicit from the group ideas about how Carmen could handle this.

**Trainer's Notes**  
*Starting and stopping the video while you present may be a challenge. If possible, prepare an assistant to pause the video as indicated in the attached script, restarting it at your indication.*

### *Interpreting in Palliative Care*

5. Play video, scene 1, lines 1.24 – 1.45. Pause video.  
Mrs. Loreto seems to be confused by this discussion of palliative care, as if she doesn't really understand what the term means. But she's not asking for clarification, and Dr. Halferty just appears to be getting frustrated. What could Carmen do?
6. Play Scene 1, lines 1.46 – 1.54. Pause video.  
Mrs. Loreto is understandably very upset by the news that the doctors have no more curative treatments to offer her. What could Carmen do?
7. Play Scene 1, line 1.58. Pause video.  
Carmen has run up against a word that has no good equivalent in the target language. Explain that there is a word in Spanish for "hospice" (*hospicio*) but the image it evokes is that of an orphanage or a place where the elderly are abandoned to die. Because of this, "hospice care" is often translated the same as "palliative care": *cuidados paliativos*. But Carmen has already used this term when the doctor was referring to "palliative care" earlier. He clearly wants to make a distinction here between the two types of care. What could Carmen do?
8. Play Scene 1, lines 1.59 – 1.78. Pause video.

### Scene 2

9. Introduce Scene 2  
Palliative care discussions take place, not only with patients, but with patients' families as well. This introduces a series of additional challenges for interpreters. The next scene shows Dr. Halferty speaking with Mrs. Loreto's adult children, Javier and Elena, about her condition.
10. Play Scene 2, lines 2.1 – 2.15. Pause video.  
Javier is getting really angry. This may get in the way of the communication. What could Carmen do?
11. Play Scene 2, lines 2.16 – 2.29. Pause video.  
Javier and Elena have gotten in a heated discussion in Spanish, and even though Carmen has used the hand signal, they aren't pausing to let Carmen interpret. What could she do?
12. Play Scene 2, lines 2.30 – 2.61. Pause video.  
Stuck again! Dr. Halferty, Elena and Javier don't seem to be understanding each other. Dr. Halferty clearly wants them to make a decision, which seems very reasonable from his point of view. But the family wants to wait till all the siblings are present, which is not at all an unusual expectation for a Hispanic family. Carmen wonders if this cultural difference is what has them stuck. But she doesn't want to stereotype the family. What could she do?

13. Play Scene 2, lines 2.62 – 2.67. Pause video.

Why won't these two pause between speaking so that Carmen can interpret? Now, if Carmen just interprets, Dr. Halferty won't know who said what, and the exchange won't make any sense. What could Carmen do?

14. Play Scene 2, lines 2.68 – 2.72. Pause video.

### Scene 3

15. Introduce Scene 3

That communication worked out well, thanks in large part to Carmen's expertise in facilitating communication and her skill in knowing when to intervene and when to stay quiet.

But interpreters interpret for many types of providers. Sometimes the most challenging interpretations aren't those with lots of technical terminology, but those with emotionally difficult content, or with complex social interactions.

Introduce the next scene, in which Carmen will interpret one more time for Mrs. Loreto, this time at a long-term care facility where Mrs. Loreto is in a hospice program. Carmen has met Beverly Jamison, the facility's chaplain, outside Mrs. Loreto's room and has done a pre-session with her. The two are now meeting Mrs. Loreto.

16. Play Scene 3, line 1. Pause video.

What a shock. Mrs. Loreto looks much worse than she did last time Carmen interpreted for her. It's clear she really is dying. Carmen's not sure how to talk to a person who is close to death. In general terms, what would be both professional and compassionate?

17. Play Scene 3, lines 2 – 7. Pause video.

Carmen is faced with a choice. Mrs. Loreto doesn't know what a chaplain is. What could she do?

18. Play Scene 3, line 8 – 49. Pause video.

In line 3.49, Carmen is shocked to hear Mrs. Loreto's thoughts. For the sake of discussion, let's suppose that Carmen's own spiritual beliefs are quite different from Mrs. Loreto's and that the idea that God would abandon someone for not going to mass is deeply offensive. Carmen finds the thought of even uttering this idea profoundly distasteful. What could she do?

19. Play Scene 3, line 50 – 54. Pause video.

What is Beverly doing? Is she just chatting with the patient? See if the class can see some purpose to her questions. Share the information on FACT (see content).

20. Play Scene 3, line 54 – 64. Pause video.

Carmen finds herself faced with the possibility of interpreting a prayer that she does not know. And not just a conversational prayer, but a prayer that is written in what is called “frozen register” (see the definition under Content). Elicit ideas from the group as to how handle interpreting various types of prayer and sacred writings. Emphasize respect.

21. Play Scene 3, line 65 – 69. Pause video.

In line 3.69, Beverly and Mrs. Loreto prepare to say the Hail Mary together. Let’s imagine that Carmen is not familiar with this prayer in Spanish. What could she do?

22. Play the end of the scene.

23. Summarize the key points of the session and break for lunch at 12:00.

## **Content**

### **Scene 1: Patient-provider encounter**

#### Interpreter pre-session

The initial scene of the video serves to review some good interpreter practices that even trained interpreters can forget. For example, even though the doctor is a bit impatient, Carmen does a pre-session, in which she:

- introduces herself,
- informs provider that she’ll be doing a pre-session with the patient,
- asks the doctor to speak directly to patient,
- informs him that she’ll be interpreting everything,
- asks him to pause after every couple of thoughts, and
- shows him the “pause” signal.

Carmen’s pre-session is quick, to-the-point, professional, and friendly. She is also careful to set her cell phone to vibrate before entering the patient’s room.

#### Doctor speaks some Spanish

In lines 1.8 – 1.9, we see that the doctor has started speaking Spanish, without allowing Carmen do her pre-session. Carmen has a few options here.

- She could skip the pre-session and just start interpreting. This would be a poor choice. The pre-session is important in helping the patient understand how to work with the interpreter. Since Carmen has never worked with Mrs. Loreto before, she really needs to do a pre-session with her.
- She could skip the interpretation, since the doctor apparently speaks Spanish and the conversation isn’t clinical, and go right into the pre-session. This would also be a poor choice. Dr. Halferty has clearly said that he speaks only very limited Spanish, so he will need Carmen to interpret Mrs. Loreto’s speech. Even though the conversation is not clinical, it is important in establishing a relationship between Dr. Halferty and Mrs. Loreto that will be especially

important considering the difficult news to follow. Interpreting it reinforces both the importance of the patient-provider relationship, and the commitment of the interpreter to interpret everything.

- She could politely remind the doctor that she needs to do her pre-session before the session starts. This would be all right, but it is not Carmen's best option. Dr. Halferty is appropriately taking the lead in establishing a rapport with Mrs. Loreto. While Carmen's pre-session with Mrs. Loreto is important, there is a smoother way of slipping it in other than appearing to correct the doctor.
- She could interpret only Mrs. Loreto's speech back to the doctor, and then initiate the pre-session with the patient. This is Carmen's best choice. Carmen doesn't need to interpret Dr. Halferty's opening speech, as Mrs. Loreto will understand him. Dr. Halferty, however, may not understand Mrs. Loreto, as he has already said that he speaks only a very little Spanish, so her response does need to be interpreted. In addition, interpreting Mrs. Loreto's speech back to Dr. Halferty will give Carmen a perfect opportunity to slip smoothly into her pre-session, which she already told the doctor she would be doing.

#### Interpreter is unsure of meaning

In line 1.23, we see that Carmen isn't sure what "metastasized" means. Suppose that Carmen thinks it means that the cancer is now in Mrs. Loreto's liver, but she isn't positive. What could she do?

- Since she's pretty sure what the word means, Carmen could just interpret it that way, but this is a poor choice. Interpreters should not guess, especially in high-stakes conversations such as those involving discussion of diagnosis or prognosis. Making a mistake in this conversation could lead to confusion as to Mrs. Loreto's condition, which could have a direct impact on the choices she makes about her future care.
- Since she isn't totally sure what the word means, Carmen could just leave the phrase out. This is also a poor choice, but one that, unfortunately, interpreters make all too often. Editing what was said because the interpreter doesn't know what it means violates the Interpreter Code of Ethics. Mrs. Loreto needs to hear everything the doctor says in order to make choices about her future care. Try again.
- Since she isn't totally sure what the word means, Carmen could just use the word in English. There are times when using a word in its English form is appropriate, but this is not one of those times. "Metastasize" is a high-register word even in English, and it is unlikely that Mrs. Loreto would understand it, leading to confusion that could impact Mrs. Loreto's choices about her future care.

- Since she isn't totally sure what the word means, she could ask the doctor to clarify. This is the best choice. Interpreters should not guess as to a speaker's meaning, especially in high-stakes conversations such as those involving discussion of a new diagnosis or prognosis. If Carmen is not confident that she understands what the doctor said, she must ask for an explanation to clarify.

#### Patient is confused

In line 1.45, Mrs. Loreto seems to be confused by this discussion of palliative care, as if she doesn't really understand what the term means. But she's not asking, and Dr. Halferty just seems to be getting frustrated. What could Carmen do?

- Clearly, Mrs. Loreto doesn't understand that she is going to die. Carmen could explain it to her in more direct, simpler terms. This is a poor option. While it is appropriate for the Carmen to identify and be concerned that Mrs. Loreto does not appear to understand what the doctor is trying to say, it is not the interpreter's place to explain healthcare concepts. This is the provider's role. Palliative care providers are particularly sensitive to appropriate ways to discuss end-of-life issues.
- Carmen could do nothing. Dr. Halferty is responsible for the interview and, if Mrs. Loreto doesn't understand, he'll figure it out and deal with it. This is not the best option. It is true that Dr. Halferty is responsible for this interview, and he may eventually figure out that Mrs. Loreto is confused, but after three conversational exchanges, he hasn't picked up on it yet. It would not be outside the interpreter's role of facilitating understanding in communication for Carmen to take an additional step.
- Carmen could share her concerns that Mrs. Loreto may not understand the implications of palliative care and then let Dr. Halferty decide how to proceed. This is the best option. After several conversational exchanges, Dr. Halferty doesn't seem to recognize Mrs. Loreto's lack of understanding. In the interest of facilitating understanding in communication, Carmen could share this concern with Dr. Halferty, as long as she maintains transparency as she does so.

#### Patient is upset

In line 1.54, Mrs. Loreto is understandably upset by the news that the doctors have no more curative treatments to offer her. What could Carmen do?

- Carmen could reach over and give Mrs. Loreto a hug or squeeze her hand. However, while there may be times when touching a patient may be appropriate, this is not one of those times. Dr. Halferty is clearly a very compassionate doctor, who has no doubt dealt with many distraught patients and who, given the chance, will most likely provide appropriate support to Mrs. Loreto. Touching the patient at this point might make Carmen feel better, but it would intrude on the patient-provider communication, drawing attention away from the provider to the interpreter.

- Carmen could intervene transparently and inform Dr. Halferty that this display of emotion is common in Hispanic culture. This is a poor choice. Mrs. Loreto's reaction is also common in the dominant culture and does not need explaining.
- Carmen could go get some tissue for Mrs. Loreto. This is a kind gesture that might be appropriate under other circumstances. Carmen's role, however, is to facilitate communication. If she becomes distracted with getting tissues, she robs both Mrs. Loreto and Dr. Halferty of their voices and their ears just at the point when communication is most critical.
- Carmen could do nothing.  
This is the best option. Mrs. Loreto's reaction is entirely natural and one that would not be misunderstood in the dominant culture. It is not disrupting communication, there is no confusion, and Dr. Halferty is clearly a compassionate doctor who has a great deal of experience responding to upset patients. While Carmen may feel upset at seeing Mrs. Loreto's distress, she needs to compartmentalize this feeling until the interpretation is done, and deal with it later. There is really no reason for Carmen to intervene at all at this moment.

#### Lack of linguistic equivalence

In line 1.58, Carmen runs up against a word that has no good equivalent in the target language. There is a word in Spanish for "hospice" (*hospicio*) but the image it evokes is that of an orphanage or a place where the elderly are abandoned to die. Because of this, "hospice care" is often translated the same as "palliative care": *cuidados paliativos*. But Carmen has already used this term when the doctor was referring to "palliative care" earlier. He clearly wants to make a distinction here between the two types of care. What could Carmen do?

- Carmen could use the term "palliative care," *cuidados paliativos*. However, if Carmen simply uses this term, it will not be clear that Dr. Halferty is offering something different from what he discussed with Mrs. Loreto earlier.
- Carmen could use the cognate for hospice, *hospicio*. Knowing the image that this term evokes for many Spanish speakers, it is clear that *hospicio*, while a cognate of "hospice," is not an accurate interpretation, as it does not convey the same meaning. Remember that interpreters interpret meaning, not words.
- Carmen could create a word picture for the term "hospice."  
This is part of the best answer. However, considering that Dr. Halferty speaks some Spanish, and the need for Mrs. Loreto to clearly understand this concept in order to be able to answer the doctor's question, there is a better, more complete answer.
- Since Dr. Halferty speaks some Spanish, Carmen should explain why she can't use the cognate and suggest a word picture for the doctor's approval. Since Dr.



Halferty speaks some Spanish, he may pick up on whatever word picture Carmen decides to substitute for this sensitive term, so sharing the paraphrase with him and asking permission is a good idea. By explicitly discussing this with him, Carmen is also alerting Dr. Halferty to a linguistic difference that may be important for future conversations he has with Spanish speakers.

## **Scene 2: Family conference**

### Family member is angry

In line 2.15, we see that Javier is getting really angry. This may get in the way of the communication. What could Carmen do?

- Carmen could intervene to calm Javier down, so that the conversation can proceed more normally. On the other hand, Javier has the right to express his feelings; indeed, it is important that Dr. Halferty address Javier's anger and frustration so that the family can come to a decision of how to proceed. If the interpreter shuts Javier down, his concerns cannot be addressed, and this may impact the outcome of the conversation. Remember, the interpreter is not responsible for **what** is said, only for making sure that it was **understood**.
- Carmen could interpret what Javier said, but without the angry tone so the doctor is not offended, as this could impact the rapport between the family and the doctor. However, removing the angry tone of voice actually changes the meaning of Javier's speech, so such an interpretation would be inaccurate. Dr. Halferty needs to hear how angry Javier is so that he can address that anger. Indeed, Javier's reaction is not unusual, and a provider experienced in end-of-life care will know how to deal with it.
- Carmen could intervene to explain to Javier that in the U.S., the patient has the right to make decisions about her own health, so this is his mother's choice, not his. While helping patients understand the culture of the healthcare system is sometimes appropriate, this is not the time. Javier is not confused about how the U.S. healthcare system works; he is angry that his mother is going to die. Dr. Halferty can help Javier deal with that anger, but only if he knows what was said.
- Carmen could interpret exactly what Javier said, in a tone of voice just a bit less angry than the tone Javier used. This is her best option. The role of the interpreter is to facilitate understanding in communication. While it may be uncomfortable at times, the speakers decide what they want to say, and the interpreter's responsibility is to make sure it was understood by the listener. This includes speech that is angry, offensive, frustrated, sad; patients and their families have the right to express and to be understood while expressing all of these emotions. And when patients and families are dealing with serious illness, it is not uncommon for them to express a great deal of upset and unhappiness. It is the interpreter's job to interpret everything just as it was said.

Why use a tone of voice just a bit less angry than Javier? This assures that the interpreter is not perceived as mocking the patient.

Family gets into a side conversation

In line 2.29, Javier and Elena have gotten in a heated discussion in Spanish, and even though Carmen has used the hand signal, they aren't pausing to let Carmen interpret. What could she do?

- Carmen could simply not interpret this discussion, as it was not meant for the doctor. When Javier and Elena are done, Carmen should begin interpreting again from there. This is a poor option that will lead to Dr. Halferty missing the concerns being expressed by Javier and Elena. If Javier and Elena spoke English, Dr. Halferty would be able to understand their argument and address their concerns. The interpreter's job is to make sure that everyone in the room understands everything that is said, regardless of the person to whom the speech is directed.
- Carmen could wait until Javier and Elena stop and then summarize their argument. This is better than not interpreting their conversation at all, but it is not the best option. Summarization, by definition, will lead to much content being omitted. It is important for Dr. Halferty to hear everything that is being said, just as he would if Javier and Elena were arguing in English.
- Carmen could start to take notes. When Javier and Carmen finally stop, she can use the notes to interpret their argument. This is a reasonable option, and depending on Carmen's skills, it might be the best option. If Carmen is skilled at note-taking, she will be able to recreate the argument verbatim when it is over. However, while the discussion is going on, Dr. Halferty will have no idea of what is happening.
- Carmen could move closer to the doctor and do a simultaneous interpretation of the argument. This may be the best option, if Carmen is skilled in simultaneous interpreting. Using a technique called *chuchotage*, Carmen can move closer to the doctor and quietly interpret what is being said as it is being said. This way, Dr. Halferty can follow the discussion without losing time.

Generally, simultaneous interpreting doesn't work well in interpreting dialogues, as the speaker tends to stop talking when the interpreter starts interpreting. In this case, however, Javier and Elena are focused on talking to each other, so the *chuchotage* will be unobtrusive.

Lack of understanding, possibly due to cultural differences

In line 2.61, the conversation gets stuck again. Dr. Halferty, Elena and Javier don't seem to be understanding each other. Dr. Halferty clearly wants them to make a decision, which seems very reasonable from his point of view. But the family wants to wait until all the siblings are present, which is not at all an unusual expectation for a

Hispanic family. Carmen wonders if this cultural difference is what has them stuck, however, she doesn't want to stereotype the family. What could she do?

- Carmen could intervene and urge Javier and Elena to make a decision. This is a poor option. Decisions are up to the patient, the provider and the family. Interpreters should not even express opinions about what decision should be made, much less urge any party to take a particular course of action.
- Carmen could intervene and share the name of an immigration lawyer who could get Ramón an emergency medical visa so he can come. This is also a poor option. Whether and how Ramón might be able to come to be with the family is not the problem here. The problem is that the doctor and the family have not been able to agree on a course of action, and neither understands the other's point of view.
- Carmen could do nothing and let Dr. Halferty work this out. This is not a bad option, but it is not the best option. It may be that with time, Dr. Halferty could work through this impasse. However, the conversation has already gone back and forth several times, and it seems to be going nowhere, largely because neither side is understanding the other.
- Carmen could intervene and share her perspective with Dr. Halferty. This is the best option, which is called "culture brokering." As long as she is transparent, Carmen can share her knowledge of the culture, reinforcing that waiting for all siblings would be not uncommon for many Hispanic/Latino families. Sharing this cultural insight may help Dr. Halferty bridge the gap. It will be important, however, that Carmen avoid stereotyping this family in the process.

#### Family side conversation

In lines 2.64 – 2.67 we see the two family members talking to each other again, without pausing so that Carmen can interpret. Now, if Carmen just interprets, Dr. Halferty won't know who said what, and the exchange won't make any sense. What could Carmen do?

- Carmen could just interpret the last thing said. This would be a poor decision. Dr. Halferty needs to hear everything that it said, even if it is not directed at him.
- Carmen could simply interpret everything that was said. This is a possible option, but it is not the best option. At least Dr. Halferty would hear everything that was said, and he could, of course, ask if he was confused. However, there is another option that would make the conversation clearer so that Dr. Halferty wouldn't have to ask for clarification.
- Carmen could intervene and ask Javier and Elena to repeat what they said, one at a time. This is also a possible option, but it is not the best option. This approach has the benefit of making sure that everything is communicated, but it

rather invasive, and Javier and Elena may not be able to repeat exactly what they said.

- Carmen could interpret what both Javier and Elena have said, using an open-hand to gesture to the person whose speech she is interpreting at that moment. This is the best option. This technique allows Dr. Halferty to both hear what was said and to know who said it. Had Javier and Elena spoken longer together, Carmen might have done better using *chuchotage* again, but because this exchange was short, the use of the open-hand gesture will be smoother and less invasive.

Why an open-hand gesture? Why not point a finger? Gestures have meaning, and it is important to use a gesture that is not offensive. Generally speaking, an open-handed gesture with the palm up can be used in many cultures to point to someone or something in a respectful way. Of course, the interpreter must choose a gesture that is appropriate to the culture of the individuals for whom he or she is interpreting.

### **Scene 3: Chaplain's visit**

#### Interpreter is shocked by the patient's physical state

At the beginning of the third scene, we see Mrs. Loreto again, this time in hospice care. And what a shock. Mrs. Loreto looks much worse than she did last time Carmen interpreted for her. It's clear she really is dying. Carmen's not sure how to talk to a person who is close to death. What would be both professional and compassionate?

- Carmen could maintain a solemn demeanor, in keeping with the tragic circumstances. There is no need for this, neither from providers nor from interpreters. Many patients come to peace with their impending death and may be in a positive, not funereal, frame of mind, even joking and laughing at times..
- Carmen could make a point of being in an attempt to make Mrs. Loreto feel better. This is not a good option either. False cheerfulness in front of any patient will easily be identified as insincere and will neither make the patient happier nor lead to trusting relationships. Being quietly neutral is a good way to start, to see how the patient is feeling and what he or she needs.
- If Carmen is feeling uncomfortable with the fact that Mrs. Loreto is dying, she could withdraw from the encounter. It is true that interpreters should withdraw if they are so affected by an interaction that they are **literally unable to interpret**. However, if interpreters withdrew any time the situation became uncomfortable, patients and providers would be routinely robbed of language services in the most important communications. Unless Carmen feels that this is one of the rare occasions when she is so affected that she is unable to interpret, this is not the best option.
- Carmen could treat Mrs. Loreto as she would any other patient, with sincere

professional kindness, entering the encounter emotionally neutral and matching her responses to the mood of the conversation. This would be the best approach. It is important for the interpreter to see the patient not as a dying person, but simply as a person.

Patient is confused but doesn't ask

In line 3.7, Carmen is faced with a choice. Mrs. Loreto doesn't know what a chaplain is. What could she do?

- Carmen could ignore this fact and let Beverly start speaking, hoping that the chaplain's role will become clear with time. This is a poor option. While Mrs. Loreto may not say anything, she will be confused as to who Beverly is and why she is there. This confusion might lead to mistrust, undermining the chaplain's whole purpose and the goals of the conversation.
- Carmen could explain to Mrs. Loreto what a chaplain is. Hopefully, she would explain it in a way that would be both accurate and appropriate. However, if she were mistaken in her explanation, Mrs. Loreto could come away with a very confused idea as to the purpose of the visit, which, again, would undermine the purpose of the communication.
- Carmen could tell Beverly that she is going to explain what a chaplain is, and then do so. While being transparent is better than providing the explanation without Beverly knowing, Carmen still runs the risk of misrepresenting Beverly's purpose in the visit.
- Carmen could inform Beverly that Mrs. Loreto doesn't know what a chaplain is. By simply providing this information, Carmen is prompting Beverly to explain this concept herself. This is definitely the best option. Different chaplains may explain their work in different ways, depending on personal style and on the patients' needs. By allowing Beverly to describe her work in her own way, Carmen is enabling both Beverly and herself to work from their respective strengths. Beverly has the expertise to explain what a chaplain is, and Carmen has the expertise to provide accurate interpretation.

Interpreter is disturbed by patient's words

In line 3.49, Carmen is shocked to hear Mrs. Loreto's thoughts. For the sake of discussion, let's suppose that Carmen's own spiritual beliefs are quite different from Mrs. Loreto's and that the idea that God would abandon someone for not going to mass is deeply offensive. Carmen finds the thought of even uttering this idea profoundly distasteful, even blasphemous. What could she do?

- Carmen could withdraw from this session, since this discussion is offensive to her own beliefs. Such an action, however, would leave Beverly and Mrs. Loreto without an interpreter. While the law does uphold the right of any healthcare provider (including interpreters) to withdraw from appointments that run counter

to their personal morals, this is a right that should be invoked only in the most serious of cases.

- Carmen could intervene to reassure Mrs. Loreto that God would never abandon her. This, however, would be completely outside the scope of the interpreter's role, which is to facilitate understanding in communication between people speaking different languages.
- Carmen could intervene to explain to Beverly that this belief is common among Mexican Catholics and suggest that she reassure Mrs. Loreto that God would never abandon her. This is not the best option, because there is no need for culture-brokering in this case. There has been no evidence of cultural misunderstanding between Beverly and Mrs. Loreto; Carmen is simply uncomfortable with the belief that Mrs. Loreto has expressed. Carmen should first allow Beverly, in her role as a chaplain, to address Mrs. Loreto's spiritual needs and concerns. If there is cultural misunderstanding later in the conversation, Carmen should intervene at that point.
- Carmen could simply interpret what was said, keeping her own beliefs to herself. This is the most professional of the options. Interpreters will frequently be required to interpret speech with which they personally do not agree, and most interpreters manage this by remembering that the words they are speaking are not coming from them, but from the speaker. Listeners who understand the interpreter's role will not attribute the speech to the interpreter, but they will be grateful to be able to hear and understand what the speaker wished to communicate.

In this whole section up to line 3.54, it may appear that Beverly is simply chatting with Mrs. Loreto; however, she is really doing much more. She is both establishing a trusting relationship with Mrs. Loreto and conducting an introductory spiritual assessment that follows the acronym FACT:

- F:     What is the patient's **Faith** or belief?
- A:     Is she **Active** in her faith community, and does she have **Available** what she needs to **Access** her faith?
- C:     How is she **Coping** with her medical situation and does she have any specific **Concerns**?
- T:     What would be an effective **Treatment plan**.

In this way, chaplains are much like physicians, taking a history, diagnosing the problem, and negotiating a treatment plan with the patient. As such, their interactions with patients should be given as much importance by interpreters as the interactions of any clinical provider.

Interpreting prayer

In line 3.64, Carmen finds herself faced with the possibility of interpreting a prayer that she does not know. And not just a conversational prayer, but a prayer that is written in what is called “frozen register.” Frozen register means that the vocabulary and word order are not changeable; the Pledge of Allegiance and the Lord’s Prayer are examples of frozen register. What could Carmen do?

- Carmen could interpret the prayer accurately and completely, as she always does, being faithful to the meaning. The problem is that speech in frozen register cannot be interpreted for meaning; it must be interpreted into the exact designated vocabulary and word order. “I promise to the faithful to America’s flag” is, in the case of the Pledge of Allegiance, not the same as “I pledge allegiance to the flag of the United States of America.” In most cases, interpreting for meaning would be fine, but in this case, it is likely to produce a version of the Hail Mary that will be unknown and possibly offensive to the listener.
- Carmen could withdraw, giving the reason that this interpretation is beyond her skills. This, however, leaves Beverly and Mrs. Loreto without a way to communicate. As it is unlikely they will get another interpreter for this part of the session, it is likely that Carmen’s withdrawal would essentially terminate the visit.
- Carmen could ask for a moment to find a computer and see if she can locate the prayer in Spanish on the internet. Many interpreters do carry with them versions of common prayers or sacred writings in both their working languages, often on their phones or PDAs. However, stopping to look up the prayer on the internet in the middle of the session will take too long and again, will likely result in the session being ended prematurely.
- Carmen could inform Beverly and Mrs. Loreto that she isn’t familiar with this prayer and, out of respect, suggest that they pray it together, each in their own language. This is the best option, especially considering that Carmen does not share Mrs. Loreto’s religious beliefs. Since both of these women know the prayer’s meaning, it doesn’t really need to be interpreted as a communicative event; it is the sharing of the prayer that carries meaning in this moment.

Patient and provider praying

In line 3.69, Beverly and Mrs. Loreto prepare to say the Hail Mary together. What could Carmen do?

- Since Carmen is no longer interpreting, she could check her voice mail and complete the paperwork for this encounter. This, however, would be disrespectful to both Mrs. Loreto and Beverly. Whether Carmen shares Mrs. Loreto’s faith beliefs or not, it is imperative that she remain respectful and attentive throughout the interaction.

### *Interpreting in Palliative Care*

- Carmen could excuse herself and leave. This is a better solution than checking voice mail while the other two pray, but it still sends the message that this final prayer is unimportant, when in fact, it may be the most critical part of the entire conversation in terms of Mrs. Loreto's emotional healing. In addition, Carmen's expertise may also be needed after Beverly and Mrs. Loreto finish praying.
- If Beverly has the prayer written down, Carmen could join in. While this would not be disrespectful, the role of the interpreter is to stay in the background. This is a moment of bonding between Beverly and Mrs. Loreto.
- Carmen could stand respectfully in silence while Beverly and Mrs. Loreto pray. This is the most appropriate option. Carmen's respectful silence does not undermine the moment, and she remains in the background. For some interpreters, it may be difficult to stay present and respectful during prayers from a faith tradition different from their own. The heart of cultural competence, however, is to make room in the world for someone else's beliefs, whether you share them or not. And interpreters must be, above all things, culturally competent, since cross cultural interactions are at the heart of all we do.



## Lesson 2: Interpreting Skills applied to Palliative Care

### Video script, Scene 1

- 1.1 Carmen Dr. Halferty? Hi, I'm Carmen. I'm one of the hospitals contracted interpreters, and I've been asked to interpret for your meeting with Mrs. Loreto this afternoon.
- 1.2 Dr. Halferty Hi, Carmen, thanks for coming. Yeah, were going to be talking with Jacinta Loreto. We've been treating her for pancreatic cancer, but an abdominal CT is showing metastasis to the liver. I really don't have any more curative options to offer her, so today were going discuss a transition to palliative care.
- 1.3 Carmen I understand. I haven't interpreted for Mrs. Loreto before, so when we go in, I'd like to introduce myself before we get going and let her know how the interpretation will work. Have you worked with an interpreter before?
- 1.4 Dr. Halferty Yes, on occasion.
- 1.5 Carmen Great. So, if you've worked with interpreters in the past, you probably know to speak directly to Mrs. Loreto as if she spoke English. I'm going to interpret everything you say, meaning for meaning, exactly as you say it, just as I will for her. If there's anything you don't want her to hear, don't say it in front of me, OK? Because I have to interpret everything. Also, please pause after every couple of thoughts so I can interpret. And if I make this sign (*holds up hand, palm out*), it means I need you to pause or slow down.
- 1.6 Dr. Halferty Fair enough. Let's go on in.
- 1.7 Carmen Just a sec. Let me put my cell phone on vibrate (*sets phone to vibrate*). OK, let's go.

#### **PAUSE THE VIDEO**

*(Dr. Halferty and Carmen enter Mrs. Loreto's room, where she is in a hospital bed. Dr. Halferty enters first.)*

- 1.8 Dr. Halferty Buenas tardes, Sra. Loreto. ¿Cómo le va? Y eso es todo mi español.
- 1.9 Mrs. Loreto ¡Ay, doctor, Ud., cómo me hace reír!

#### **PAUSE THE VIDEO**

- 1.10 Carmen Doctor, you always make me laugh! Buenas tardes, Mrs. Loreto, soy Carmen. Soy intérprete profesional, y voy a interpretar su conversación con el doctor esta tarde.
- 1.11 Mrs. Loreto Un gusto conocerla, Señorita.

### *Interpreting in Palliative Care*

- 1.12 Carmen El gusto es mío. Durante la conversación, Ud. puede hablarle directamente al doctor, como si entendiera español, y yo interpretaré todo lo que Uds. digan, exactamente como lo dicen. Por favor, haga una pausa de vez en cuando para que yo pueda interpretar y, si levanto la mano así, le estoy pidiendo que pare para que yo pueda interpretar. Hable sin miedo, señora, porque todo lo que conversen aquí yo lo mantengo en confianza. ¿Está bien?
- 1.13 Mrs. Loreto Si, está bien. A ver qué nuevas me trae el doctor hoy.
- 1.14 Carmen Go ahead, doctor. I'll start interpreting now.
- 1.15 Dr. Halferty Well, before we start, let's get some chairs, as this may take a while.
- 1.16 Carmen Bueno, antes de comenzar, busquemos unas sillas, ya que esto puede ser una larga conversación.
- 1.17 Dr. Halferty OK then. Mrs. Loreto, you may remember that we did a CT scan of your abdomen last week.
- 1.18 Carmen Mrs. Loreto, quizá se acuerde que la semana pasada le hicimos una tomografía de su abdomen.
- 1.19 Dr. Halferty Well, we got the results back, would you like me to tell you the full details? Or, if not, is there somebody else you'd like me to talk to?
- 1.20 Carmen Pues, aquí tengo los resultados. ¿Prefiere que le dé todos los detalles a usted? O, si no, ¿prefiere que se los dé a otra persona?
- 1.21 Mrs. Loreto A mí, por favor; hableme a mí.
- 1.22 Carmen No, talk to me, please.
- 1.23 Dr. Halferty Well, I'm afraid that the news is not good. The test showed that the cancer has metastasized to your liver.

### **PAUSE THE VIDEO**

- 1.24 Carmen Como intérprete, Mrs. Loreto, necesito aclarar una frase que usó el doctor.  
(*To doctor*) Doctor, as the interpreter, I need to ask what you mean by 'metastasized.'
- 1.25 Dr. Halferty That means it has spread, in this case, to the liver.
- 1.26 Carmen Lamento decirle que no son buenas las noticias. La tomografía mostró que el cáncer se ha extendido al hígado.
- 1.27 Mrs. Loreto Yo ya sabía que algo no andaba bien. Lo presentía.
- 1.28 Carmen I knew something wasn't right. I just felt it.

### *Interpreting in Palliative Care*

- 1.29 Mrs. Loreto      Ay, no. Entonces ahora ¿qué? No más quimioterapia, por favor. Otra vez no.
- 1.30 Carmen          Oh dear. So, what now? No more chemotherapy, please. Not again.
- 1.31 Dr. Halferty      No, I know that was hard for you last time, and I'm afraid we've exhausted whatever benefit we could get from chemotherapy anyway. Actually . . . I think it's time we talked about a different kind of treatment regimen: palliative care.
- 1.32 Carmen          No, ya sé que le fue muy difícil la vez pasada, y además la quimioterapia ya no ayudaría de todos modos. Entonces . . . creo que ha llegado el momento de hablar de otra clase de tratamiento los cuidados paliativos.
- 1.33 Mrs. Loreto      ¡Con tal de que no sea quimioterapia! Así que, ¿en qué consiste este tratamiento?
- 1.34 Carmen          Just as long as there's no more chemotherapy! So, what would this treatment look like?
- 1.35 Dr. Halferty      Instead of trying to cure the cancer, we'll be focusing on controlling the symptoms being caused by the cancer -- like the pain and the nausea from the bowel obstruction.
- 1.36 Carmen          En vez de seguir tratando de curar el cáncer, nos vamos a enfocar en controlar los síntomas causados por el cáncer, como el dolor y las náuseas causadas por el bloqueo intestinal.
- 1.37 Dr. Halferty      We can do everything possible to make you comfortable so that you can enjoy the best quality of life possible in the time you have left.
- 1.38 Carmen          Podemos hacer todo lo posible para que esté cómoda y pueda disfrutar de la mejor calidad de vida posible en el tiempo que le queda.
- 1.39 Mrs. Loreto      ¡Me parece muy bien! No puedo ni pensar en recibir más quimioterapia.
- 1.40 Carmen          That's good! I just can't face getting more chemotherapy.
- 1.41 Mrs. Loreto      Y ¿cuánto me va a durar este nuevo tratamiento?
- 1.42 Carmen          So, how long will this new treatment last?
- 1.43 Dr. Halferty      Well, as long as you need it.
- 1.44 Carmen          Pues, hasta que ya no lo necesite.
- 1.45 Mrs. Loreto      Aja . . .

### **PAUSE THE VIDEO**

- 1.46 Carmen          I see . . . Mrs. Loreto, como intérprete, creo que puede haber una

### *Interpreting in Palliative Care*

confusión. Déjeme preguntarle al doctor. Dr. Halferty, as the interpreter, I'd like to say that I think Mrs. Loreto may not understand the implications of palliative care. I'm concerned that she thinks you're still looking for a cure.

- 1.47 Dr. Halferty      Let me try again. Mrs. Loreto, I think I wasn't very clear. Your cancer has spread to the point that there's nothing we can do to cure it or even to stop it from growing. But we can help you feel as comfortable as possible until you pass.
- 1.48 Carmen          Mrs. Loreto, creo que no me expresé claramente. El cáncer ya se extendió tanto que no hay ningún tratamiento que lo pueda curar ni detener su crecimiento. Pero sí podemos ayudarle a sentirse lo más cómoda posible hasta que se le acabe el tiempo.
- 1.49 Mrs. Loreto:      Me está diciendo que me voy a morir.
- 1.50 Carmen          You're telling me I'm going to die . . .
- 1.51 Dr. Halferty      Yes. I'm very sorry . . . I wish the news were different.
- 1.52 Carmen          Sí. Lo siento mucho . . . como quisiera que no fuera así.
- 1.53 Mrs. Loreto      No lo esperaba . . . tan pronto . . .
- 1.54 Carmen          I didn't expect it . . . so soon . . .

#### **PAUSE THE VIDEO**

- 1.55 Dr. Halferty      I can see you're upset. Tell me more about how you are feeling. You look worried. What worries you the most?
- 1.56 Carmen          Veo como le ha afectado esta noticia. Dígame, ¿cómo se siente? Parece preocupada. ¿Qué es lo que más le preocupa?
- 1.57 Mrs. Loreto      Pues, para mis hijos esto va a ser un golpe fuerte . . .
- 1.58 Dr. Halferty      You know, patients who want the best treatment of their symptoms, and who would no longer benefit from chemotherapy, are eligible for a type of care called hospice care. Have you ever heard of that?

#### **PAUSE THE VIDEO**

- 1.59 Carmen          Sabe, los pacientes que quieren el mejor tratamiento para sus síntomas y quienes ya no pueden beneficiarse de quimioterapia, califican para otro programa. Como intérprete, necesito aclarar lo que dijo el doctor. As the interpreter, I'd like to say, there is a word for "hospice" in Spanish, but it has a very negative connotation. I am going to use instead the term in English and describe it as a special kind of palliative care program. Is that OK?
- 1.60 Dr. Halferty      Yes, that's fine.

### *Interpreting in Palliative Care*

- 1.61 Carmen Este es un programa especial de cuidados paliativos que se llama, en inglés, hospice.
- ¿Alguna vez ha escuchado hablar de este programa?
- 1.62 Mrs. Loreto No.
- 1.63 Dr. Halferty Well, hospice care is a special type of care for people who are near the end of their lives. You could either be at home or in a long-term care facility, and a team of doctors, nurses, social workers and chaplains would help control your symptoms like the pain that you're afraid of.
- 1.64 Carmen Este programa especial de cuidados paliativos es específicamente para personas acercándose al final de sus vidas. Ud. podría estar en su casa o en un centro para el cuidado de la salud a largo plazo. Un equipo de doctores, enfermeras, trabajadores sociales y capellanes ayudarían a controlar sus síntomas como el dolor que Ud. teme.
- 1.65 Dr. Halferty They'd also help you do what's most important to you with the time that you have. And they'd be there to provide support for your family.
- 1.66 Carmen Además, le pueden ayudar a hacer lo que Ud. considera más importante en el tiempo que le queda. También, este equipo podría servir como apoyo moral para su familia.
- 1.67 Mrs. Loreto No sé, doctor. Puede que sea lo mejor . . . no sé. . .
- 1.68 Carmen I don't know, doctor. . Maybe this would be best. . . I don't know . . .
- 1.69 Mrs. Loreto Yo soy ya muy vieja para estar tomando estas decisiones. ¿Por qué no habla con mis hijos?
- 1.70 Carmen I'm too old to be making these decisions. Why don't you talk to my children?
- 1.71 Dr. Halferty I could do that.
- 1.72 Carmen Si, yo podría hablar con ellos.
- 1.73 Mrs. Loreto ¿Sabía Ud. que tengo cinco hijos? Ramón, Ernesto, Julieta, Elena y Javier. Ernesto y Julieta viven en Tejas, y Ramón sigue en Zacatecas. El único que sigue en nuestra tierra. Ojalá lo pudiera ver antes de que Dios me lleve.
- 1.74 Carmen Did you know I have five children? Ramón, Ernesto, Julieta, Elena y Javier. Ernesto and Julieta live in Texas, and Ramón is still in Zacatecas. The only one still in our homeland. I wish I could see him before it's my time.
- 1.75 Dr. Halferty I wish for that for you, too. You know, it's OK to want your next-of-kin or some other specific person to make those decisions. You could fill out a healthcare proxy or Power of Attorney for Health Care. That gives someone you trust the right to make these decisions for you.

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- 1.76 Carmen      Deseo lo mismo para usted. Sabe, no hay problema si Ud. prefiere que el pariente más cercano u otra persona tome estas decisiones. Ud. podría escribir ya sea un poder de atención médica o un poder notarial para asuntos médicos. Cualquiera de estos documentos permite que alguien en quien usted confía pueda tomar decisiones por usted.
- 1.77 Mrs. Loreto      Hable con Ramón. Él sabrá qué hacer.
- 1.78 Carmen      Talk to Ramón. Ramón will know what to do.

***PAUSE THE VIDEO***

## Lesson 2: Interpreting Skills applied to Palliative Care

### Video script, Scene 2

- 2.1. Dr. Halferty      Thanks for meeting with me today about your mom.
- 2.2. Carmen            Gracias por reunir conmigo hoy para hablar sobre la salud de su mamá.
- 2.3. Javier              No, más bien, le agradecemos a Ud. ¿Cómo está mi madre? No entendemos por qué sigue en el hospital.
- 2.4. Carmen            No, on the contrary -- thank YOU for meeting with us. So, how is my mother? We don't understand why she's still in the hospital.
- 2.5Dr. Halferty        I wish I had better news for you. The most recent CT showed that the cancer has spread to your mother's liver. That is very serious. There are no more treatments that would be effective against the cancer. We think it's time to transition her to hospice care.
- 2.6. Carmen            Cómo quisiera tener mejores noticias para Uds. La última tomografía que sacamos mostró que el cáncer ya se encuentra en su hígado, lo que es grave. Ya no nos queda ningún tratamiento que pudiera ser efectivo contra el cáncer. Creemos que ya es hora de hacer un cambio a cuidados paliativos.
- 2.7. Javier              Y ¿qué es eso? ¿Un tratamiento nuevo?
- 2.8. Carmen            And what is that? A new kind of treatment?
- 2.9. Dr. Halferty        Hospice care is a medical program provided by a team of healthcare professionals including doctors, nurses, social workers, and chaplains. They would treat her symptoms, like the pain, in order to make her more comfortable, and offer support to both your mother and your family. But there's nothing more we can do to cure the cancer.
- 2.10. Carmen           Los cuidados paliativos son parte de un programa médico ofrecido por un equipo de profesionales de salud, incluyendo doctores, enfermeras, trabajadores sociales y capellanes. A su mamá, le darían tratamiento para sus síntomas, como el dolor, para que esté más cómoda, y ofrecer apoyo moral, tanto a su mamá como a Uds. y su familia. Pero no hay más que podamos hacer para curar el cáncer.
- 2.11. Javier            Entonces, está bien, ¿verdad? Si está cómoda, no hay problema.
- 2.12. Carmen            So, that's OK, right? If she's comfortable, then there's no problem.
- 2.13. Dr. Halferty       Well, the cancer will keep growing. And eventually, that will be incompatible with life.

### *Interpreting in Palliative Care*

- 2.14. Carmen      Pues, el cáncer va a seguir creciendo. Eventualmente, el cáncer será incompatible con la vida.
- 2.15. Javier      No entiendo. ¿Me está diciendo que se va a morir? (*getting angry*) ¿Que la van a dejar morir?

### **PAUSE THE VIDEO**

- 2.16. Carmen      I don't understand. Are you saying that my mother's going to die? (*a bit angry*) That you're going to let her die?
- 2.17. Dr. Halferty      I can understand your anger, Mr. Dominguez. Sometimes it makes me angry too.
- 2.18. Carmen      Entiendo su enojo, Sr. Dominguez. A veces, me enoja a mí también.
- 2.19. Dr. Halferty      I wish we had something else we could do for your mother, to cure the cancer, but once this type of cancer metastasizes to the liver, we're really out of options.
- 2.20. Carmen      Ojalá hubiera algo más que pudiéramos hacer para su mamá, para curar el cáncer, pero una vez que este tipo de cáncer se extiende al hígado, la verdad, no nos quedan más opciones.
- 2.21. Elena      (*devastated, teary*) Si no la pueden curar, entonces ¿qué?
- 2.22. Carmen      If you can't cure her, then what?
- 2.23. Dr. Halferty      There are lots of things the hospice team can do to help your mother be more comfortable as the end approaches. Like using medications to control her pain and nausea. The hospice team would focus on helping her have energy to enjoy life as much as possible at home with you.
- 2.24. Carmen      Un equipo de atención paliativa tiene muchas estrategias para ayudarle a su mamá a sentirse más cómoda mientras se acerca el fin. Por ejemplo, pueden darle medicamentos para controlar el dolor y la náusea. El equipo se enfocaría en ayudarle a tener la energía para gozar de la vida en casa con Uds. por todo el tiempo posible.
- 2.25. Dr. Halferty      I want you to know that I've talked with your mother about this, and she understands that there is nothing left we can do to cure the cancer.
- 2.26. Carmen      Y quiero que sepan que he conversado con su mamá sobre todo esto, y ella entiende que no hay más que podamos hacer para curar el cáncer.
- 2.27. Javier      (*angrily*) Pues, ¡Yo no estoy de acuerdo! ¡Tienen que hacer algo! No pueden simplemente dejarla morir –
- 2.28. Elena      Javier, por favor, el doctor está intentando ayudar. Y si mamá está de acuerdo –



### *Interpreting in Palliative Care*

- 2.29. Javier            ¿Cómo va a ser posible? ¿Tú vas a estar de acuerdo con que la dejen morir? Pues, por mi parte, yo no la voy abandonar.

#### **PAUSE THE VIDEO**

- 2.30. Carmen            I can't believe this! You're OK with just letting her die? Well, as far as I'm concerned, I'm not going to abandon her!
- 2.31. Elena            (*crying*) Javier, ¿cómo me puedes decir eso? ¡No es justo! Tú sabes que yo haría lo que sea para mamá. Pero el doctor dice que no hay nada más que puedan hacer. . . . Debemos traer a Ramón, a Julieta y Ernesto. Debemos decidir juntos, cuándo lleguen todos.
- 2.32. Carmen            How can you say that to me? That's not fair! You know I'd do anything for mother. But the doctor says there *isn't* anything more that they can do. . . We should bring Ramón, Julieta and Ernesto . . . We should decide all together, when everyone's here.
- 2.33. Javier            (*disgusted noise*) Ja, Ramón.
- 2.34. Carmen            (*disgusted noise*) Huh, Ramón.
- 2.35. Elena            ¡Por ella lo digo! Ella lo va a querer. Y tú lo sabes.
- 2.36. Carmen            For her sake, I'm telling you. She's going to want it. And you know it.
- 2.37. Dr. Halferty        I can hear how upset you both are about this news, and I don't blame you. This is very hard to hear.
- 2.38. Carmen            Puedo ver cómo esta noticia les ha afectado. Y entiendo. Es muy difícil.
- 2.39. Dr. Halferty        But I want to assure you that if there were anything at all we could do that would give us hope for a cure, we would do it.
- 2.40. Carmen            Pero quiero asegurarles que si hubiera algo, cualquier cosa, que nos diera esperanza de curar el cáncer, lo haríamos.
- 2.41. Dr. Halferty        There just isn't anything.
- 2.42. Carmen            Simplemente, no nos queda ninguna opción.
- 2.43. Dr. Halferty        I explained this to your mother and she *seemed* to understand.
- 2.44. Carmen            Le explique todo a su mamá, y parecía entender.
- 2.45. Dr. Halferty        And then I spoke to her about transitioning to hospice care, but she really didn't want to talk about that.
- 2.46a. Carmen            Además consulté con ella sobre una transición a cuidados paliativos pero en verdad, ella no quería hablar del asunto.

### *Interpreting in Palliative Care*

- 2.46b. Dr. Halferty She HAS agreed to name a surrogate decision maker, who would be available to help us make these decisions.
- 2.47a. Carmen Ella sí está de acuerdo en nombrar a una persona que estaría disponible para ayudarnos a tomar estas decisiones.
- 2.47b. Dr. Halferty She wanted to name her son Ramón, but I understand that he lives in Mexico. Is that right?
- 2.48. Carmen Quería nombrar a su hijo Ramón, pero entiendo que vive en Méjico, ¿verdad?
- 2.49. Elena Si, vive en Zacatecas.
- 2.50. Carmen Yes, he lives in Zacatecas.
- 2.51. Dr. Halferty I think it would be wiser to name one of the two of you who live here. After all, you could talk with her about her wishes and you would be nearby if we needed to ask questions.
- 2.52. Carmen Creo que sería mejor nombrar uno de Uds., que viven aquí. En fin, Uds. podrían consultar con ellas sobre sus preferencias. Y estarían disponibles si tuviéramos que hacerles una pregunta.
- 2.53. Elena Debemos esperar que llegue Ramón, Julieta y Ernesto. Pero *(pause, realizing)* Ramón no tiene visa para venir.
- 2.54. Carmen We should wait until Ramón, Julieta and Ernesto get here. But *(pause)* Ramón doesn't have a visa that would allow him to come.
- 2.55. Dr. Halferty My point exactly. Elena, you are your mother's principle caregiver. Maybe she would agree to name you as her decision-maker.
- 2.56. Carmen Precisamente. Elena, Ud. ha sido la que principalmente ha cuidado a su mamá. Quizá estaría de acuerdo que en Ud. tome las decisiones por ella.
- 2.57. Elena No, no, debemos esperar que lleguen los otros.
- 2.58. Carmen No, no, we should wait until the others get here.
- 2.59. Dr. Halferty *(at a loss)* But it sounds like that could be quite a while . . . And we really need someone named to make decisions for your mom. We don't know how quickly this cancer may advance . . .
- 2.60. Carmen Pero, parece que podría ser un largo rato hasta que lleguen . . . Y, es muy importante nombrar a alguien que pueda tomar decisiones para su mamá. No sabemos qué tan rápido puede avanzar este cáncer . . .
- 2.61. Javier Elena tiene razón. Cuando todos lleguen, podemos decidir.

**PAUSE THE VIDEO**

### *Interpreting in Palliative Care*

- 2.62. Carmen Elena's right. When everyone gets here, then we can decide. *(long pause. Looks up at Elena and Javier)*. Como intérprete, quiero aclarar un punto con el doctor.
- (looks at doctor)* Doctor, as the interpreter, I'd like to say that in Mexico, it's common for families to expect to consult all together about this kind of serious decision. You might want to see if that's true for this family.
- 2.63. Dr. Halferty Hm. *(To family)* Mr. and Ms. Dominguez, is this a decision you can make between the two of you? Or is it absolutely essential to consult with your brothers and your sister first?
- 2.64. Carmen Sr. Dominguez, Srta. Dominguez, ¿pueden Uds. dos tomar esta decisión? O ¿es absolutamente necesario consultar con sus hermanos primero?
- 2.65. Elena *(surprised)* Pues, claro, ¡no podemos tomar una decisión como ésta solos!
- 2.66. Javier Así es. Tenemos que hablar con mis hermanos.
- 2.67. Elena Pero, ¿cómo vamos a traer a Ramón?

### **PAUSE THE VIDEO**

- 2.68. Carmen *(gesturing palm up to Elena)* Of course -- we can't make a decision like that alone! *(gesturing palm up to Javier)*. That's right. We have to talk to our brothers and sister first. *(gesturing palm up to Elena)* But how are we going to get Ramón here?
- 2.69. Dr. Halferty OK. I'll see if we can get a Social Worker to work on getting an emergency medical visa for Ramón so that he can come to be with your mother. If that doesn't work out, we'll set up a conference call so you can all talk and make some decisions.
- 2.70. Carmen Bueno. Voy a ver si una de las trabajadoras sociales puede conseguir una visa de emergencia para Ramón, para que pueda venir para acompañar a su mamá. Si no logramos la visa, podemos hacer unas llamadas por teléfono para que todos puedan consultar y tomar unas decisiones.
- 2.71. Elena Gracias, doctor. Que Dios lo bendiga.
- 2.72. Carmen Thank you, doctor. God bless you.

### **PAUSE THE VIDEO**

## Lesson 2: Interpreting Skills applied to Palliative Care

### Video scripts, Scene 3

3.1 Beverly: Mrs. Loreto? My name is Beverly Jamison. I'm one of the hospital chaplains, and I thought I'd stop by to see how you are feeling.

#### **PAUSE THE VIDEO**

3.2 Carmen: Sra. Loreto? Soy Beverly Jamison, una de los capellanes del hospital. Vengo a visitarla, a ver cómo se siente. *(Looks up, to chaplain).* As the interpreter, I'd like to say hello to Mrs. Loreto – I've interpreted for her before, and under the circumstances, it would be polite for me to say hi before we begin. Also, I'd like to ask if she knows what a chaplain does..

3.3 Beverly Of course, by all means.

3.4 Carmen *(to patient, extends a hand to shake hands. Mrs. Loreto is too weak to shake, so Carmen just squeezes her hand gently, where it lies on the bed.)* Sra. Loreto, ¿se acuerda de mí? Soy Carmen -- fui su interprete cuando estaba en el hospital.

3.5 Mrs. Loreto Sí, mi'ja, sí, me acuerdo de Ud. Qué bien que haya venido.

3.6 Carmen *(warm smile)* Es un placer verla de nuevo. Voy a interpretar para esta visita con la capellana. ¿Sabe qué es un capellán?

3.7 Mrs. Loreto No, pues.

#### **PAUSE THE VIDEO**

3.8 Carmen No tiene cuidado – creo que ella se lo puede explicar. Si me permite, voy a comenzar a interpretar ahora. *(steps back next to chaplain. Speaks to chaplain)* Mrs. Loreto said she's not familiar with what a chaplain does; I told her that you might explain. I'll start interpreting now.

3.9 Beverly Great. *(Steps forward, takes Mrs. Loreto's hand, speaks directly to her.)* Mrs. Loreto, it's a pleasure to meet you. Again, my name is Beverly. I'm one of the chaplains here.

3.10 Carmen Sra. Loreto, es un placer de conocerla. De nuevo, soy Beverly, una de los capellanes aquí.

3.11 Beverly Carmen tells me you may not be familiar with what a chaplain does. Well, we recognize that people have different religions or no religion at all, but that we all have a spiritual life. Chaplains provide spiritual support for patients and their families. We're also just good people to talk to if you have something on your mind or if you're feeling lonely.

*Interpreting in Palliative Care*

- 3.12 Carmen Carmen me dice que posiblemente Ud. no sabe lo que hace un capellán un capellán. Pues, reconocemos que cada quien tiene su propia religión, o ninguna religión, pero todos tenemos una vida espiritual. Los capellanes atendemos a las necesidades espirituales de los pacientes y sus familias. También somos buenos para escuchar si Ud. quiere compartir cualquiera preocupación o si se siente sola.
- 3.13 Mrs. Loreto ¿Ud. es Católica?
- 3.14 Carmen Are you Catholic?
- 3.15 Beverly No, but I minister to a lot of Catholic patients. How about you?
- 3.16 Carmen No, pero atiando a muchos pacientes Católicos. Y ¿Ud?
- 3.17 Mrs. Loreto Si, señora, soy bien Católica. Voy a misa dos veces a la semana – o sea, *(faltering, looks away, sad)* iba a misa . . .
- 3.18 Carmen Yes, ma'am. I am a good Catholic. I go to mass twice a week – or rather, I used to go to mass . . .
- 3.19 Beverly It sounds as if you miss going to mass.
- 3.20 Carmen Se me hace que Ud. echa de menos la oportunidad de ir a misa.
- 3.21 Mrs. Loreto Así es.
- 3.22 Carmen Yes, I do.
- 3.23 Beverly Well, tell me, is there a church where you usually go to mass?
- 3.24 Carmen Pues, dígame, ¿hay una iglesia en particular donde Ud. Iba a misa?
- 3.25 Mrs. Loreto Nuestra Señora de los Dolores.
- 3.26 Carmen Our Lady of Sorrows.
- 3.27 Beverly Oh, yes, what a lovely church! I know the priest there – Father Durán.
- 3.28 Carmen Ah, sí, ¡qué bella iglesia! Conozco el señor cura allá – el padre Durán.
- 3.29 Mrs. Loreto *(perking up a bit)* Sí, sí, el padre Francisco. Lo conozco desde que llegué aquí. Qué buena gente es. Me ayudó mucho cuando recién llegué.
- 3.30 Carmen Yes, yes, Father Francisco. I've known him ever since I came here. What a wonderful person he is! He helped me a lot when I first came to live here.
- 3.31 Beverly Yes, we've served together on several interfaith committees.
- 3.32 Carmen Sí, hemos servido juntos en varios comités de líderes religiosos.

*Interpreting in Palliative Care*

- 3.33 Mrs. Loreto      *(opening up a bit, more relaxed)* Así que Ud. conoce al padre Francisco. Él es bien chistoso, ¿sabe? Siempre me decía que yo tenía seis hijos, no cinco, porque cuidaba a la iglesia como si fuera otro hijo. *(smile)*
- 3.34 Carmen          So you know Father Francisco. He is so funny, you know? He always used to tell me that I had six children, not five, because I took care of the church as if it were another child.
- 3.35 Beverly          Sounds like you spend a lot of time at the church. I'll bet you know everybody.
- 3.36 Carmen          Se me hace que Ud. pasa mucho tiempo en la iglesia. Apuesto que Ud. conoce a todo el mundo allá.
- 3.37 Mrs. Loreto      Si, conozco a todas las monjitas – la hermana Rosemary, la hermana Josefina. Y todos me conocen a mí.
- 3.38 Carmen          Yes, I know all the nuns – Sister Rosemary, Sister Josefina. And everybody knows me.
- 3.39 Beverly          It must be hard to be away from them. It sounds as if your Faith is very important to you.
- 3.40 Carmen          Debe ser difícil para Ud., no verlos. Se me hace que su fé le es muy importante.
- 3.41 Mrs. Loreto      Si, *(sad, faltering again)* nadie me viene a visitar aquí. Yo sé que me estoy muriendo. No me preocupa eso. Pero, no pensaba sentirme tan sola. Mis hijos me vienen a visitar, pero, pues, no entienden.
- 3.42 Carmen          Yes. . . nobody comes to visit me here. I know that I'm dying. And that doesn't worry me. But, I didn't think I'd feel so alone. My children come to visit, but, well, they don't understand.
- 3.43 Beverly          What don't they understand?
- 3.44 Carmen          ¿Qué es lo que no entienden?
- 3.45 Mrs. Loreto      La soledad que siento. Cómo me hacen falta mis amigas de la iglesia. Mis hijos no son religiosos, no van a misa. Pues, mi hija Elena un poco, pero . .
- 3.46 Carmen          How alone I feel. How much I miss my friends from church. My children aren't very religious, they don't go to mass. Well, my daughter Elena is a little, but . . .
- 3.47 Beverly          I met your daughter Elena the other day, and she seems like a wonderful young woman. She mentioned that you like to pray the Rosary every day.
- 3.48 Carmen          Conocí a su hija Elena. Parece una jovencita muy buena. Me mencionó que Ud. tiene la costumbre de rezar el Rosario a diario.

### *Interpreting in Palliative Care*

- 3.49 Mrs. Loreto (slowly) Si-i-i-i-. Pero ya no. Por primera vez, pienso que Dios ya no escucha mis oraciones. Me pregunto si Dios me ha abandonado también. Quizá me está castigando por no ir a misa ni a confesión.

#### **PAUSE THE VIDEO**

- 3.50 Carmen: Ye-e-e-s. But not anymore. For the first time, I think that God isn't hearing my prayers anymore. I wonder if He's abandoned me as well. Maybe He's punishing me for not going to Mass or confession.
- 3.51 Beverly It sounds so unfair. You loved and took care of your church "like a sixth child" and now you feel that everyone, including God, has abandoned you.
- 3.52 Carmen Parece injusto. Ud. amaba and cuidaba a la iglesia como a sus propios hijos, y ahora Ud. siente que todos le han abandonado, incluso Dios.
- 3.53 Mrs. Loreto Así es, precisamente así.
- 3.54 Carmen Yes, that's exactly right.

#### **PAUSE THE VIDEO**

- 3.56 Beverly You know, Mrs. Loreto, I was thinking about Padre Durán. Would you like me to arrange for him to come and visit? Perhaps he could hear your confession and say mass for you here.
- 3.57 Carmen Sabe, Sra. Loreto, estaba pensando en el Padre Durán. ¿Quisiera que lo traiga para visitarla? Quizá podría escuchar su confesión y celebrar misa aquí con Ud.
- 3.58 Mrs. Loreto (hopefully) Oh, ¿cree Ud. que vendría? Sería maravilloso.
- 3.59 Carmen Do you think he'd come? That would be wonderful!
- 3.60 Beverly I'll call him this afternoon. And, if it's OK with you, I'll stop by again too. In the meanwhile, if you need me, just ask your nurse to give me a call.
- 3.61 Carmen Me voy a comunicar con él esta misma tarde. Y, si Ud. guste, pasaré yo a visitarla de nuevo también. Mientras tanto, si me necesita, pídale a la enfermera que me llame.
- 3.62 Mrs. Loreto Ud. es tan buena para visitarme. Me siento aliviada.
- 3.63 Carmen You are so good to visit me. I feel more at peace.
- 3.64 Mrs. Loreto Oiga . . .yo sé que no es cura ni siquiera Católica, pero ¿no podría por si acaso rezar para mí antes de que se vaya? ¿Un Ave Maria? Siempre me trae paz.

#### **PAUSE THE VIDEO**

### ***Interpreting in Palliative Care***

- 3.65 Carmen Listen . . . I know that you're not a priest and not even Catholic, but before you go, could you say a prayer for me? A Hail Mary? It always brings me peace. *(Looks up to chaplain)* As the interpreter, I'd like to say that I'm not familiar with the Hail Mary in Spanish, and I don't want to use the wrong words. I'd like to suggest that you and Mrs. Loreto say the prayer together, each in your own languages.
- 3.66 Chaplain Good idea. Mrs. Loreto, why don't we say it together? Then it will bring us both peace.
- 3.67 Carmen Sra. Loreto, ¿porqué no la recitamos las dos juntas? Así, nos traerá paz a las dos.
- 3.68 Mrs. Loreto Como Ud. diga.
- 3.69 Carmen Whatever you say.

### ***PAUSE THE VIDEO***

*The chaplain reaches for rosary beads on table and looks to Loreto. Loreto moves her hand, smiles. Chaplain takes them carefully off cross and gives to Loreto's hand. Loreto holds them like welcoming back an old friend, and sighs, as they begin praying:*

- 3.70 Chaplain Hail Mary, full of grace, Our Lord is with thee.
- 3.71 Mrs. Loreto Dios te salve, María, llena eres de gracia, el Señor es contigo.



## **Lesson 3: The Vocabulary of Palliative Care**

**Time:** 12:30 – 1:30

### **Introduction**

One of the challenges of any new subject area in interpreting is the specialized vocabulary. Palliative care, hospice care and end-of-life care all share some terms that not only are specific to this practice but are often difficult to translate as well. This lesson will give participants the opportunity to learn new vocabulary in English and to practice seeking appropriate equivalents in their non-English language.

### **Learning Objectives**

At the conclusion of this lesson, participants will be able to:

1. Match 20 key palliative care terms in English to the correct definition.
2. Convert 20 key palliative care terms used in context from English to an appropriate equivalent in a non-English language.

### **Preparation**

1. Review content and lesson plan.
2. Develop a class outline based on the content and lesson plan.
3. Make sufficient copies of Handout #3 (vocabulary exercise, English-English #1), Handout #4 (vocabulary exercise, English-English #2), Handout #6 (conversion exercises) and the language-appropriate versions of Handout #5 (Bilingual Glossary of Palliative Care Terminology). If possible, copy Handouts #3 and #4 (the crossword puzzles) at 125% of normal size in order to maximize the size of the boxes and the numbers.

#### **Trainer's Note**

*Because there are so many handouts in different languages in this training, here's a suggestion for keeping them all straight. Copy all the language-specific handouts onto colored paper, using a different color for each language. That way, you will know that all the green handouts need to go to the Russian speakers (for example), all the yellow handouts to the Spanish speakers, all the pink handouts to the Korean speakers, etc.*

## **Lesson Plan**

This lesson can be done independently and/or in pairs.

1. Introduce this lesson, stressing a) the importance of being familiar with specific vocabulary in palliative care, and b) the difficulty of finding appropriate equivalents for many of the terms used.
2. Pass out the handouts and the glossaries. Give participants only the glossary that matches their language pair. For participants whose language pair does not have a glossary, provide an English-only version so that they can input their own translations as they work.
3. First, have the participants work on the first crossword puzzle. The words in the puzzle are those in the glossary. Students may work alone or in pairs. The pairs do not have to be language concordant, as the exercise is in English only. If they complete the first crossword puzzle, they may go on to the second, or they may take the second puzzle with them and work on it at home. Recommend that they spend no more than 20 minutes on this activity. At 12:55, spend ten minutes reviewing the answers and resolving any confusion.
4. At 1:05, have the participants move on to the translation exercises. Again, they may work alone or in pairs, however, for this exercise, the pairs must be language concordant.
5. At 1:20, bring the group back together and discuss which terms were difficult to render and why. This discussion may be language-specific; some terms may be difficult to render in some languages, but straightforward in other languages. While participants from one language group are discussing the difficulties they noticed in their language pair, groups speaking other languages will need to be patient.
6. At 1:30, give a summary and conclusion, and transition into the interpreting practice activity.

## **Content**

The content for this lesson can be found in the attached glossary.

## **Activity: Practice Interpreting**

**Time:** 1:30 – 2:45

### **Learning objectives**

At the conclusion of this lesson, students will have:

1. Practiced interpreting consecutively and simultaneously, using the techniques and vocabulary learned in the previous lessons.

### **Introduction**

Interpreting is both a skill and an art, and as such, it requires practice. The first three lessons of this course have introduced new information about palliative care, new vocabulary, and new skills related to interpreting. Now it is time to practice.

However, practice interpreting alone is only marginally useful. In order to improve, students need to receive immediate feedback on the quality of their rendition. The key to this activity, then, is not only to have students practice, but to have a system in place for them to receive critical feedback.

### **Preparation**

1. Review the content and the lesson plan.
2. Develop a class outline based on the content and the lesson plan.
3. Make copies of Handout #8 and #9, the interpreting dialogues, to match the language pairs of the students. Language-specific dialogues are included here in Spanish, Chinese, Vietnamese, Korean, Tagalog and Russian. For students speaking other language pairs, use the English-English dialogues.
4. Make 3-4 copies of Handout #7, the feedback forms for each participant.
5. Choose a strategy to provide interpreting feedback for every student. (See the insert on the next page dealing with strategies for providing language-specific feedback to interpreters.) Depending on the strategy you chose, make sure you have:
  - a) recruited appropriate language coaches, if at all possible.
  - b) prepared your interpreting coaches on how to give feedback.
  - c) installed enough speaker phones and secured the requisite telephone numbers.

## **Strategies for Providing Feedback to Interpreters**

There are many strategies to assure useful feedback for each student; the choice will depend on your resources and language mix. Below are a number of strategies, in descending order of effectiveness and cost, with a description of how each could be employed in a class of, for example, eight Spanish speakers, four Mandarin speakers, three Vietnamese speakers, two Tagalog speakers and one speaker of Armenian.

- a) Recruit an **in-person interpreting coach** for each language pair. An interpreting coach is a professional interpreter with experience in the subject area. In this case, you would need coaches in Spanish, Mandarin, Vietnamese, Tagalog, and Armenian. If interpreting coaches are not available, the next best thing is a language coach: a bilingual without interpreting experience but with subject matter expertise.
- b) Arrange for an **interpreting coach to be available remotely** (by phone or video), for each language pair. In the scenario above, you would need to arrange for at least one Spanish coach, one Mandarin coach, one Tagalog coach, and one Armenian coach. With so many Spanish speakers, you might want to consider arranging for more than one Spanish coach.
- c) Have **participants provide each other with feedback**, using the feedback form and guidelines included in the handout. In order for this approach to work, there must be at least three speakers of any given language pair in the class. Using this strategy, you would divide into two groups of Spanish-speakers, one group of Mandarin speakers, and one group of Vietnamese speakers. In order to accommodate the speakers of Tagalog and Armenian in this class, you would have to use strategies d) and/or e).
- d) Place single speakers of a given language in pairs, and **conference in a bilingual language coach one at a time**. Place the speakers of Tagalog and Armenian in one group. Using a speaker phone, bring in an interpreting coach in Tagalog. The Armenian speaker can read the part of the provider while one Tagalog speaker reads the part of the patient and the other interprets. The coach on the telephone can then give feedback. Have the Tagalog speakers switch roles and the other interprets. Then have the Tagalog interpreting coach hang up and get the Armenian coach on the line. Repeat the process; this time the coach will have to read the patient's part as well as give feedback.
- e) Have **participants digitally record themselves** practicing the dialogue, then listen to and critique themselves. With this strategy, the lone Armenian speaker is asked to record himself reading the part of the doctor in English, and sight translating the part of the patient into Armenian. Then he will put the scripts aside and take on the role of the interpreter, listening to the recorded dialogue and interpreting into the other voice recorder. When he is done, he can listen to his own interpretation to see how he did. This approach provides neither adequate practice nor quality feedback, but it is better than no practice at all.

- d) sent a copy of the interpreting dialogues and feedback form to any coaches who will be brought in by phone or who speak a language other than those in which exercises are provided here.
- 6. Try to find a physical space for this activity that will allow the students to physically separate their groups, one from the other. It works best if they cannot hear other groups working on the same dialogue.

## **Lesson Plan**

1. Introduce this lesson by emphasizing the importance of practice and of receiving feedback to improving interpreting skills.
2. Giving feedback
  - a) Ask for two or three volunteers to name one thing that they personally would like feedback on as they interpret. Chart their answers.
  - b) Point out that we are all good at some aspects of interpreting, and that we all need improvement in other areas. Then ask each student to write down three specific things they would like feedback on. These might include accuracy, completeness, transparency, the use of false cognates, limited vocabulary – anything that they think represents a particular difficulty for them.
  - c) Ask students if they've ever asked for feedback and been told that they are doing just fine. Ask them how they felt. Ask them if it helped them improve. Conclude that we all have aspects of our interpreting that we can improve, but being told we're doing fine (while it might make us feel good), doesn't help us improve. We depend on constructive feedback in order to identify ways to do better. Review the guidelines for giving feedback.
3. The most difficult part of this activity is forming groups and assuring that everyone understands how the exercise is supposed to work. So it is extremely important to provide clear, step-by-step instructions on how the practice session will work **before anybody moves**. Then **repeat the instructions**, having the group implement each step before you go on to the next. The instructions may differ depending on which strategy you are using for giving feedback, but here is an example.
  - a) "We're going to do some interpreting exercises now."
  - b) "Get into a group with all the other students who speak your language pair. Divide into groups of four, if you can."
  - c) "Pick one person in the group to be the physician, one person to be the patient, one person to be the interpreter, and one person to observe. These roles will change as we go along, and everyone will get to be the interpreter

- eventually. OK, raise your hand if you're the doctor. Raise your hand if you're the patient. Raise your hand if you're the interpreter. Raise your hand if you're the observer."
- d) "I am passing out some practice interpreting dialogues and feedback forms. The patient and the doctor get to look at the dialogues. **The interpreter may NOT look at the dialogue.**"
  - e) "As you begin reading the dialogues, the provider will read his/her section, then pause for the interpreter to interpret. The patient will read her section, and then pause for the interpreter to interpret. Read with expression – be actors! And don't pause in the middle of the paragraph unless the interpreter specifically asks you to do so."
  - f) "Interpreters, before beginning, share with your group the specific issues on which you would like to receive feedback. From then on, your job is to be as accurate and complete as possible. Intervene transparently if you need to ask for clarification, if you think the patient doesn't understand, if you think there's a cultural misunderstanding. Doctors and patients, if the interpreter intervenes, you'll have to go off script and make up a response."
  - g) "Start with Dialogue #1. When you reach the end of the dialogue, stop in order to give the interpreter feedback." (Your specific instructions here will vary depending on how you have arranged for feedback.)
  - h) "Then switch roles and continue on with Dialogue #2. When you have completed Dialogue #2, stop. Let the interpreter critique his or her own interpretation. Then allow the observer to give feedback, and then go on to Dialogue #3. When everyone has had a chance to interpret, come find me for additional practice exercises involving *chuchotage*."
  - i) "Are there any questions? If not, then please begin." (Some groups will not make it to the *chuchotage* exercise; that's OK,)

*Trainer's Notes*

*Some trainers may find that it is faster to bring a group of three students up front and have them demonstrate these instructions, rather than try to have the students remember the oral instructions.*

- 4. If you have some students working in language-concordant groups and others working with interpreting coaches over the phone and others working alone with digital voice recorders, set up the language-concordant groups first, then connect the telephonic coaches, then show the solo interpreters how to use the voice recorders.

### *Interpreting in Palliative Care*

5. Walk around from group to group. Make sure that the “interpreter” is not looking at the script; listen to the quality of the interpreting; provide feedback as appropriate.
6. At 2:35, bring the groups back together. With the students, analyze:
  - a) What was easy?
  - b) What was hard?
  - c) What do you need to work on?
  - d) How will you do that?
7. At 2:45, give the group a 15-minute break.

### **Content**

No new content is introduced in this activity.





## **Lesson 4: Sight Translation in Palliative Care**

**Time:** 3:00 – 3:45

### **Introduction**

Sight translation is the oral rendering in one language of a document written in another language. Most of the documents that interpreters will encounter when interpreting in palliative care will be familiar to them from interpreting in other areas of health care: consent forms, patient information forms, discharge instructions, prescriptions. There are a few documents, however, that relate more specifically to this area of interpreting and that may be new to interpreters.

This lesson, then, will serve to introduce interpreters to these palliative care documents, as well as to give them an opportunity to review and practice their sight translation skills.

### **Learning Objectives**

At the conclusion of this lesson, students will be able to:

1. Explain the purpose and general content of the POLST and the Pre-hospital DNR form.
2. Name the steps involved in sight-translation.
3. Accurately sight-translate the first page of the California POLST or the second page of the California Pre-hospital DNR form.

### **Preparation**

1. Review the content and lesson plan.
2. Develop a class outline based on the content and lesson plan.
3. Make copies of Handouts #11 and #12, the POLST and Pre-hospital DNR form.  
English: one copy for each participant.  
Non-English: one for each participant with the relevant language pair. We include translated versions of these documents in Chinese, Korean, Russian, Spanish, Tagalog, and Vietnamese.
3. Make enough copies of Handout#10, the feedback form, so that each student can have three or four.
4. Try to find a physical space for this activity that will allow the students to physically separate their groups, one from the other. This exercise works best if they cannot hear other groups working on the same sight translation.

## **Lesson Plan**

1. Introduce this lesson by explaining that most of the documents that interpreters will encounter in palliative care will be those they routinely see in other areas of care, e.g. consent forms, patient instructions, etc. A few, however, are more commonly found in palliative care. Since these may need to be sight translated, it is useful to have seen them before having to sight translate them in an actual encounter.
2. Use a question-answer format to rapidly elicit the basic steps of doing a sight translation, noting each step on the flip chart. Emphasize the importance of declining to sight translate documents that are too long, too complex or too technical.
3. By 3:05, divide interpreters into language-concordant groups of no more than three, much like you did for the interpreting exercises.
4. Pass out both the English-language and non-English-language versions of the POLST and the Pre-hospital DNR forms, as well as the feedback forms. Ask the students not to look at the translated version of the forms just yet.
5. Introduce each form, emphasizing what each is used for and the need to have a provider present to answer questions.
6. Provide instructions for this practice session:
  - a) Ask the group to choose either the POLST or the Pre-hospital DNR form.
  - b) Have the group divide up their chosen form into equal sections, one for each member of the group.
  - c) The first “interpreter” will sight translate his or her section; the other members of the group will observe and take notes on the feedback form.
  - d) When the first interpreter is done, the group will provide feedback.
  - e) The second “interpreter” will then repeat this process, and the third, until each member of the group has had a chance to sight translate.
  - f) When the group completes the sight translation, it can then use the non-English version to review the document with a special view to the parts they found difficult.
  - g) If there is time, the group may repeat this process with the second document.
7. At 3:35, reconvene the large group and debrief. What was easy? What was difficult? How did the group resolve its difficulties?
8. At 3:45, transition into the next lesson.

## **Content**

### Sight translation

Interpreters in this program should have already received basic instruction in sight translation, but this is a good opportunity to review the steps.

1. Assess whether the document in question is appropriate for sight translation.
2. Scan the document for unknown terms and concepts.
3. Clarify these terms and concepts with clinical staff, whether a doctor or a nurse.
4. Start at the very top and sight translate sentence by sentence, to the very end. Everything on the page must be translated, including titles.

A few reminders:

- The goal of sight translation is to transmit meaning accurately. Written English often involves complicated sentence structure, with multiple dependent clauses. Interpreters may need to break up the sentences into their component ideas in order to make them understandable in the target language.
- These forms have a fair amount of high-register terminology that will be hard to render accurately in the target language. Again, encourage interpreters to focus on rendering the meaning of the form, regardless of sentence structure or syntax.
- Interpreters should render the translation at a slow, even rate. Rushing through some phrases and leaving long pauses between others makes the resulting sight translation very difficult to follow.
- Interpreters should not answer patient questions about the document, especially the types of documents being used in palliative care. Patients' questions must be directed to healthcare personnel.

Finally, in addition to knowing how to do an accurate sight translation, interpreters must know how to gracefully refuse to do one. It is an unfortunate truth that interpreters are often asked to sight translate documents that are too long, too technical, or too complicated. These documents should be provided to patients in a translated format, but we know that all too often, the interpreter is asked to do a sight translation instead.<sup>1</sup>

So generally speaking, if a document is longer than one page, if the content is written in a legal register, or if there are a large number of technical medical terms, the interpreter would do well to ask the provider to review the document with the patient and allow the interpreter to interpret orally. If the interpreter is aware that the facility has translations of the document available, he or she could suggest that the translated version of the document be provided.

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<sup>1</sup> For more information on the appropriate provision of translation by interpreters, see *Sight Translation and Written Translation: Guidelines for Interpreters*. NCIHC. April 2009. [www.ncihc.org](http://www.ncihc.org).

### The documents

“POLST” refers to “Physicians Orders for Life Sustaining Treatment.” The POLST form documents what sort of treatment the patient desires toward the end of life: whether the patient wants to be resuscitated if his/her heart stops and what level of intervention and nutritional care the patient desires. The POLST gives patients who are seriously ill more control over their end-of-life care.

Unlike an advance directive, the POLST is most often filled out by the physician in consultation with the patient or the patient’s legally-recognized representative. However, a copy of the blank form may be provided to the patient; if the patient speaks limited English, he or she will require sight translation. Regardless of whether the interpreter sight translates the form in the provider’s presence or interprets the consultation between patient and provider, interpreters will need to be familiar with the POLST and know how to convey all the questions and information included on it. For more information on the POLST, see [www.capolst.org](http://www.capolst.org).

The Pre-hospital Do-Not-Resuscitate form is a document that patients fill out to provide instructions to Emergency Medical Services personnel who may be called to attend the patient at home, at a long-term care facility or anywhere outside of the hospital. The form may direct EMS workers not to attempt resuscitation if the patient has died. Patients who fill out this form may request a “Do Not Resuscitate” wrist or neck medallion; this easily identifiable piece of jewelry informs and authorizes EMS personnel to allow the wearer to die a natural death.

The Pre-hospital DNR, like the POLST, is filled out by the physician in consultation with the patient or his/her legal representative. And just as with the POLST, interpreters should not sight-translate this document unless a provider is present to explain its purpose and use and to answer questions. One copy of this form will stay with the patient; one copy is entered into the patient’s medical record, and one copy can be used by the patient to order a wrist or neck medallion. For more information on the California Pre-Hospital DNR form, go to [http://www.emsa.ca.gov/personnel/DNR\\_faq.asp](http://www.emsa.ca.gov/personnel/DNR_faq.asp).

Both the POLST and the Pre-hospital DNR can be changed or cancelled by the patient whenever he or she so desires.

## **Lesson 5: Belief and Emotion in Interpreting**

**Time:** 3:45 – 4:30

### **Introduction**

A popular myth in the language services world sees interpreters as detached, neutral converters of language, unbiased in how they transmit messages and unaffected by the content they interpret.

Nothing could be further from the truth.

Research is beginning to show the degree to which interpreters can affect and be affected by what they are interpreting, especially when this content strikes chords with deeply held beliefs or personal experience. In this, they are no different than other healthcare providers, for whom a similar and much better developed body of research already exists.

Truly professional interpreters are aware of their own beliefs and feelings and the ways in which those can potentially bias the interpretation. They are also aware of how the interpretation may impact their own emotional equilibrium, so that they can deal with these emotions in a healthy and appropriate manner. This lesson will provide an introduction to these issues.

### **Learning Objectives**

At the conclusion of this lesson, students will be able to:

1. Explain how an interpreter's experiences with end-of-life conversations and beliefs surrounding death could potentially impact the quality of his or her interpreting.
2. Identify three resources in his or her own interpreting environment to provide technical and emotional support surrounding palliative care conversations.

### **Preparation**

1. Review the content and lesson plan.
2. Develop a class outline based on the content and lesson plan.
3. Make sufficient copies of Handout #13 (When the End of Life Becomes Personal)

### **Lesson Plan**

1. Introduce this section by reminding participants that interpreting in palliative care will many times mean interpreting for a patient whom you know is dying. Point out that this most fundamental of human experiences is fraught with emotional impact, which interpreters cannot ignore. Not only can the interpretation impact

our emotions, but our emotions can impact our interpretation. Therefore, interpreters who are going to interpret in a palliative care setting must be aware of their own emotional state and of the interplay between emotion and interpreting.

2. Pass out Handout #13. This handout shares the voices of several working interpreters who agreed to be interviewed about interpreting for patients at the end of life. It also asks some questions to help interpreters think about how their own beliefs might impact their interpreting, and how they might handle the stress of interpreting in these sessions. This exercise can be done alone, in pairs, or as a class. Nobody will be forced to share their answers. Ask the class to vote. Do this exercise as a class discussion only if the vast majority of the students prefer to do so.

**Trainer's Note**

*This topic may be a difficult one for some participants. Those who come from family or ethnic cultures in which strong emotions or deeply held beliefs are not discussed publicly, those who have recently experienced loss, or those who feel confused about their own beliefs, may respond angrily, dismissively or defensively to the introduction of this material.*

*As a trainer, your best approach is to reassure participants that they will not be required to share their thoughts. At the same time, emphasize that thinking about these issues will make them better interpreters and healthier individuals.*

3. If the group decides to do this in pairs or alone, give the group half an hour to work, then call the group together. Invite people to share any insight they gained. Focus especially on techniques for dealing with emotionally difficult interpretations; note these suggestions on the flipchart.
4. If the group chooses to do these exercises as a full group discussion, start with the first bolded question on the handout, and have various participants read aloud the excerpts from the interpreters. Discuss the questions that follow. Go on to the next bolded question, and so on. Keep an eye on the time, as this discussion can become lengthy. Make sure you get to the question on how to handle emotionally difficult interpretations; write these suggestions on the flipchart.
5. At 4:25, conclude, and provide a general review of the key content you have covered for the entire day.
6. At 4:30, say a few closing remarks and then transition to the final test and class evaluation.

## **Content**

### How does belief impact interpreting?

Most interpreters would like to think that they keep their own beliefs separate from their interpreting work; refraining from imposing one's beliefs on patients and providers is one of the canons of the National Code of Ethics for Interpreters in Health Care. However, people often have very strong beliefs about death. For example what is a good death? What is appropriate behavior around the time of death? Who should be present when a person dies? As a result, even professional interpreters may find that certain things become hard to interpret, or they may find they need to watch their body language more closely so as not to display in any way their own opinions about a patient's attitude, a family's decision, a provider's approach to care. Becoming more aware of one's own beliefs and convictions is the first step to being able to compartmentalize them while interpreting. Ultimately this allows the interpreter to become a clearer channel through which the speaker's message can flow to the listener.

### How does interpreting in palliative care settings impact the interpreter?

The key message that we want participants to hear is that it is **perfectly normal** to feel a range of emotions when working with patients who are dying, from numbness to a slight sadness to significant emotional distress. Some interpreters will be more affected than others; and interpreters will be more affected with some patients than with others. There is no shame in any of these reactions. There is only the need to be aware of them and to be prepared to handle them in a professional manner.

### How can interpreters handle this emotional stress?

It is important for interpreters to be prepared to manage their emotions both in the moment and in the long term.

Patients and their families depend on the interpreter to communicate with the clinicians, so interpreters must strive their utmost to manage their feelings during the encounter so that they can continue interpreting. Interpreters who are so affected by their own emotions that they cannot continue to interpret must, of course, withdraw. The interpreters interviewed for this course had some interesting techniques for maintaining their ability to interpret under stressful circumstances (see Handout #13).

What about tears? Crying is a normal expression of sadness, and in some cases (such as the death of a patient) may be appropriate if it is sincere. Other professional staff sometimes cry at the loss of a long-term patient; it is just a human thing to do. As interpreters, the focus is to hold it together until the actual interpreting is done.

Interpreters must also find a way to manage the long-term stress and sadness of dealing on a daily basis with patients who are seriously ill, especially if multiple deaths come one after another. Each individual must find his or her own coping methods, but they usually fall into one of two general categories: take a break, or talk to someone.

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1. Take a break

This can be a vacation, a walk in the woods, playing with kids, going to the movies, an afternoon at the shooting range – anything that is relaxing and reminds the interpreter of the happier, less stressful sides of life.

2. Talk to someone

Interpreters can talk to managers, professional colleagues, spiritual advisors, counselors, friends, family – anyone who is a good listener – just as long as they do not disclose any of the patient's personal information in the discussion.

Interpreters who do not have effective methods for handling stress over time can end up with compassion fatigue or even psychological dysfunction resulting from vicarious trauma. Compassion fatigue is a protective mechanism in which the interpreter simply stops feeling empathy for patients or finds himself feeling angry with them for their problems. Vicarious trauma is the traumatization of someone from being constantly exposed to others' emotional pain. It can manifest as flashbacks, nightmares, difficulty sleeping, irritability and anger. Due to the short amount of time you have to discuss this issue, the focus of this class should be more on how to manage stress than on the consequences of not managing it well.



## **Activity: Evaluation**

**Time:** 4:30 – 5:00

### **Introduction**

One of the great things about on-site trainings is that, as the trainer, you can adjust and improve the training every time you give it. You need a course evaluation, however, in order to know what and how to change the course to make it better.

### **Learning Objectives**

At the conclusion of this lesson, students will have:

1. Completed the post-test
2. Completed an evaluation form.

### **Preparation**

1. Review the content and lesson plan.
2. Develop a class outline based on the content and lesson plan.
3. Make copies of Handout #14 (the post-test) and Handout #15 (the evaluation form).

### **Lesson Plan**

1. Ask participants to clear their desks.
2. Explain the purpose of the post-test and the evaluation form.
3. Pass out the test.
4. As participants complete the test, have them hand it in and pick up an evaluation form.
5. When they have completed the evaluation form, they are free to leave.
6. Correct the tests after the course is over, and send out certificates of completion to those who pass.

### **Content**

There are two kinds of evaluation that you will need in order to know how to adjust the course. The first is an evaluation of what the students have learned. Optimally, you would like to test both knowledge and skills acquisition. However, since this is a very short course and there is a limited time available for testing, the learning evaluation will

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take the form of a short paper-and-pencil pre- and post-test, both of which can be found in this curriculum.

The post-test is designed to show how well the participants have learned the course content. A passing grade on the post-test will lead to the award of a certificate of completion (also included in this curriculum). The pre-test contains a sub-set of the questions found on the post-test; by comparing students' performance on the two, you will be able to tell how much they knew upon entering the course and how much they learned from the course.

The second form of evaluation is a process evaluation, which assesses the course itself. The short evaluation form, found in the appendices, is designed to elicit information about what worked in the course, what didn't, what was useful, and what was not. Review of the evaluation forms will tell you what you need to change the next time you offer the course.