

Caduceus

A PUBLICATION OF THE MEDICAL DIVISION OF THE AMERICAN TRANSLATORS ASSOCIATION

SUMMER 2011

ata

CONTENT: Part Two

7

Interpreting Bad News: What Interpreters Might Learn from Medical Training and Research

13

Ann's Acronyms

15

Division Counts



This article was originally published by *The ATA Chronicle* in August 2009.

by **Laura Espondaburu**

If you feel uncomfortable interpreting bad news for a patient, you are not alone. Doctors, medical students, and other health professionals agree that delivering bad news is one of the hardest tasks of the profession. Bad news can take many forms and is not limited to emergency room visits. Interpreters can be called upon to deliver bad news at an oncology clinic, at a patient's bedside, or during a genetic counseling interview, a fetal ultrasound, or even an eye exam.

As varied as the settings are for such news, there are just as many definitions of what constitutes "bad news." For example, writing for *American Family Physician*, Gregg Vandekieft calls bad news "any news that drastically and negatively alters the patient's view of his or her future."¹ Another article in *Western Journal of Medicine* states that "bad news results in a cognitive, behavioral, or emotional deficit in the person receiving the news that persists for some time after the news is received."² Although these definitions vary according to individual perception, the self-evident commonality among them is the fact is that you, as the interpreter, are going to be dealing with a highly emotionally charged situation. You need to be prepared for what will be encountered during these sessions so that you can adjust your delivery according to the situation.

Although there are no significant data available on the specific impact of these sessions on interpreters, a qualitative study among 43 professional medical interpreters identified some of the challenges for the interpreter, including:

- Dealing with tension associated with being torn between providing a strict interpretation and acting as an advocate or cultural broker.
- Overcoming personal difficulty interpreting bad news.
- Feeling abandoned or abused by clinicians.
- Experiencing difficulty striking a balance between focusing on the patient and focusing on the family.³

The purpose of this article is to review the literature on communication techniques practiced by doctors when

delivering bad news, particularly the Project to Educate Physicians on End-of-Life Care (EPEC) guidelines, to see what interpreters might learn from these techniques. This literature seems to be a good starting point for a conversation among interpreters on best practices to interpret the delivery of bad news, and on how to train to do the best job possible under difficult circumstances.

We will focus on EPEC because it is the most widely used model to educate doctors on how to deliver bad news to patients.⁴ This model has six steps based on the SPIKES protocol (Setting, Perception, Invitation, Knowledge, Emotions, and Strategy and Summary) developed by a group of oncologists from Canada and the U.S.⁵

Step 1: Setting Up the Interview

During this stage, the doctor should plan what will be discussed with the patient during the interview, review the medical facts of the case, and make sure all of the necessary information is available. If they have limited experience with this type of interview, doctors are encouraged to rehearse what they will say.

Doctors should also consider practical details, such as having a box of tissues available, preventing interruptions (holding calls and turning off pagers), and allotting adequate time. They should verify who needs to be present (e.g., other staff, family members, or people who are part of the patient's support network). If it is a pediatric case, the doctor should talk with the parents first. If the patient or any of the family members do not speak the same language as the clinician, a trained medical interpreter should be scheduled to come in and assist. In these cases, EPEC-trained doctors may choose a triangular seating arrangement where both patient and interpreter are within view. It is up to them to create the right environment.

Although the EPEC recommendation includes briefing the interpreter, interpreters often arrive at a consult or patient's bedside without prior knowledge of the situation they are entering. Despite this, there are some basic steps you can take to remain in control of the situation and establish a professional protocol:

- Whenever possible, ask the doctor to give you a few minutes before meeting the patient to tell you the words he or she will use to start the conversation, as



well as the medical terms related to diagnosis and treatment. Write these down.

- If you are unfamiliar with a term, ask the doctor to explain, or to consider using a different approach to delivery so you can interpret adequately. Be frank about your level of comfort with either the medical information or the process of giving bad news. This will help the doctor decide the best way to approach the conversation.
- Explain the importance of avoiding medical jargon, euphemisms, and idioms.
- Remind providers to speak in short segments and to pause.
- Since these meetings might involve doctors, nurses, social workers, chaplains, hospice personnel, etc., it would be a good idea to write the names and titles of the individuals involved in advance. If not, write their names as they introduce themselves. These names will be very important for the patient and for family members in the days to follow.

Step 2: Patient's Perception

During this portion of the interview the doctor will try to determine if the patient and his or her family know enough about the patient's health to comprehend the bad news they will hear. Although these questions might seem to "beat around the bush," the patient's answers will determine how much information the doctor provides initially. As the interpreter, it is important that you not only interpret the questions accurately, but also make a special effort to render the register adequately to help the doctor get a feel for how much detail is appropriate. Typical questions asked by the doctor include:

- "What do you understand about your illness?"
- "How would you describe your medical situation?"
- "Have you been worried about your illness or symptoms?"
- "What did other doctors tell you about your condition or any procedures that you have had?"
- "When you first had symptom X, what did you think it might be?"
- "What did Doctor X tell you when he sent you here?"
- "Did you think something serious was going on when...?"

A critical piece of information for the doctor is whether the patient is in denial of his or her illness, or perhaps has

unrealistic expectations regarding treatment. Thus, it is also important for you to "listen" for any signs of wishful thinking on the patient's part, and to render these statements faith-fully (e.g., "I'll be better in a few days."). Also keep in mind that silence might be a normal response when a patient anticipates bad news.

Step 3: Obtaining the Patient's Invitation

The amount of information a patient wants to hear will vary greatly depending on such factors as personality, socioeconomic status, previous experiences with the health care system, and ethnicity. The role of the doctor at this point of the conversation is to assess how much the patient and family want to know. Some possible questions you might hear include:

- "If this condition turns out to be something serious, do you want to know?"
- "Would you like me to tell you the full details of your condition? If not, is there somebody else you would like me to talk to?"
- "Some people really do not want to be told what is wrong, but want their families to know. What do you prefer?"
- "Do you want me to explain exactly what I think is going wrong?"
- "To whom should I talk to about these issues?"



In addition to preparing accurate equivalents of these questions in the target language, you might find it helpful at this point in the interview to prepare for the possibility of conflict. Research indicates that the amount of information desired varies greatly among individuals, even within a small group.⁶ As such, it is important for the integrity of the communication that you *look* neutral if there are different opinions within the family group. Remember that *being* neutral is not enough—you also have to look it!

Step 4: Giving Knowledge and Information to the Patient

Doctors are trained to convey information to patients in a straight-forward and compassionate manner. As

previously mentioned, they also need to avoid monologues, jargon, and euphemisms. Doctors are taught to stop frequently, to check for understanding, and to use silence and body language as tools to facilitate the discussion. Special care must be taken to ensure that the message is not softened with vagueness. Here are some phrases a doctor might use:

- “I feel badly to have to tell you this, but the growth turned out to be cancer.”
- “I’m afraid the news is not good. The biopsy showed that you have uterine cancer.”
- “Unfortunately there is no question about the test results: it’s cancer.”
- “The report of the amniocentesis is back, and it’s not what I had hoped. It showed that the baby has Down syndrome.”
- “I’m afraid I have bad news. The bone marrow biopsy shows your daughter has leukemia.”

Note that the phrase “I’m sorry” may be misconstrued by the patient or family to imply that the physician is responsible for the situation. It may also be misunderstood as pity. If you use this phrase when interpreting, adjust the wording to convey empathy (e.g., “I’m sorry to have to tell you this...”).

The phrases above might be some of the most difficult a person hears regarding the state of his or her health or the health of a loved one. It is your job as the interpreter to make sure that you have understood the doctor. If the words used are unfamiliar to you or have more than one meaning, ask for clarification. To the extent possible, mimic the speaker’s body language and tone. Wait a few extra seconds before jumping in to interpret. Do not rush your words.

As a way to start building skills in this area, translate the bulleted phrases in this section into your target language and practice saying them aloud. Consult books, native speakers, or any other resources you have access to until you know you have a clear yet compassionate vocabulary. Are these words simple? Are the expressions easy to understand, unambiguous, and devoid of jargon and euphemisms? How do you say “I’m sorry” in your target language? Can you say it with compassion without implying fault? Record yourself and listen. Write down possible translations until you are satisfied with at least one or two expressions.

Step 5: Emotions and Responding to Feelings

The response to bad news varies from patient to patient and within the same family. Common emotions are anger, sadness, love, anxiety, and relief. Individuals might also experience denial, blame, guilt, disbelief, fear, or a sense of loss. They might also feel the need to intellectualize reasons for the situation (“This happened because...”). Some people may try to leave the room or withdraw into themselves.

What happens when the patient is a child? This is a situation where it might be particularly difficult for the doctor to explain a diagnosis. These are some of the comments a doctor might make:

- “I imagine this is difficult news...”
- “You appear to be angry. Can you tell me what you are feeling?”
- “Does this news frighten you?”
- “Tell me more about how you are feeling about what I just said.”
- “What worries you most?”
- “I wish the news were different.”
- “I’ll try to help you.”
- “Is there anyone you would like for me to call?”
- “I’ll help you tell your son.”
- “Your Mom and Dad are sad now. They’ll feel better when you feel better.”

The doctor should allow time for the patient to express his or her immediate feelings, without rushing the patient or the family. The doctor may also remind families that their reactions are normal, may offer water or some other refreshment, or touch the patient’s shoulder or offer other reassurances. Be aware of intended silences designed to give the patient and family members time to process information. If being in a room full of silent people makes you uncomfortable, practice techniques to look relaxed and calm. Your demeanor should show respect and compassion. Restlessness may convey a sense of rush.

Avoid passing judgment on the patient’s or the family’s reaction, as this will interfere with your interpreting and will not add value to the communication. It is particularly important for interpreters to understand that each patient or family is unique and cannot be viewed as faithful representatives of an immutable culture.⁷ As the

National Code of Ethics for Interpreters in Health Care explains: "Knowledge about a particular cultural norm does not translate directly into knowledge about a particular person or family system. Whether or not a particular individual or family system adheres to certain norms is something that needs to be confirmed."⁸ Share any cultural information that you think might be relevant to help the doctor understand a particular reaction, and remind him or her that the most important thing is to ask the patient and his or her family how they are feeling.

Step 6: Strategy and Summary

The most significant goal of this step is to reassure the patient and family of the continuation of care. A study published in *Journal of Palliative Medicine* indicated that more than one meeting might provide better long-term results in the care of the terminally ill patient.⁹ Research data also suggest that providing an audiotape of the interview might be very useful to the patient, as well as giving written information or directing the patient to reliable online resources.¹⁰

The importance of communicating information about a prognosis also varies for different patients. Before talking about a prognosis with a patient, a medical provider will ask some of these questions:

- "What are you expecting to happen?"
- "How specific do you want me to be?"
- "What experiences have you had with others with a similar illness?"
- "What experiences have you had with others who have died?"
- "What do you hope/dream will happen?"
- "What is your nightmare about what will happen?"

Some possible responses to a patient's questions might include:

- "You have hours to days."
- "You have days to weeks."
- "You have weeks to months."
- "You have months to years."

A doctor might also be less specific:

- "One-third of people will do well a year from now and half will live about six months. Exactly what will happen for you, I don't know"
- "We need to hope for the best while we plan for the worst."

LINKS

**American Psychological Association
Managing Traumatic Stress: Tips for
Recovering from Disasters and Other
Traumatic Events**

[http://apahelpcenter.org/articles/
article.php?id=22](http://apahelpcenter.org/articles/article.php?id=22)

End of Life Care Research Program

[http://depts.washington.edu/eolcare/
publications/index.html](http://depts.washington.edu/eolcare/publications/index.html)

**National Mental Health Information
Center**

[http://mentalhealth.samhsa.gov/cmhs/
EmergencyServices](http://mentalhealth.samhsa.gov/cmhs/EmergencyServices)

**Project to Educate Physicians on End-
of-Life Care (EPEC) guidelines**

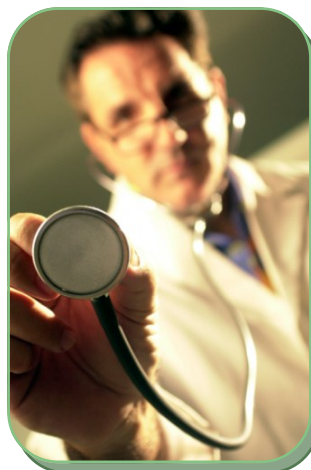
www.epec.net/EPEC/webpages/index.cfm

Role Exchange in Medical Interpretation

www.springerlink.com/content/14726v7187u00537

Western Journal of Medicine Archives (1974-2002)

www.pubmedcentral.nih.gov/tocrender.fcgi?journal=183&action=archive



Again, as the interpreter, it is important to convey these messages accurately. To be successful, it helps to research equivalent phrases in the target language long before you are called upon to use them. Just as doctors are prone to euphemism and vague responses, your own attempt to soften the bluntness of the message may lead you to less specific expressions. You might also be tempted to distance yourself from the emotions by interpreting literally. To avoid this scenario, you would do well to study the following types of statements doctors can use to express compassion or to further gauge a patient's emotional state and level of comprehension.¹¹

Empathic Statements (used while the patient and relatives regain composure, or to acknowledge the clinician's own sadness):

- "I also wish the news were better."
- "I can see how upsetting this is to you."
- "I can tell you weren't expecting to hear this."
- "I know this is not good news for you."
- "I am sorry to have to tell you this."
- "This is very difficult for me also."
- "I was hoping for a better result."

Exploratory Questions (when the emotions are not clearly expressed):

- “How do you mean.”
- “Tell me more about it.”
- “Could you explain what you mean?”
- “You said it frightened you?”
- “Could you tell me what you’re worried about?”
- You said you were concerned about your children. Tell me more.”

Validating Responses (lets the patient know that their feelings are legitimate):

- “I can understand why you felt that way.”
- “I guess anyone might have the same reaction.”
- “You were perfectly correct to think that way.”
- “Yes, your understanding of the reason for the tests is very good.”
- “It appears that you thought things through very well.”
- “Many other patients have had a similar experience.”

Epilogue

Having confidence in your ability to interpret bad news will help lower your anxiety level when working in a clinical environment. There are many ways to prepare for this type of situation. Start practicing now by translating the statements and questions included in this article into your target language. Once you have them written down, practice saying them aloud. Make an audio file of your rendition so you can play it back and evaluate tone and content. Continue to practice to acquire and preserve your skills. It would also be a good idea to consult books or articles in medical magazines written on grief and loss within your target language. The Internet also offers new possibilities for obtaining materials. Just be sure to use good judgment to determine if what you are reading is one person’s opinion or a well-researched study. Talk to as many members of your target language community as possible and ask them how they feel about this topic. Pay attention to the language they use and the expectations they have from providers. Ask them what words they feel are caring or uncaring, cold, or disrespectful.

One possible source for additional information is a study that was conducted to identify “caring behaviors” in doctors.¹² Within the communication area, the researchers

identified six practices that I find quite useful for interpreters:

- Listen, ask questions, and look for clues using your intuition.
- Inform as needed.
- Choose words carefully and check for meaning.
- Be direct and straightforward, but not abrupt.
- Be consistent in your verbal and nonverbal communication.
- Use a soft but confident tone.
- Let your pace be dictated by the patient.
- Maintain a comfortable appearance.

Although we, as interpreters, do not have control over the amount of listening a physician does or how much information is provided, we are responsible for choosing our words very carefully and checking for understanding. The importance of our tone of voice, our pace, and our non-verbal communication should not be overlooked. Imagine yourself as an actor dubbing dialogue in a movie:

how you say things is just as important as what you say. Your position, your tone, and your body language are your means to create a compassionate environment. If you know beforehand that you will be interpreting in this type of situation, allow plenty of time for the session. Make sure to avoid all interruptions, as nothing is more important than communicating with the patient.

Finally, there is a very important aspect of delivering bad news that I will not explore in this article, but I encourage interpreters to take into account. Keep in mind that delivering bad news can be traumatic for the interpreter. If you are part of a large organization, seek the support of employee programs through human resources. Large health institutions hold meetings you can attend or have counselors available to help you process what is known as secondary/vicarious trauma. If you are an independent contractor, you may need to read up on the topic and follow the advice of experts to stay emotionally healthy and to prevent what institutes like the American Academy of Family Physicians call compassion fatigue.¹³

By better understanding the dynamics of these types of sessions and learning more about delivering bad news, you, as an interpreter, can contribute to making the experience a little easier for the patients you serve.

Notes

1. Vandekieft, Gregg K. "Breaking Bad News." *American Family Physician* (December 2001), 1975- 1978. (www.aafp.org/afp/20011215/1975.html)
 2. Back, Anthony L., and Curtis J. Randall. "Communicating Bad News." *Western Journal of Medicine* (May 2002), 177-180. (www.pubmedcentral.nih.gov/article-render.fcgi?artid=1071708)
 3. Norris, W. M.; M. D. Wenrich; E. L. Nielsen; P. D. Treece; J. C. Jackson; and J. R. Curtis. "Communication about End-of-Life Care Between Language-discordant Patients and Clinicians: Insights from Medical Interpreters." *Journal of Palliative Medicine* (October 2005), 1016- 1024.
 4. Emanuel, L.; F. D. Ferris; and C. F. von Günter. "Communicating Bad News." In *EPEC Participant's Handbook* (EPEC Project, Robert Wood Johnson Foundation, 1999).
 5. Baile, W. F.; R. Buckman; R. Lenzi; G. Glober; E. A. Beale; and A. P. Kudelka. "A Six-step Protocol for Delivering Bad News: Application to the Patient with Cancer." *The Oncologist* (Volume 5, 2000), 302-311
 6. Eggly, Susan; Louis Penner; Terrance Albrecht; Rebecca Cline; Tanina Foster, Michael Naughton; Amy Peterson; and John Ruckdeschel. "Discussing Bad News in the Outpatient Oncology Clinic: Rethinking Current Communication Guidelines," *Journal of Clinical Oncology* (February 2006), 712-719.
- Also see: <http://annonc.oxfordjournals.org> and www.aafp.org/afp/20080115/167.html
7. Koenig, Barbara A. "Cultural Diversity in Decision-making about Care at the End of Life." In *Approaching Death: Improving Care at the End of Life*, ed., Institute of Medicine (Washington, DC: National Academies Press, 1997).
 8. A National Code of Ethics for Interpreters in Health Care (July 2004), 11 and 23. (www.ncihc.org)
 9. Bruera, E; J. L. Palmer; E. Pace; K. Zhang; J. Willey; F. Strasser; and M. I. Bennett. "A Randomized, Controlled Trial of Physician Postures When Breaking Bad News to Cancer Patients." *Journal of Palliative Medicine* (September 2007), 501-505.
 10. Bruera, E; E. Pituskin; K. Calder; C. M. Neumann; and J. Hanson. "The Addition of an Audiotape Recording of a Consultation to Written Recommendations for Patients with Advanced Cancer: A Randomized, Controlled Trial." *Cancer* (December 1999), 2420- 2425.
 11. Baile, W.F., et al.
 12. Quirk, M.; K. Mazar; H.L. Haley; M. Philbin; M. Fischer; K. Sullivan; and D. Hatem. "How Patients Perceive A Doctor's Caring Attitude" (Patient Education Counsel, September 2008), 359-366.
 13. Pfifferling, John-Henry, and Kay Gilley. "Overcoming Compassion Fatigue: When Practicing Medicine Feels More Like Labor Than a Labor of Love, Take Steps to Heal the Healer." *Family Practice Management* (American Academy of Family Physicians, April 2000), 39. (www.aafp.org/fpm/20000400/39over.html)



Laura Espondaburu is a medical interpreter and an ATA-certified English to Spanish translator. Contact: lauraespondaburu@msn.com.



... and other French-English medical conundrums

by Ann Wiles

with thanks to Joanne Archambault

This issue: TVC

The translation of acronyms and abbreviations is a familiar minefield and a big headache for medical translators. In this and future articles, I hope to help diffuse both the minefields and the headaches for French to English medical translators. For information on my background, please visit www.awiles.net.

TVC in French

Based on translations by other translators and advice on translator forums, the obvious translation of the French medical acronym TVC seems to be CVP in English. While this is sometimes the appropriate translation, it is often inappropriate. TVC can stand for either "tension veineuse centrale" or "turgescence des veines du cou" in French. How do you know which to use?

JVD in English

Let's start with TVC translated as JVD. According to the Djordjević dictionary, "turgescence des veines du cou" translates as "venous engorgement in the neck" with "turgescence" defined as "distention" in the same dictionary entry. The acronym in French would be TVC even though the dictionary entry for TVC as an acronym does not list "turgescence des veines du cou" as the definition in French or JVD in English. According to Dr. Jennifer Nastelin, the English medical term is "jugular venous distention" or "JVD." In my experience, documentation of JVD as the translation for TVC is next to impossible to find, but the translation is very clear when context and usage are considered. I have seen it consistently in thousands of medical records over several decades.

The "JVD" comes near the beginning of the physical exam under the head and neck exam. Assessment of

JVD is a standard part of essentially every complete physical exam. There is no number associated with it, just "no JVD" or "JVD present" in English and "TVC normal" or "TVC +" in French, for example. JVD may be checked on a daily basis as part of patient follow-up. It depends on the patient population, but most patients have no JVD. In records I've translated, patients who have jugular venous distention have acute pulmonary edema, severe CAD, or decompensated CHF. According to *The Merck Manual*, jugular venous distention is associated with "heart failure, volume overload, constrictive pericarditis, tricuspid stenosis, superior vena cava obstruction, or reduced compliance of the RV" (right ventricle). As Dr. Nastelin says, these patients "are really in trouble."

CVP in English

Now let's consider TVC translated as CVP. According to the Djordjević dictionary, TVC translates as CVP, and the French "tension veineuse centrale" translates to "central venous pressure." That's fine in the proper context. According to Dorland, CVP is "the venous pressure as measured at the right atrium, obtained by means of a central venous catheter whose distal end is attached to a manometer." CVP is measured during shock, for example, to help determine fluid volume status and monitor fluid replacement.

CVP is a monitored parameter, and it requires insertion of a central venous line. An x-ray is taken after catheter insertion to verify that the tip of the CVP catheter is in the superior vena cava. CVP is a quantitative measurement of pressure in critically ill patients in Intensive Care or in the Emergency Room. It is part of objective signs such as blood pressure, wedge pressure, PAP, and blood gases. CVP is checked on a regular and frequent basis until



the CVP catheter is removed. I have translated medical records in which the CVP was monitored postoperatively or was measured during echocardiography.

JVD or CVP? Some clues

- Assessment of JVD is part of virtually every complete physical exam.
- Assessment of JVD is not a quantitative measurement.
- "JVD" occurs near the beginning of the medical record and near the beginning of the initial physical exam.
- The physician usually writes "no JVD" in English if none is present.
- CVP is measured on critically ill patients after insertion of a central venous line.
- It is measured frequently and is quantitative.
- "CVP" will occur many times in a medical record starting with insertion of the central line and ending when the line is removed.
- The patient is usually in Intensive Care or in the Emergency Room in serious condition.

When translating TVC from French to English in a

medical context, it is important to distinguish between CVP and JVD, since the two terms refer to very different concepts. JVD applies to almost every patient, while CVP is used only in specific situations. JVD is commonly used once or a few times within a medical record, whereas CVP is used frequently.

¹ French-English *Dictionary of Medicine*, Svetolik P. Djordjević, Schreiber Publishing, 2004

² An internist specializing in cardiology on the staff of the University of Michigan Health System, Ann Arbor Michigan

³ *The Merck Manual*, Merck Research Laboratories, 2006

⁴ *Dorland's Illustrated Medical Dictionary*, Elsevier, 2003



Ann Wiles is an ATA-certified French-English translator specializing in medical, pharmaceutical, and business. She has 10 years of translation experience, over 20 years of healthcare experience, and holds a bachelor's degree in nursing and an MBA. Ann can be contacted at ann@awiles.net.



DIVISION		
Code	Name	Total
CLD	Chinese Language Division	753
FLD	French Language Division	1,943
GLD	German Language Division	1,486
ID	Interpreters Division	3,740
ILD	Italian Language Division	930
JLD	Japanese Language Division	867
KLD	Korean Language Division	360
LD	Literary Division	2,189
LTD	Language Technology Division	2,466
MD	Medical Division	3,270
ND	Nordic Division	433
PLD	Portuguese Language Division	1,088
S&TD	Science and Technology Division	1,189
SLD	Slavic Languages Division	1,076
SPD	Spanish Language Division	4,272
TCD	Translation Company Division	2,940
GRAND TOTAL		29,002

As of June, 2011

