Medical Interpreting Basics for Bilingual Staff at Nemours Children's Hospital

Overview

The 2-day workshop *Medical Interpreting Basics for Bilingual Staff* will introduce bilingual staff to the basics of medical interpreting so that they may put their language skills to use in assisting LEP patients throughout the hospital. The course will cover modes of interpretation, interpreting ethics and basic guidelines for interpreting in the hospital. Students will participate in hands-on exercises to practice their interpreting skills, as well as acquire self-assessment techniques to be able to learn their own limits in regards to the extent of language assistance they are able to provide.

Course Learning Objectives

1. Learn Nemours's requirements for medical interpretation.
2. Learn Nemours's requirements for patient care in a language other than English.
3. Recognize the limits of what a bilingual staff member should do in a language access situation.
4. Identify responsibilities of bilingual staff members when interpreting or providing patient care.
5. Learn how bilingual staff members will be assessed and what the results of this assessment are.
6. Become familiar with the basics of interpreting and the skills involved.
7. Learn what culture is, and why it is important to medical interpreting.
8. Learn how and when an interpreter should act as a cultural broker.
9. Learn how to manage an interpretation session.
10. Become familiar with and utilize the Kolb learning cycle to improve interpreting skills.

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Nemours. Children's Hospital

Medical Interpreter Training

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interpreter-training.com/Nemours

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Part 1: Interpreting Protocol

Understanding the role of the interpreter and the best practices when providing language access

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To interpret effectively in the hospital, I must:

- Transmit everything that is said accurately and completely
- NOT paraphrase, summarize, change or omit anything
- Make sure message is understood by all parties

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Required KSAs for interpreters

- Fluency in both languages
- Extensive vocabulary in both languages
- Ability to ensure accuracy of meaning
- Willingness to follow Code of Ethics
- Above-average memory and multi-tasking competencies
- Ability to function in the Consecutive and Sight Translation modes
- Ability to switch into Simultaneous mode if necessary

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Medical Interpreters need to know:

- The ins and outs of health care professions
- What documents pertain to medical encounters
- The different medical specialties and departments
- What parties are involved in health care matters
- Most common medical tests, instruments and procedures
- General medical vocabulary

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There is a difference…

- Being bilingual and
- Being an interpreter:
  - Family and friends
  - Informal
  - Medical
  - Court
  - Conference

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What am I to do?

Do I Interpret or Translate?

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During an Interpreted Medical Encounter:

- What is the role of the interpreter?
- What is the purpose of the interpretation?

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Role of the Interpreter

The main objective of the interpreter is:
to facilitate understanding between people
who are attempting to communicate with each other
in two different languages.

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To facilitate understanding

- Interpreter must be an active participant
- Make (an action or process) easy or easier (Oxford Dictionary)
- Interpreting is not about words, it's all about MEANING!
- Don't assume, check for understanding

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Medical Interpreting:
A collaborative environment
-Doctor, patient and interpreter have the same goal

- Not just repeating words
- Meaning of words
- Checking for understanding

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Communication…

- Cannot facilitate communication on all levels
- Focuses on an understanding of what was said

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Barriers to Communication

What can create a barrier to communication in a medical interview between two people who speak different languages?

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The Four Barriers to Communication

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1) **Linguistic barriers**: differences in spoken language
2) **Barriers of register**: medical language can be very complicated and difficult to understand
3) **Cultural barriers**: differences in beliefs around health and illness
4) **Systemic barriers**: health insurance, Medicare, Medicaid, medical procedures and understanding diagnosis and treatment

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Overcoming Communication Barriers

Communication barrier	Role of the Interpreter
Linguistic barriers – differences in spoken language	Conduit – interpreting everything exactly with No additions No omissions No editing No polishing

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Overcoming Communication Barriers

Communication barrier	Role of the Interpreter
Barriers of register – language can be very complicated and difficult to understand	Clarifier – •interpreter adjusts register, • creates word pictures of terms that have no linguistic equivalent, checks for understanding

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Overcoming Communication Barriers

Communication barrier	Role of the Interpreter
Cultural barriers – differences in beliefs around health and illness	Culture Broker – interpreter provides cultural interpretation for understanding the message

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Overcoming Communication Barriers

Communication barrier	Role of the Interpreter
Systemic barriers – healthcare system barriers, i.e., health insurance, Medicare, Medicaid, diagnosis and treatment	Advocate – interpreter acts on behalf of the patient – concerned with quality of care and access to care – outside of the medical interview

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Incremental Intervention

ASSESS THE SITUATION:

Adopt an increasingly interventionist role but…

ONLY if it is clearly required!

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Modes of Interpretation

- Consecutive
- Sight Translation
- Simultaneous

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Be prepared:

- Accept assignments in accordance with your specialties and skill level
- Gather details about the case, your contact and any other information that might help you prepare
- Study up on any pertinent vocabulary
- Know the location and how to get to it

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Always:

- Introduce yourself to personnel:
  - Name and language
  - Ask about previous experiences with interpreters
  - Explain the function of the interpreter if needed
  - Determine the goal of the encounter
- Position yourself so you can see and hear everyone

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During the assignment:

- Always interpret in the first person
- Refer to yourself in the third person
- Ask for clarification and repetition if necessary
- Do not reproduce gestures
- Do not hold uninterpreted conversations

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Remember your CIFEs!

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Part 2: Interpreting Ethics

Understanding the responsibilities and challenges facing the interpreter when providing language access

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What if?

- The patient responds in English?
- The patient makes a mistake?
- The patient is lying?
- The medical professional or the patient start sentences with "Tell him/her that…"?
- Someone challenges your interpretation?
- You're told not to interpret something?
- You forgot part of the utterance?

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What are Ethics?

Ethics…

"The discipline of dealing in what is good and bad, right and wrong, moral duty and obligation, or Acting in accord with approved standards conforming to professional endorsed principles and practices."

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"Ethics is the Moral Philosophy of Practice… In Professional Life."

Jacob T. Levy

- **MORALS**
- "Rules or habits of conduct with regard to standards of right and wrong in relation to human action and character"
- "Arising from conscience"
- "Define a personal character"
- **ETHICS**
- "The study of standards of conduct and moral judgment"
- "The system of morals of a particular philosopher, religion, group profession, etc."
- "Personal rules for behavior based on beliefs about how things should be"
- **CODES**
- "A body of laws of a nation, state, city, or organization, arranged systematically for easy reference"
- "Any accepted system of rules and regulations pertaining to a given subject"
- "A set of principles or values that govern conduct…"

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Why have a Code of Ethics?

"…provide a common base of understanding of our profession and foster consistency in its practice, thus improving the quality of interpreter services across the United States."

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Why do we have Different Codes of Ethics?

- ❑ Environment
- ❑ Purpose of Encounter
- ❑ Role of the Interpreter

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IMIA Code of Ethics

(est. 1987- earliest U.S. Code of Ethics for medical interpreters)

- 1. Interpreters will maintain confidentiality of all assignment-related information.
- 2. Interpreters will select the language and mode of interpretation that most accurately conveys the content and spirit of the messages of the parties involved.
- 3. Interpreters will refrain from accepting assignments beyond their professional skills, language fluency, or level of training.

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IMIA Code of Ethics

(est. 1987- earliest U.S. Code of Ethics for medical interpreters)

- 4. Interpreters will refrain from accepting an assignment when family or close personal relationships affect impartiality.
- 5. Interpreters will not interject personal opinions or counsel patients.
- 6. Interpreters will not engage in interpretations that relate to issues outside the provision of health care services unless qualified to do so.

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IMIA Code of Ethics

(est. 1987- earliest U.S. Code of Ethics for medical interpreters)

- 7. Interpreters will engage in patient advocacy and in the intercultural mediation role of explaining cultural differences and practices to health care providers and patients only when appropriate and necessary for communication purposes, using professional judgment.
- 8. Interpreters will use skillful unobtrusive interventions so as not to interfere with the flow of communication in a triadic medical setting.

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IMIA Code of Ethics

(est. 1987- earliest U.S. Code of Ethics for medical interpreters)

- 9. Interpreters will keep abreast of their evolving languages and medical terminology.
- 10. Interpreters will participate in continuing education programs as available.
- 11. Interpreters will seek to maintain ties with relevant professional organizations in order to be up-to-date with the latest professional standards and protocols.
- 12. Interpreters will refrain from using their position to gain favors from clients.

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- The patient was rambling, not adhering to conventional western discourse patterns (question > to-the-point answer)
- The patient has told me something that may be relevant, but has asked me not to tell the physician

- The patient makes various derogatory remarks about the physician, and clearly does not trust him.
- I understand the word in the source language, but do not know how to say it in the target language.
- The physician has been speaking for a very long time, and I am not going to remember some parts of what he said.

Part 3: Interpreting Skills

Understanding strategies for confidence, accuracy and success when providing language access

Agustin's Golden Rule:

"Did you hear what you just said?"

Weightlifting for Medical Interpreters™

(Work that brain muscle!)

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Interpreting Style

- So you are:
  - Intuitive
  - Counter-intuitive

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Scenario 1

Please think about your answer now.		Clearly say your answer now.	
Timers: Click number to begin			
8	8	30	30
8	8	30	30
8	8	30	30
8	8	30	30

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Scenario 2

Please think about your answer now.		Clearly say your answer now.	
Timers: Click number to begin			
8	8	30	30
8	8	30	30
8	8	30	30
8	8	30	30

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Consecutive Interpretation

- Improve your AIM
  - Attend
    - Sorry, you must pay

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Finished files are the result of years of scientific study combined with the experience of years.

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Consecutive is the Most Reliable Form of Interpretation

Because the interpreter hears the **complete** thought *before* beginning to interpret

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Consecutive

Patricia Michelsen-King

- **More attention focused on Meaning the better the Recall**
- **Basic skills: Attend & Understand**

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Being there

- **Understanding Original** is essential.
- It's not the words, it's: **The Meaning**
- **Familiarity** with subject = Routinization
- **Ambiguity** inherent in language, context is everything
- Linguistic and **Extra-linguistic** knowledge

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Paremiology

Παροιμία + λόγος

- Study of proverbs
- How does this help?
- Understanding interpretation
  - Intra-lingual interpretation
  - Inter-lingual interpretation

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"REM TENE
VERBA SEQUENTUR"

- CATO

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"GRASP THE
MEANING
AND THE WORDS
WILL FOLLOW"

-CATO

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Consecutive Interpretation

- Improve your AIM
  - Attend
    - Sorry, you must pay
  - Inscribe
    - A picture is worth a 1000 words

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Note-taking

Take notes in the Source Language

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Note-taking *Not one correct way*

Patricia Michelsen-King

- Divide page in half.
  - Take notes vertically
- Make notes simple and concise
  (Write main ideas, trigger words)
- Draw, make your own symbols
- Practice, practice, practice

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Note-taking

Abstract ideas from SL

- Placement of ideas on page
  - Indentation, verticalization
- Abbreviation
  - helps to write first and last letters of a word
- Symbols
  - Mathematical, arrows, Greek letters
- Lines
  - Negation, repetition, underlining

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Note-taking

- Indentation and '/'
  - Showing continuing ideas
  - Showing relationship

    - ***I was attending a meeting, on Saturday, June 15, in California, when I got the call about his death.***

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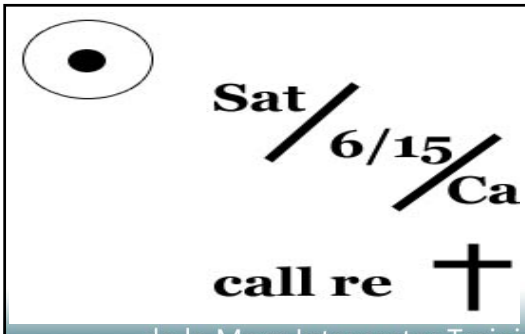

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Now, let's talk about Saturday, November 9, the day of the accident. When you came about in your car, did you call your brother before or after John told you that the paramedics were on their way?

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Nw, lt's tlk bout Sat, Nov 9, the dy of th accident, whn u cme bout in your car, did u cll your brthr bfr r ftr Jhn tld u tht th prmdcs were n thr wy?

Less Notes = More Concentration
(Memory Aides Only)

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Consecutive Interpretation

- Improve your AIM
  - Attend
    - Sorry, you must pay
  - Inscribe
    - A picture is worth a 1000 words
  - Memorize
    - Chain it together

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The Chain Method

"A chain is as strong as its weakest link"

- Visualization
- The Linking Rules:
  - It is all about you
  - Size does matter
  - Go ahead be silly

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Dissecting Consecutive

- The formula is in the question
  - Mental templates
- The long answer: tell me about it
  - Mental pictures "A chain is as strong as its weakest link"

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Thank you!

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Our Team

- Expertise and experience
- Leader in training initiatives for court & medical interpreters

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Nemours Children's Hospital Policy on Communicating with Persons with Limited English Proficiency

PURPOSE

To promote effective communication between the health care team at Nemours Children's Hospital (NCH) and affiliated ambulatory service areas and patients, families and visitors with special communication needs including interpretive services.

POLICY

1. Nemours Children's Hospital will take reasonable steps to ensure that persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits. The policy of Nemours Children's Hospital is to ensure meaningful communication with LEP patients and their families and their authorized representatives involving their medical conditions and treatment. The policy also provides for communication of information contained in vital documents, including but not limited to, waivers of rights, consent to treatment forms, financial and insurance benefit forms, etc. All interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served, and patients/clients and their families will be informed of the availability of such assistance free of charge.

2. Language assistance will be provided through use of competent bilingual staff, staff interpreters, contracts or formal arrangements with local organizations providing interpretation or translation services, or technology and telephonic interpretation services. All staff will be provided notice of this policy and procedure, and staff that may have direct contact with LEP individuals will be trained in effective communication techniques, including the effective use of an interpreter.

3. Nemours Children's Hospital will conduct a regular review of the language access needs of our patient population, as well as update and monitor the implementation of this policy and these procedures, as necessary.

PROCEDURE

IDENTIFYING LEP PERSONS AND THEIR LANGUAGE

Nemours Children's Hospital will promptly identify the language and communication needs of the LEP person. If necessary, staff will use a language identification card (or "I speak cards," available online at www.lep.gov) or posters to determine the language. In addition, when records are kept of past interactions with patients or family members, the language used to communicate with the LEP person will be included as part of the record.

OBTAINING A QUALIFIED INTEPRETER

1. The KidsTRACK Manager or their designee is responsible for:
    a. Maintaining an accurate and current list showing the name, language, phone number and hours of availability of bilingual staff;
    b. Contacting the appropriate bilingual staff member to interpret, in the event that an interpreter is needed, if an employee who speaks the needed language is available and is qualified to interpret;
    c. Obtaining an outside interpreter if a bilingual staff or staff interpreter is not available or does not speak the needed language. Nemours Children's Hospital manages an active list of vendors to provide onsite interpreters. Please contact the KidsTRACK program at 407-567-3208 during normal business hours and the Patient Flow Supervisor during after hours for connection to these vendors in support of appropriate patient care.

2. Some LEP persons may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the LEP person will not be used as interpreters unless specifically requested by that individual and **after** the LEP person has understood that an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the person's file. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided to the LEP person.
3. Children and other clients/patients/residents will **not** be used to interpret, in order to ensure confidentiality of information and accurate communication.

PROVIDING WRITTEN TRANSLATIONS

1. When translation of vital documents is needed, each unit in Nemours Children's Hospital will submit documents for translation into frequently-encountered languages to the KidsTRACK Manager or their designee. Original documents being submitted for translation will be in final, approved form with updated and accurate legal and medical information.
2. Facilities will provide translation of other written materials, if needed, as well as written notice of the availability of translation, free of charge, for LEP individuals.
3. Nemours Children's Hospital will set benchmarks for translation of vital documents into additional languages over time.

PROVIDING NOTICE TO LEP PERSONS

Nemours Children's Hospital will inform LEP persons of the availability of language assistance, free of charge, by providing written notice in languages LEP persons will

understand. At a minimum, notices and signs will be posted and provided in intake areas and other points of entry, including but not limited to the emergency room, outpatient areas, etc. Notification will also be provided through one or more of the following: outreach documents and community-based organizations.

MONITORING LANGUAGE NEEDS AND IMPLEMENTATION

On an ongoing basis, the KidsTRACK Manager or their designee will assess changes in demographics, types of services or other needs that may require reevaluation of this policy and its procedures. In addition, Nemours Children's Hospital will regularly assess the efficacy of these procedures, including but not limited to mechanisms for securing interpreter services, equipment used for the delivery of language assistance, complaints filed by LEP persons, feedback from patients and community organizations, etc.

CLAS Standards

National Standards on Culturally and Linguistically Appropriate Services (CLAS)

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

CLAS **mandates** are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).

CLAS guidelines are activities recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).

CLAS recommendations are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

Standard 1
Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2
Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3
Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4
Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5
Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6
Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7
Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8
Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9
Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and

linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10
Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11
Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12
Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13
Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14
Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

SUMMARY OF HIPAA REGULATIONS

The Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services ("HHS") issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). 1 The Privacy Rule standards address the use and disclosure of individuals' health information—called "protected health information" by organizations subject to the Privacy Rule — called "covered entities," as well as standards for individuals' privacy rights to understand and control how their health information is used. Within HHS, the Office for Civil Rights ("OCR") has responsibility for implementing and enforcing the Privacy Rule with respect to voluntary compliance activities and civil money penalties.

STATUTORY & REGULATORY BACKGROUND

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of HHS to publicize standards for the electronic exchange, privacy and security of health information. Collectively these are known as the Administrative Simplification provisions. HIPAA required the Secretary to issue privacy regulations governing individually identifiable health information, if Congress did not enact privacy legislation within OCR Privacy Rule Summary 2 Last Revised 05/03 three years of the passage of HIPAA. Because Congress did not enact privacy legislation, HHS developed a proposed rule and released it for public comment on November 3, 1999. The Department received over 52,000 public comments. The final regulation, the Privacy Rule, was published December 28, 2000. In March 2002, the Department proposed and released for public comment modifications to the Privacy Rule. The Department received over 11,000 comments. The final modifications were published in final form on August 14, 2002.3 A text combining the final regulation and the modifications can be found at 45 CFR Part 160 and Part 164, Subparts A and E on the OCR

WHO IS COVERED BY THE PRIVACY RULE

The Privacy Rule, as well as all the Administrative Simplification rules, apply to health plans, health care clearinghouses, and to any health care provider who transmits health information in electronic form in connection with transactions for which the Secretary of HHS has adopted standards under HIPAA (the "covered entities"). Health Plans. Individual and group plans that provide or pay the cost of medical care are covered

entities. Health plans include health, dental, vision, and prescription drug insurers, health maintenance organizations (“HMOs”), Medicare, Medicaid, Medicare+ Choice and Medicare supplement insurers, and long-term care insurers (excluding nursing home fixed-indemnity policies).
Health Care Providers. Every health care provider, regardless of size, who electronically transmits health information in connection with certain transactions, is a covered entity. These transactions include claims, benefit eligibility inquiries, referral authorization requests, or other transactions for which HHS has established standards under the HIPAA Transactions Rule. Using electronic technology, such as email, does not mean a health care provider is a covered entity; the transmission must be in connection with a standard transaction. The Privacy Rule covers a health care provider whether it electronically transmits these transactions directly or uses a billing service or other third party to do so on its behalf. Health care providers include all “providers of services” (e.g., institutional providers such as hospitals) and “providers of medical or health services” (e.g., non-institutional providers such as physicians, dentists and other practitioners) as defined by Medicare, and any other person or organization that furnishes, bills, or is paid for health care.

Health Care Clearinghouses. Health care clearinghouses are entities that process nonstandard information they receive from another entity into a standard (i.e., standard format or data content), or vice versa.

WHAT INFORMATION IS PROTECTED

Protected Health Information. The Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information "protected health information (PHI)."12 OCR Privacy Rule Summary 4 Last Revised 05/03 “Individually identifiable health information” is information, including demographic data, that relates to: the individual’s past, present or future physical or mental health or condition, the provision of health care to the individual, or the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual.13 Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

GENERAL PRINCIPLE FOR USES AND DISCLOSURES

Basic Principle. A major purpose of the Privacy Rule is to define and limit the circumstances in which an individual's protected heath information may be used or disclosed by covered entities. A covered entity may not use or disclose protected health information, except either: (1) as the Privacy Rule permits or requires; or (2) as the individual who is the subject of the information (or the individual's personal representative) authorizes in writing. Required Disclosures. A covered entity must disclose protected health information in only two situations: (a) to individuals (or their personal representatives) specifically when they request access to, or an accounting of disclosures of, their protected health information; and (b) to HHS when it is undertaking a compliance investigation or review or enforcement action.17 See OCR "Government Access" Guidance.

PERMITTED USES AND DISCLOSURERS

Permitted Uses and Disclosures. A covered entity is permitted, but not required, to use and disclose protected health information, without an individual's authorization, for the following purposes or situations: (1) To the Individual (unless required for access or accounting of disclosures); (2) Treatment, Payment, and Health Care Operations; (3) Opportunity to Agree or Object; (4) Incident to an otherwise permitted use and disclosure; (5) Public Interest and Benefit Activities; and (6) Limited Data Set for the purposes of research, public health or health care operations.18 Covered entities may rely on professional ethics and best judgments in deciding which of these permissive uses and disclosures to make.

AUTHORIZED USES AND DISLCOSURES

Authorization. A covered entity must obtain the individual's written authorization for any use or disclosure of protected health information that is not for treatment, payment or health care operations or otherwise permitted or required by the Privacy Rule.44 A covered entity may not condition treatment, payment, enrollment, or benefits eligibility on an individual granting an authorization, except in limited circumstances.45 An authorization must be written in specific terms. It may allow use and disclosure of protected health information by the covered entity seeking the authorization, or by a third party. Examples of disclosures that would require an individual's authorization include disclosures to a life insurer for coverage purposes, disclosures to an employer of the results of a pre-employment physical or lab test, or disclosures to a pharmaceutical firm for their own marketing purposes. All authorizations must be in plain language, and contain specific information regarding the information to be

disclosed or used, the person(s) disclosing and receiving the information, expiration, right to revoke in writing, and other data. The Privacy Rule contains transition provisions applicable to authorizations and other express legal permissions obtained prior to April 14, 2003.

LIMITING USES AND DISCLOSURES TO THE MINIMUM NECESSARY

Minimum Necessary. A central aspect of the Privacy Rule is the principle of "minimum necessary" use and disclosure. A covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request.50 A covered entity must develop and implement policies and procedures to reasonably limit uses and disclosures to the minimum necessary. When the minimum necessary standard applies to a use or disclosure, a covered entity may not use, disclose, or request the entire medical record for a particular purpose, unless it can specifically justify the whole record as the amount reasonably needed for the purpose.

NOTICE AND OTHER INDIVIDUAL RIGHTS

Privacy Practices Notice. Each covered entity, with certain exceptions, must provide a notice of its privacy practices. The Privacy Rule requires that the notice contain certain elements. The notice must describe the ways in which the covered entity may use and disclose protected health information. The notice must state the covered entity's duties to protect privacy, provide a notice of privacy practices, and abide by the terms of the current notice. The notice must describe individuals' rights, including the right to complain to HHS and to the covered entity if they believe their privacy rights have been violated. The notice must include a point of contact for further information and for making complaints to the covered entity. Covered entities must act in accordance with their notices. The Rule also contains specific distribution requirements for direct treatment providers, all other health care providers, and health plans.

ADMINISTRATIVE REQUIREMENTS

HHS recognizes that covered entities range from the smallest provider to the largest, multi-state health plan. Therefore the flexibility and scalability of the Rule are intended to allow covered entities to analyze their own needs and implement solutions appropriate for their own environment. What is appropriate for a particular covered entity will depend on the nature of the covered entity's business, as well as the covered entity's size and resources. Privacy Policies and Procedures. A covered entity must develop and implement written privacy policies and procedures that are consistent with the Privacy Rule.64 Privacy Personnel. A covered entity must designate a privacy official responsible for developing and implementing its privacy policies and procedures,

and a contact person or contact office responsible for receiving complaints and providing individuals with information on the covered entity's privacy practices.

ORGANIZATIONAL OPTIONS

The Rule contains provisions that address a variety of organizational issues that may affect the operation of the privacy protections.
Hybrid Entity. The Privacy Rule permits a covered entity that is a single legal entity and that conducts both covered and non-covered functions to elect to be a "hybrid entity."
Affiliated Covered Entity. Legally separate covered entities that are affiliated by common ownership or control may designate themselves (including their health care components) as a single covered entity for Privacy Rule compliance.
Organized Health Care Arrangement. The Privacy Rule identifies relationships in which participating covered entities share protected health information to manage and benefit their common enterprise as "organized health care arrangements
Covered Entities With Multiple Covered Functions. A covered entity that performs multiple covered functions must operate its different covered functions in compliance with the Privacy Rule provisions applicable to those covered functions
Group Health Plan disclosures to Plan Sponsors. A group health plan and the health insurer or HMO offered by the plan may disclose the following protected health information to the "plan sponsor"—the employer, union, or other employee organization that sponsors and maintains the group health plan

OTHER PROVISIONS: PERSONAL REPRESENTATIVES AND MINORS

Personal Representatives. The Privacy Rule requires a covered entity to treat a "personal representative" the same as the individual, with respect to uses and disclosures of the individual's protected health information, as well as the individual's rights under the Rule.84 A personal representative is a person legally authorized to make health care decisions on an individual's behalf or to act for a deceased individual or the estate. The Privacy Rule permits an exception when a covered entity has a reasonable belief that the personal representative may be abusing or neglecting the individual, or that treating the person as the personal representative could otherwise endanger the individual.

STATE LAW

Preemption. In general, State laws that are contrary to the Privacy Rule are preempted by the federal requirements, which means that the federal requirements will apply.85 "Contrary" means that it would be impossible for a covered entity to comply with both the State and federal requirements, or that the provision of State law is an obstacle to accomplishing the full purposes and objectives of the Administrative Simplification provisions of HIPAA.86 The Privacy Rule provides exceptions to the general rule of federal preemption for contrary State laws that (1) relate to the privacy of individually identifiable health information and provide greater privacy protections or privacy rights with respect to such information, (2) provide for the reporting of disease or injury, child abuse, birth, or death, or for public health surveillance, investigation, or intervention, or (3) require certain health plan reporting, such as for management or financial audits.

ENFORCEMENT AND PENALTIES FOR NONCOMPLIANCE

Compliance. Consistent with the principles for achieving compliance provided in the Rule, HHS will seek the cooperation of covered entities and may provide technical assistance to help them comply voluntarily with the Rule.87 The Rule provides processes for persons to file complaints with HHS, describes the responsibilities of covered entities to provide records and compliance reports and to cooperate with, and permit access to information for, investigations and compliance reviews. Civil Money Penalties. HHS may impose civil money penalties on a covered entity of $100 per failure to comply with a Privacy Rule requirement.88 That penalty may not exceed $25,000 per year for multiple violations of the identical Privacy Rule requirement in a calendar year. HHS may not impose a civil money penalty under specific circumstances, such as when a violation is due to reasonable cause and did not involve willful neglect and the covered entity corrected the violation within 30 days of when it knew or should have known of the violation.

COMPLIANCE DATES

Compliance Schedule. All covered entities, except "small health plans," must be compliant with the Privacy Rule by April 14, 2003.90 Small health plans, however, have until April 14, 2004 to comply. Small Health Plans. A health plan with annual receipts of not more than $5 million is a small health plan.91 Health plans that file certain federal tax returns and report receipts on those returns should use the guidance provided by the Small Business Administration at 13 Code of Federal Regulations (CFR) 121.104 to calculate annual receipts. Health plans that do not report receipts to the Internal

Revenue Service (IRS), for example, group health plans regulated by the Employee Retirement Income Security Act 1974 (ERISA) that are exempt from filing income tax returns, should use proxy measures to determine their annual receipts

Learning Goals:
Understand the concept of culture and its importance in medical interpreting.
Understand the role of the interpreter as a culture broker.

What is culture and why is it important in medical interpreting?

"Culture" is a big word that takes on many different meanings depending on its context. For our purposes, we will define culture as ***a shared set of belief systems, values, practices and assumptions which determine how we interact with and interpret the world***. You can begin to see from this definition how our culture influences the way we understand situations and communicate with others.

When you say the word "culture," the first things that come to mind are often art, music, food, literature, holidays and other practices and traditions common to a group of people. These elements form part of a person's culture, but for our purposes they are not the only important aspects. Culture within the context of medical interpreting has more to do with understanding the impact of our different assumptions, practices and values on our everyday interactions and our ability to communicate effectively with those around us.

What is the role of the interpreter as ***culture broker***?

As medical interpreters, we are not just helping people to overcome differences in language, but differences in culture as well. Within each medical encounter there are several cultures present. These include: the culture of the patient, the culture of the doctor/nurse, the culture of the interpreter, and the culture of the health care system surrounding the encounter. These different cultures may have widely varying views on health, disease, ways to treat illness, hygiene and death. It is part of the interpreter's job as a ***culture broker*** to be aware of all the cultures present and use this awareness to facilitate communication between patient and provider.

Cultural Factors within Medical Encounters:

In this section we will summarize some common factors to be aware of when it comes to the role of culture within medical encounters.

Nonverbal communication is communication that takes place without the use of words. In many ways, nonverbal cues can be even more important to the effective communication between two people than words. Through nonverbal communication, people express their emotions and their level of comfort within a given situation. Nonverbal communication is also used to demonstrate our feelings toward the person we're communicating with, whether they be feelings of respect, amicability, fear, skepticism, etc.

Just as with spoken language, nonverbal communication varies from culture to culture. A gesture or behavior in one culture may mean a completely different thing in another. The following are examples of some aspects of nonverbal communication that vary from culture to culture:
Tone and volume of voice
Eye contact
Posture
Gestures
Physical contact and personal space
Punctuality

The interpreter should look out for instances where cultural differences in nonverbal communication may result in a lack of understanding on behalf of either of the parties present in the medical encounter. For example, if the non-English speaking patient makes a hand gesture that the English-speaking doctor seems puzzled by, the interpreter can explain the meaning of the gesture. It is also important to look out for nonverbal clues that indicate that a person may not be understanding what is being said.

Another aspect of culture that comes into play during medical encounters entails the power dynamics between different individuals. Power dynamics are important in how we treat and communicate with others. We speak and behave differently depending on whom we are addressing. For example, most people act differently towards their coworkers as opposed to their boss or supervisor. A person's culture influences how they perceive the power dynamics of any given situation. When individuals of different cultural backgrounds are present during a medical encounter, their differing notions of

power dynamics may make communication more difficult. Below are some examples of relationships whose power dynamics may differ from culture to culture:
Doctor-patient relationship
Younger-elder relationship
Relationship between family members
Relationship between man and woman

It is important for the interpreter to be aware of the differences in power dynamics across cultures, as these can create barriers to understanding. For example, if a patient comes from a culture where doctors are considered to have a lot of authority, they may not feel comfortable speaking out to say they do not understand an instruction that their doctor has provided. Maybe after providing instructions for taking medication the doctor will say, “Do you understand?” and the patient will nod politely. If the interpreter has reason to think that perhaps the patient does not in fact understand and is just nodding to be polite, it is part of the interpreter’s job to intervene and check for understanding.

INTERNATIONAL MEDICAL INTERPRETERS ASSOCIATION (IMIA)
CODE OF ETHICS

1. Interpreters will maintain confidentiality of all assignment-related information.

2. Interpreters will select the language and mode of interpretation that most accurately conveys the content and spirit of the messages of their clients.

3. Interpreters will refrain from accepting assignments beyond their professional skills, language fluency, or level of training.

4. Interpreters will refrain from accepting an assignment when family or close personal relationships affect impartiality.

5. Interpreters will not interject personal opinions or counsel patients.

6. Interpreters will not engage in interpretations that relate to issues outside the provision of health care services unless qualified to do so.

7. Interpreters will engage in patient advocacy and in the intercultural mediation role of explaining cultural differences/practices to health care providers and patients only when appropriate and necessary for communication purposes, using professional judgment.

8. Interpreters will use skillful unobtrusive interventions so as not to interfere with the flow of communication in a triadic medical setting.

9. Interpreters will keep abreast of their evolving languages and medical terminology.

10. Interpreters will participate in continuing education programs as available.

11. Interpreters will seek to maintain ties with relevant professional organizations in order to be up-to-date with the latest professional standards and protocols.

12. Interpreters will refrain from using their position to gain favors from clients.

Introduce yourself to the interpreter. Determine the interpreter's level of English proficiency and professional training and request that the interpreter interpret everything into the first person (to avoid "he said, she said

Acknowledge the interpreter as a professional in communication. Respect his or her role.

During the medical interview, **speak directly to the patient**, not to the interpreter.

Speak more slowly rather than more loudly.

Speak at an even pace in relatively short segments. Pause so the interpreter can interpret.

Assume, and insist, that **everything** you say, everything the patient says, and everything that family members say **is interpreted**.

Do not hold the interpreter responsible for what the patient says or doesn't say. The interpreter is the medium, not the source, of the message. If you feel that you are not getting the type of response you were expecting, restate the question or consult with the interpreter to better understand if there is a cultural barrier that is interfering with communication.

Be aware that **many concepts you express have no linguistic or conceptual equivalent in other languages**. The interpreter may have to paint word pictures of many terms you use. This may take longer than your original speech.

Give the interpreter time to restructure information in his/her mind and present it in a culturally and linguistically appropriate manner. **Speaking English does not mean thinking in English.**

Remember that your patient may have been a victim of torture or trauma. This may also be true for the interpreter. If you need to ask questions that may be extremely **personal or sensitive**, explain to the patient that doing so is part of your evaluation and reiterate that the information will remain confidential.

Avoid: Highly idiomatic speech, complicated sentence structure, sentence fragments, changing your idea in the middle of a sentence, and asking multiple questions at one time. Also avoid making assumptions or generalizations about your patient or their experiences. Common practices or beliefs in a community may not apply to everyone in that community.

Encourage the interpreter to ask questions and to alert you about potential cultural misunderstandings that may come up. Respect an interpreter's judgment that a

particular question is culturally inappropriate and either rephrase the question or ask the interpreter's help in eliciting the information in a more appropriate way.

Avoid patronizing or infantilizing the patient. A lack of English language skills is not a reflection of low cognitive function or a lack of education. Your patient may be a college professor or a medical doctor in her own country just as easily as she may be a farm worker.

Ask the patient **what he/she believes the problem is**, what causes it, and how it would be treated in their country of origin.

Ask the patient to **repeat back** important information that you want to make sure is understood.

Be patient. Providing care across a language barrier takes time. However, the time spent up front will be paid back by good rapport and clear communication that will avoid wasted time and dangerous misunderstandings.

Allow time for a pre-session with the interpreter. When working with a professional face-to-face interpreter to facilitate communication with a limited English proficient (LEP) refugee, a pre-session can be helpful to both the healthcare provider and the interpreter.

CIFE

Confidential
In the first person
Flow control
Everything is interpreted

Section 3: Interpreting Skills

David Kolb's Learning Cycle

I'm going to share with you what I believe will take you to the next step as interpreters. We may already be good interpreters but we can all get better, right? Here's what I want to tell you. In 1999 I heard Bill Clinton speak and he mentioned that "A great man" – at that time I didn't know who – once said, "The best definition of madness I know is when people continue to do the same thing over and over again, and expect different results." That is a wonderful quote, and I think it applies perfectly to us interpreters. Because one of the things that I've noticed, in Florida, for instance is that when we started testing people, the first group that tested was 99% staff interpreters, some of them with seventeen years of experience, and the passing rate of that first attempt in Florida was 43%. This meant that more than half of people who were staff interpreters didn't pass the test, so they were required to re-take and pass the test within a year or two, and many of them studied and passed – but some of them didn't. And I remember asking them "How did you prepare?" And they'd say: "I asked for more assignments," "I even volunteered for the weekend." Does that sound familiar? They were doing exactly the same things that they were doing before, but expecting the results to be different. Guess what? They were not. So one thing is clear to me: wherever you are on the scale of interpretation, wherever you are today, that's where you are today, and unless you change something it would be crazy to think you're going to get any better. Unless you change something, it would be crazy to believe that you're going to do better. So this seminar is all about changing.

Now, the important thing is, how do we change? It took me a long time to kind of understand this, but then I found the writings of this gentleman: David Kolb. David Kolb is an experiential psychologist and his premise is basically that to learn something, you have to experience it. In fact, for adults to learn something, they must do four things, or follow a four-stage learning cycle.

The first stage of the learning cycle is called

Experiencing: you carry out the task without reflection, just intention According to Kolb this is the beginning of learning something. But if you really want to learn something you must complete all four steps of the cycle. The next step is called

Reflection: You step back from the task and you review what has been done and experienced. To become a good interpreter you have to listen to your interpretation and think, as you are reflecting on this, if I were a Non-English speaker who heard this for the first time, would I understand it? Does that make sense to me? So you start

reflecting on how it feels to experience, now as a recipient of the service, what you just did. That's called reflection. The next step is:

Conceptualization: Which means you interpret the events you noticed, but using a theory. So, if this happened, why was it happening? As a frame of reference I suggest you use my theory about the importance of the three legs for a good court interpreter:

#1: Language Expertise

Being a good court interpreter requires a very high level of language expertise. Studies in the Federal Court Exam show that the most successful people, the ones that attain the rate of passing – of course this is in Spanish but I think we can extrapolate to other languages – traditionally have a level of sophistication in both languages equivalent to a two-year college degree. I'm not saying that you must have a college degree. So that means that you don't necessarily have to go to school and get that degree, but you need to have that level of sophistication. That's the difference. What does "fluent" mean? Being fluent means that you can say what you can think. You can say what you can think. So, if you think about a person that is, let's say, five or six years old, and is born in a monolingual household and grows up in that monolingual household, by the time they're five years old, are they fluent in their language? Yes, of course they are. Therefore, being an interpreter is not about fluency; it's about level of sophistication in the language, how much can you say but also how much can you understand and transform from one language to the other.

Now, #2: Innate Talent

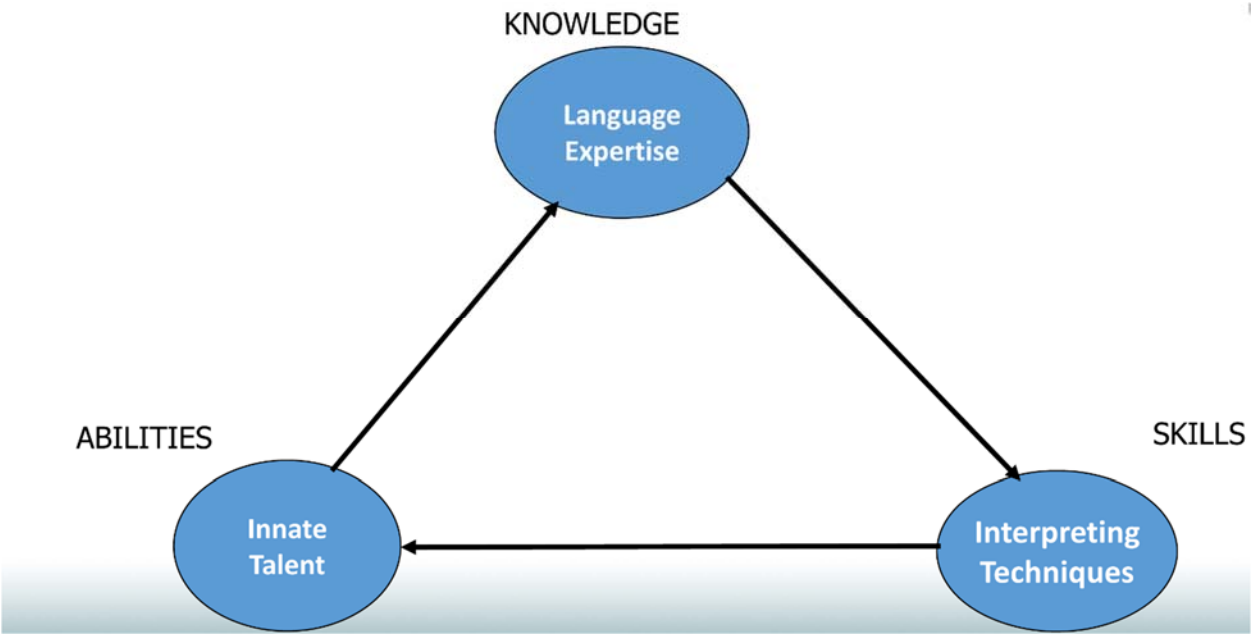
That is something that cannot be taught and I strongly believe all of us are born with certain talents, and we know them from a young age, after a few years we discover, "Man, I can draw really well," and people start telling you that. To be an interpreter you certainly require multi-tasking talent.

#3 is: Interpreting Technique

This is the one that I think we have to work on, and this is what I want to share with you, what I have learned about interpreting technique in these 25 years of experience. If we combine all three parts we find what they are always talking about on the exam, the famous KSA: the knowledge, skills and ability to be a good interpreter. The fourth stage of the learning cycle is called:

Planning: take the new understanding and decide the tasks that I'm going to follow to refine my performance in a specific task. So a good interpreter is going to say, "Okay, I have language expertise problems with anatomy." So guess what my next task is? Well, I'm going to have to design some training that includes a lot of human anatomy exercises. And by the way, was it the source or target that was my problem? Was it the source, in English, because I didn't know what the body parts were? Or did I know what the parts were, but I just didn't know how to say them in Spanish? Or is it both? So I'm

going to have to design a program that will achieve the goal acquiring the knowledge I don't have about that specific subject. It is all about change, that's what this seminar is all about.



CONSECUTIVE INTERPRETATION

In Consecutive Interpreting, you must constantly analyse during the note-taking process the incoming message and note the most salient points to help improve your memory processes during interpretation. During consecutive interpreting the interpreter has the opportunity to make notes and may refer to those notes while rendering the interpretation. Both consecutive and simultaneous interpreting require that you understand the message, analyse it, transfer it into the target language mentally, and, finally, reformulate the message in the target language. When you take notes during consecutive interpreting you should take notes in the source. Some interpreters find consecutive interpreting more difficult because of the amount of time that passes between hearing the source message and rendering the interpretation. Although consecutive is more time consuming than simultaneous interpretation, consecutive interpretation allows for more precision and is therefore often the preferred method in highly sensitive meetings where a slip of the tongue could lead to disaster. (Mikkelson, 1983, p. 5),

Taking notes can relieve the burden of memory, but you must know how to take notes effectively during the interpreting process. Analysis allows you to understand the meaning of the source message as best you can with your current resources and skill level. You must understand the source message before you can interpret. We must also be aware that some expressions that have functions only in the source language and will have no communicative purpose in the target language.

How would you interpret the following phrases?

It’s raining cats and dogs

There’s a cathedral, an open square and several outdoor cafes on the piazza.

The pediatric neurosurgeon determined that my baby has normal reflexes but found that she is profoundly deaf by using a tuning fork.

Note-taking:

Professionals often use notes in their work and that people in everyday life make notes to remind them of things they want to do or need to remember. Some studies suggest note-taking may interfere with listening, while other studies suggest the opposite. This difference may be due to the speed of delivery and effectiveness of the note-taker. Howe (1970) found that the fewer the notes, the better the recall. Jones (1998) says note-taking is a strategy that can reduce the cognitive load on memory during consecutive interpreting. You must be able to practice note-taking and use note-taking in professional settings.

There are actually two main functions associated with note-taking:
1) the process of taking the notes and
2) the process of reviewing the notes.
It appears to help in analysis and processing of information, and the interpreter is more likely to remember something that s/he acted upon him/herself. Note-taking helps to store the information in memory. Also, it was stated that the benefit comes from reviewing the notes rather than taking the notes. Therefore the notes serve as an external memory storage device.
Another reason to take notes is to minimize mental fatigue as the mental effort is spread out over the entire process instead of all the hard work during the first stage. When a speech contains numbers or names, it is even more important to use note-taking to reduce the load on memory. Notes can help the interpreter reproduce the content of the speech, so the notes should indicate which points are most important and which are supporting. In order to determine which points are main and which are supporting, the interpreter must analyze the message. The process of note-taking helps to clarify the structure of the source message. The benefits of note-taking, organizing, focus, and enhancing memory are interacting and reinforcing each other continuously.
Note-Taking Strategies:
Keep your notes to a minimum. Very few words of the original message are written down, because interpreters focus on ideas, not words.
Technical terms, numbers and names should be written down but notes should always reflect what the interpreter has understood not just what you heard. Some interpreters write single words and some symbols that represent entire concepts. Use a note pad or a writing surface that is convenient and easy to hold, like a steno-pad. Notes should be taken only on one surface of the note pad rather than trying to switch from front to back of page. Notes should be easily legible and unambiguous. For ex: abbreviations must refer to a single lexical item and symbols should not be invented on the spot as it will be too hard to remember what the new symbol means when rendering the message.
Seleskovitch (1995) says that experienced interpreters who are skilled in taking notes during CI do not focus on the method of note-taking but rather on the meaning of the passage. There are many different note-taking systems as there are interpreters and each interpreter's system is unique. Therefore note-taking should be a personal, non-prescriptive system. It is important to keep in mind that the ultimate goal is an accurate interpretation.

Section 4: Exercises

ETHICS SCENARIOS

Open Questions
You are an interpreter arriving on time for an assignment. You are shown to the consultation room where the doctor is already waiting impatiently with the patient. You begin to introduce yourself and explain the codes of practice, but the doctor ignores you asks what the problem with the patient is. You should...

Even though you began to explain the proper procedure, the doctor insisted on beginning the interview and continues to address their questions to you, instead of the patient, saying things like “tell him I need to know how long he has experienced these symptoms”. You should…

The doctor says that they need to consult with another colleague briefly, so they ask you to stay with this patient and interview them, asking questions about their medical history until the doctor is able to return. You should…

Predicaments
Predicament: The patient was rambling, not adhering to conventional western discourse patterns (question > to-the-point answer)
Dilemma: Shall I explain about the patient to the physician?

Predicament: The patient has told me something that may be relevant, but has asked me not to tell the physician
Dilemma: Shall I risk losing the patient’s trust or shall I risk not disclosing the information?

Predicament: The patient makes various derogatory remarks about the physician, and clearly does not trust him.
Dilemma: Shall I let the doctor in on what the patient is saying?

Predicament: I understand the word in the source language, but do not know how to say it in the target language.
Dilemma: Shall I ask for time off to check the term, or shall I make do with a more general term or paraphrase (e.g. instead of edema say an accumulation of fluids)?

Predicament: The physician has been speaking for a very long time, and I am not going to remember some parts of what he said.
Dilemma: Do I indicate this to the physician and ask him to stop or do I risk forgetting some points, rather than interrupt?

MEDICAL TERMINOLOGY

Do you know these common abbreviations?

Abbreviation	Term	Foreign Language Term
ENT		
GP		
EKG		
BP		
DJD		
NSAID		
MRI		
PET		
AIDS		
HIV		
RBC		
CAD		

Abbreviation	Term	Foreign Language Term
CPR		
ECHO		
GERD		
GI		
UTI		
HPV		
IUD		
ADHD		
TIA		

MEDICAL TERMINOLOGY

Do you know these common abbreviations?

Abbreviation	Term	Foreign Language Term
ENT	Ear, Nose and Throat	
GP	General Practitioner	
EKG	Electrocardiogram	
BP	Blood Pressure	
DJD	Degenerative Joint Disease	
NSAID	Nonsteroidal anti-inflammatory drug	
MRI	Magnetic Resonance Imaging	
PET	Positron Emission Tomography	
AIDS	Acquired Immunodeficiency Syndrome	
HIV	Human Immunodeficiency Virus	
RBC	Red Blood Cell (count)	
CAD	Coronary Artery Disease	

Abbreviation	Term	Foreign Language Term
CPR	Cardiopulmonary resuscitation	
ECHO	Echocardiography	
GERD	Gastrointestinal reflux disease	
GI	Gastrointestinal	
UTI	Urinary Tract Infection	
HPV	Human Papillomavirus	
IUD	Intrauterine Device	
ADHD	Attention-Deficit Hyperactivity Disorder	
TIA	Transient Ischemic Attack	

SIGHT TRANSLATION: NARRATIVE REPORT

On the above date at 18:12 hours, Officer Browning responded to Fire Station 44 at 132 N. Fountain Drive in Pierson in response to a report of an injured person. Upon arrival contact was made with EMT Smith who stated that the victim and the defendant arrived at the fire station and that the victim had an injury to her right eye but due to the language barrier, Smith was unable to determine what happened. While the victim was being treated by fire/rescue personnel, Office Browning attempted to talk with the defendant but a language barrier complicated matters. Officer Browning then made contact with Deputy Hernandez and had him telephone the fire station and translate for the defendant. During the phone conversation, the defendant stated that he and the victim had an argument over family matters and that the defendant could not stand it anymore and then punched the victim in the right eye. The victim sustained swelling, redness and partial tearing of the cornea. It was advised that the victim had surgery to her right eye in the past and that this incident had re-injured what was repaired by said surgery. The defendant was placed under arrest and transported to the County Jail. Photos were taken of the victim's injuries which were submitted into evidence. Victim was also given a Victim's Rights Pamphlet.

CONSECUTIVE EXERCISE: INTERVIEW

Doctor: Come on in and have a seat.
Patient: Muchas gracias
Doctor: Hello my name is Dr. John Smith; I am an internist here at the hospital. What is your name?
Patient: Paula Ocampo
Doctor: Ok Ms. Ocampo how would you like me to call you?
Patient: Umm… Me puede llamar por mi nombre, Paula.
Doctor: Is that ok…? Alright. Well for me to be able to help you today, I need to take a medical history which will involve me asking you questions about your health and also about your social circumstances. Is that ok with you?
Patient: Si, claro que si doctor lo que usted necesite..
Doctor: Ok, before we start I just wanted to confirm your personal information, so it's Paula Ocampo, you are 46-years-old and is this your address?
Patient: Si correcto esa soy yo y esa es mi dirección actual.
Doctor: Perfect, Great, Excellent, So… How can I help you today?
Patient: Bueno, la verdad es que he estado tosiendo mucho y pues me tiene un poco preocupada. .
Doctor: Right… How long has cough been there for?
Patient: Pues yo diria que ya llevo como 3 o 4 días.
Doctor: Has it…? And have you gotten any other symptoms with that cough?
Patient: Tengo la garganta muy irritada y eso se me ha ido empeorando también.
Doctor: Right and the sore throat has that been there the same amount of time?
Patient: Si, yo diría que me empezó al mismo tiempo que la tos.
Doctor: I'm sorry to hear that; and the cough and sore throat, is it worse any particular time of day or night?
Patient: Bueno la tos probablemente es peor en la mañana cuando me acabo de levantar. Lo de la garganta irritada lo siento en todo momento, para ser sincera.
Doctor: Is it? Are you able to swallow with that sore throat?
Patient: Si, si puedo tragar.
Doctor: You can; and you can drink, ok. And the cough can you describe it to me?
Patient: Pues es como una tos muy fuerte y escupo mucha flema, eso si.

Doctor: Right, ok and what color is the phlegm that you are coughing up?
Patient: Es como verde y espesa,
Doctor: Is it large amounts, or just a little bit?

Patient: Pues yo diría que es bastante. Me da pena decirlo pero tengo que escupir muy a menudo.
Doctor: Is there any blood in it?
Patient: No, no he visto nada de sangre.
Doctor: Ok, and how bad on a scale of one to ten, is that cough of yours, ten being the worst possible.
Patient: Bueno, cuando menos un seis o tal vez siete.
Doctor: Right, and is there any area in your throat or anywhere in your chest that is painful?
Patient: Bueno pues de tanto toser, si me duele la garganta y el cuello. Pero aparte de eso es nada más la garganta que me molesta constantemente.
Doctor: And the sore throat, does it travel anywhere else? Any other sort of radiation of pain?
Patient: No, No nada más eso.
Doctor: Ok. Has any other person been affected by this, have they been sort of coughing around you, been in contact with anyone?
Patient: Bueno pues mi marido estuvo tosiendo la semana pasada.
Doctor: Has he? Ok, and has he been feeling sick himself?
Patient: Bueno estuvo en la casa unos dias sin ir a trabajar pero ya está bien.
Doctor: Ok, what makes the cough and sore throat better for you, is there anything you can take that makes you feel better?
Patient: Bueno pues con la tos nada me ayuda en realidad, usted sabe, yo he usado esos remedies que venden en la farmacia pero no ayudan. Con lo de la garganta, si tomo algo caliente ayuda un poco.
Doctor: Ok, ok, anything else to make this cough worse at all?
Patient: No, nada mas.
Doctor: Nothing at all, ok, what do you think it is?
Patient: Pues yo no se que será, me imagino que necesito antibióticos.
Doctor: Right, right ok… I just want to ask you more specific questions. Now you said there is no blood in the phlegm. But is there any fever any shivering?
Patient: Primero si me daban muchos escalofríos, pero ya no.

Doctor: Ok and what about breathlessness, you got any breathing problem or chest tightness.
Patient: No
Doctor: Nothing at all? Ok, and when you go to bed at night are you able to lie down on your same amount of pillows, as always?
Patient: Si.

Doctor: You are… Ok, and what about your eating? Because I know you are coughing up lots of green phlegm. Is there any dripping at the back of your throat at all?
Patient: No
Doctor: Nothing like that? Ok, and have you had any unexplained weight loss at all?
Patient: No para nada.
Doctor: Any recent travel abroad?
Patient: No, hace mucho tiempo que no salgo al extranjero.
Doctor: I just want to go through of some of your key body system, just to find out about your overall health. Do you suffer from headaches at all?
Patient: A veces si me vienen dolores de cabeza.
Doctor: How often do you get headaches?
Patient: Mas o menos una vez al mes digamos..
Doctor: And have seen you seen your doctor for that?
Patient: No, lo que normalmente hago es tomarme alguna medicina para el dolor de cabeza y se me quitan. .
Doctor: Have you had any head injuries?
Patient: No
Doctor: And what about your vision do you wear glasses?
Patient: No
Doctor: Ok, vision is good?
Patient: Yo digo que si.
Doctor: Ok, do you ever suffer from nasal congestions or sinus problems?
Patient: Las únicas veces que se me tapa la nariz es si estoy cerca de un gato, esos animales me causan alergia.

COMMON ELEMENTS OF A MEDICAL INTERVIEW

Taking a patient's medical history is an important first step in treating him/her. Each medical provider has their own style and technique, but many interviews will include the common phrases listed below. It is important for the interpreter to be familiar with common topics and questions that are likely to come up during a standard medical interview. Being familiar with common phrases will allow you to interpret them quickly and accurately.

Do you know how to interpret the following common phrases?

- Please tell me your first and last name.
- How old are you?
- What do you do for a living?
- Is there much physical activity associated with your work?
- How can I help you today?
- What brings you in to see me today?
- When did your symptoms start?
- Have you taken any kind of medicine for your symptoms?
- What kind of medicine did you take and how much have you taken?
- Did the medicine help?
- Is there anything that makes your symptoms worse?
- Is there anything that makes your symptoms better?
- Do you feel any pain?
- Can you show me where the pain is located?
- Can you describe the pain for me?
- Is it stabbing or burning?
- Is it constant or intermittent?
- Is it sharp or dull?
- On a scale of one to ten, how would you rank the pain?
- Does the pain radiate to any other part of your body?
- Do you have any current health problems, such as diabetes or high blood pressure?
- How long have you had this condition?
- Are you seeing a doctor for this condition?
- Are you taking any medications for this condition?
- Can you tell me the name of the medication?

- Do you know what doses you take?
- How often do you take this medication?
- Do your parents have any health problems? How old are they.
- Do you have any brothers or sisters? How old are they? Do they have any health problems?
- Is there a history of (high blood pressure, cancer, asthma, diabetes …etc.) in your family?
- Are you taking any prescription medications?
- Do you use any alternative treatments or remedies for any health problems?
- Are you taking any over-the-counter (OTC) medicines?
- Do you smoke?
- How much do you smoke?
- How old were you when you started smoking?
- Do you drink alcohol?
- About how many drinks do you consume per week?
- Do you have any allergies to food or medications?
- Is your cough worse in the morning, in the evening or at night?
- Do you have any difficulty breathing?

Medical Terminology Exercise 1: Matching Prefixes

Match prefixes in the left column with their meanings in the right column. (Answers may be used more than once.)

_____ 1. bi-

_____ 2. di-

_____ 3. hyper-

_____ 4. hypo-

_____ 5. macro-

_____ 6. micro-

_____ 7. mono-

_____ 8. multi-

_____ 9. nulli-

_____ 10. poly-

_____ 11. primi-

_____ 12. quadri-

_____ 13. tetra-

_____ 14. tri-

_____ 15. uni-

A. above normal

B. below normal

C. first

D. four

E. half or partly

F. large

G. many

H. none

I. one

J. small

K. three

L. two

Medical Terminology Exercise 2:
Diagnostic Procedures and Therapeutic Intervention

1. The term for an illuminated instrument, generally introduced through a natural opening is:
    A. Endoscope
    B. Endoscopy
    C. Fluoroscope
    D. Fluoroscopy
2. A term for a hollow, flexible tube that can be inserted into a body cavity to withdraw or instill fluids is:
    A. Catheter
    B. Endoscope
    C. Stethoscope
    D. Tomogram
3. Using heat to relieve pain or to speed healing is called:
    A. Cryotherapy
    B. Pharmacotherapy
    C. Radiation therapy
    D. Thermotherapy
4. The term that means *the introduction of a catheter* is:
    A. Catheter
    B. Catheterization
    C. Catheterize
    D. Fluoroscopy

5. The procedure in which the image is digitized and immediately displayed on a monitor or recorded on film is:

    A. Auscultation

    B. Computed radiography

    C. Endoscopy

    D. Thermometry

6. A general term for a procedure that requires entry of a body cavity or interruption of normal body function is:

    A. Acute

    B. Benign

    C. Inspection

    D. Invasive

7. A Latin term that means a *hollow, flexible tube that is inserted into vessels or cavities* is:

    A. Analgesia

    B. Cannula

    C. Pulse

    D. Tympanic

8. Identification of a disease or condition by a scientific evaluation is:

    A. Diagnosis

    B. Physical examination

    C. Prognosis

    D. Vital signs

9. The rhythmic expansion of an artery that occurs as the heart beats is the:

    A. Blood pressure

    B. Diastolic pressure

    C. Prognosis

    D. Pulse

10. The term for tapping the body with the fingertips or fist to evaluate internal organs or to evaluate fluid in a body cavity is:

    A. Auscultation

    B. Inspection

    C. Palpation

    D. Percussion

Medical Terminology Exercise 3: Matching Anatomical Terms

Match words in the left column with their meanings in the right column.

1. _____ transverse
2. _____ sagittal
3. _____ coronal
4. _____ thoracic
5. _____ dorsal
6. _____ ventral
7. _____ lateral
8. _____ RUQ
9. _____ LLQ

A. A lower anatomical division of the abdomen

B. An upper anatomical division of the abdomen

C. Body cavity containing the spinal and cranial cavities

D. Body cavity containing the thoracic and abdominopelvic cavities

E. Body cavity housing just the chest

F. Plane that divides the body into front and back

G. Plane that divides the body into right and left halves

H. Plane that divides the body into top and bottom portions

I. Toward the side

Medical Terminology Exercise 4: Matching Common Names of Bones

Match the scientific name of the bone in English in the left column with its common name in Spanish in the right column.
Different hip bones will have the same common name.

_____ 1. carpal
_____ 2. clavicle
_____ 3. cranium
_____ 4. femur
_____ 5. ilium
_____ 6. ischium
_____ 7. patella
_____ 8. phalanges
_____ 9. pubis
_____ 10. scapula
_____ 11. sternum
_____ 12. tarsus

A. hueso del tobillo
B. huesos de los dedos
C. hueso del pecho
D. hueso que une el pecho con el hombro
E. hueso pélvico
F. hueso de la rodilla
G. omóplato
H. cráneo
I. hueso del muslo
J. hueso de la muñeca

Medical Terminology Exercise 5: Matching general medical terms

Match the term in English in the left column with its translation in Spanish in the right column.

Column I	Column II
____ 1. Fibula	A. Axila
____ 2. Cough	B. Estornudo
____ 3. Tinnitus	C. Sopor
____ 4. Chicken pox	D. Acidez
____ 5. Calf	E. Tos
____ 6. Tweezers	F. Cálculo biliar
____ 7. Underarm	G. Peroné
____ 8. Wart	H. Ceja
____ 9. Eyelid	I. Pinzas
____ 10. Gallstone	J. Pantorrilla
____ 11. Intoxicated	K. Verruga
____ 12. Heartburn	L. Varicela
____ 13. Drowsiness	M. Talón
	N. Zumbido de oídos
	O. Ebrio
	P. Párpado

Exercise 5: Scenarios

Scenario 1

A: Now, let's try an ankle stretch exercise. Sit with your leg out straight. Then, loop this towel around the ball of your foot and pull back.

B: Mmm siento que se estira, pero también me duele. Ouch! Ouch! ¿Cuánto tiempo tengo que tenerlo estirado, doctor? No creo que aguante mucho.

A: You need to pull to feel a stretch, but not pain. Release the pressure. You need to hold a stretch twenty to twenty-five seconds.

B: Si me pongo la toalla un poquito más hacia los dedos, ya no me duele. ¿Está buen puesta así, doctor?

Scenario 2

A: You are due in only three weeks. The ultrasound shows that your baby is healthy and is already in head-first position. So, most probably, you will have a vaginal delivery as planned.

B: Ahora solo me preocupa este sarpullido. Empieza en el vientre, y esa me corre hasta las piernas, y las pompas. Me da muchísima comezón.

A: This rash will not harm you or your baby. It will disappear after you have your baby. However, to soothe the itch, I will prescribe an antihistamine. Take Chlor-Trimeton, 4 milligrams, one tablet every 4 hours.

B: Gracias, doctor. ¿Hay alguna crema que me ayude a calmar la hinchazón, y lo rojo de la piel?