



PALLIATIVE CARE CASE OF THE MONTH

“Lost in Translation: The role of the medical interpreter in Palliative Care goals of care discussions”

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Volume 23, No. 130

February 2023

Case: M.P. is an 82-year-old man with a complex medical history including multiple strokes, which have resulted in significant neurological deficits causing recurrent admissions to the hospital and requiring tracheostomy and gastrostomy tube placement. Our team was consulted for goals of care.

M.P.’s family is Filipino, and his family’s native language is Visayan dialect. The medical team had primarily been communicating in English with the patient’s daughters, who would then translate for their mother. The patient was unable to meaningfully participate in conversations as he was non-responsive.

During our first official meeting with the family, we involved a Visayan translator. Our team could only secure audio translation as there were not video or in-person options for this dialect through UPMC. During the family meeting, our team delivered the headline, “Your father will not regain function beyond what he can do now. We are worried that he will continue to have many hospitalizations and will end up spending most of his time here in the hospital rather than at home with your family.”

The younger daughter responded, “I can’t say that to my mother. That will be too hard for her to hear. I will tell her what I think she can handle.” The daughter then turned to her mother, delivered a message, and the medical translator translated for us what the daughter had said. The message was very different – more vague and softer. The patient’s wife was tearful after her daughter relayed her message. After attending to family member’s emotions, the daughter relayed to our team that her mother wanted to defer decision making to her children, which was confirmed by the medical translator.

After the family meeting, our team debriefed. We considered what might be the best way to respond when a family member asks to knowingly change the message of our headline. Furthermore, we wondered what roles the medical translator plays in palliative care.

Background:

The use of trained professional interpreters, rather than ad-hoc interpreters, such as family members, family friends, and bilingual staff members, results in better quality of care,^{2,4,9} improved communication,^{5-6,12} fewer errors in interpretation,⁸ and improved patient satisfaction^{3,14} for patients and families with limited English proficiency (LEP).^{7,11} Furthermore, involvement of a trained interpreter can relieve family members of the emotional burden of having to relay serious news to a loved one.⁹

In the context of palliative care, to ensure that all our patients and families receive adequate information and have good understandings of their life-limiting illnesses, it is important that we utilize trained medical interpreters with patients and families with LEP. The use of professional medical interpreters in the delivery of palliative care services to LEP patients has been associated with improved understanding of diagnosis and prognosis and improved symptom management at the end of life.¹⁶ Existing research has found that utilization of family members as ad-hoc interpreters leads health care providers to worry about filtering of information, inaccurate translation, and juggling patient and family preferences of information disclosure with the ‘Western’ view of truth telling.¹⁰

Interestingly, there has been some literature that reports failure to interpret or misinterpretation by both professional interpreters and family interpreters when it comes to prognosis.¹ Butow et al. found that 23% of doctor prognostic speech units were not interpreted, and 27% were interpreted non-equivalently (across both professional and family interpreters). This finding highlights the importance of active negotiation of prognostic disclosure with the health care team, the patient and family, and the medical interpreter.

Even when a medical interpreter is used, there is still room for improvement. One study conducted by Pham et al. found a 55% chance that an alteration in translation would occur during medical interpretation of ICU family meetings. Most alterations were thought to have potentially negative effects on the family conference, most related to changes in the description of the patient’s disease or prognosis.¹⁵

Reflection:

Despite our use of a medical interpreter during the family meeting, the patient’s daughter chose to alter the message we wanted to convey to her mother. In the moment, when the daughter turned to us to let us know that she couldn’t translate that message directly, it did not feel like our place to try and negotiate what she was going to share with her mother. Rather, it appeared to us that, based on family dynamics and perhaps cultural background, the daughter felt comfortable in her knowledge of the best way to relay serious news to her mother. Perhaps the daughter expected that her mother would defer decision making to her children and therefore ‘softened the message our team conveyed.

When reflecting on this family meeting, there are many things that we could have done to improve the encounter. Many of these reflections are based on “Top Ten Tips Palliative Care Clinicians Should Know About Working with Medical Interpreters” by Latif et al.¹³

Personal details in the case published have been altered to protect patient privacy.

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Reflection continued:

1. Conduct a pre-encounter huddle – this would have helped the interpreter understand the different family members involved in the conversation and have contextual understanding of M.P.'s case. Additionally, the pre-encounter huddle would offer an opportunity to build better rapport so the interpreter might feel more comfortable intervening if they are sensing a culturally based tension during the meeting.
2. Although not an option for this case, video interpretation and in-person interpretation would have been best so that the interpreter could see what was happening in the room and be able to interpret facial expressions.
3. Discuss with the translator ahead of time potentially “untranslatable” words, such as palliative care, hospice, and goals of care. Keep an open dialogue with the translator throughout the encounter if she is encountering terms that cannot directly translate in the Visayan dialect.
4. Recognize the medical translator as a cultural mediator. Prior to the interaction, she may have been able to provide anticipatory guidance on approaching the conversation and could have provided context on cultural nuances regarding patient and family roles in decision making and disclosure of information before we even started the family meeting.
5. Explicit inquiry about patient and family preferences regarding who would be participating in medical discussions and disclosure of serious news at the start of the family meeting.
6. Including the medical interpreter in our post-encounter team debrief to hear her feedback and thoughts on what transpired and how to better approach future meetings with this family. As well, the post-encounter debriefing serves as a time to acknowledge that the medical interpreter is vulnerable to experiencing vicarious trauma and can provide holding space for her to discuss emotions arising from the case following the difficult encounter.

References:

1. Butow, Phyllis N., et al. "Should culture affect practice? A comparison of prognostic discussions in consultations with immigrant versus native-born cancer patients." *Patient education and counseling* 92.2 (2013): 246-252
2. Cashman, R. "Two studies focus on interpreter services." *Discharge planning update* 12.3 (1992): 10-12.
3. David, Rand A., and Michelle Rhee. "The impact of language as a barrier to effective health care in an underserved urban Hispanic community." *The Mount Sinai Journal of Medicine, New York* 65.5-6 (1998): 393-397.
4. Drennan, Gerard. "Counting the cost of language services in psychiatry." *South African Medical Journal* 86.4 (1996).
5. Ebdon, Philip, et al. "The bilingual consultation." *The Lancet* 331.8581 (1988): 347.
6. Flores, Glenn, et al. "Errors in medical interpretation and their potential clinical consequences in pediatric encounters." *Pediatrics* 111.1 (2003): 6-14.

References continued:

7. Flores, Glenn. "The impact of medical interpreter services on the quality of health care: a systematic review." *Medical care research and review* 62.3 (2005): 255-299.
8. Flores, Glenn, et al. "Errors of medical interpretation and their potential clinical consequences: a comparison of professional versus ad hoc versus no interpreters." *Annals of emergency medicine* 60.5 (2012): 545-553.
9. Hadziabdic, Emina, et al. "Family members' experiences of the use of interpreters in healthcare." *Primary health care research & development* 15.2 (2014): 156-169
10. Hampers, Louis C., and Jennifer E. McNulty. "Professional interpreters and bilingual physicians in a pediatric emergency department: effect on resource utilization." *Archives of pediatrics & adolescent medicine* 156.11 (2002): 1108-1113.
11. Kai, Joe, J. Beavan, and C. Faull. "Challenges of mediated communication, disclosure and patient autonomy in cross-cultural cancer care." *British Journal of Cancer* 105.7 (2011): 918-924.
12. Karliner, Leah S., et al. "Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature." *Health services research* 42.2 (2007): 727-754.
13. Kline, Frank, et al. "The misunderstood Spanish-speaking patient." *The American Journal of Psychiatry* (1980)
14. Latif, Zara, et al. "Top ten tips palliative care clinicians should know about working with medical interpreters." *Journal of Palliative Medicine* 25.9 (2022): 1426-1430.
15. Lee, Linda J., et al. "Effect of Spanish interpretation method on patient satisfaction in an urban walk-in clinic." *Journal of general internal medicine* 17.8 (2002): 641-646.
16. Pham, Kiemanh, et al. "Alterations during medical interpretation of ICU family conferences that interfere with or enhance communication." *Chest* 134.1 (2008): 109-116.
17. Silva, Milagros D., et al. "Interpreting at the end of life: a systematic review of the impact of interpreters on the delivery of palliative care services to cancer patients with limited English proficiency." *Journal of pain and symptom management* 51.3 (2016): 569-580.

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