Caduceus

A PUBLICATION OF THE MEDICAL DIVISION OF THE AMERICAN TRANSLATORS ASSOCIATION

FALL / WINTER 2010

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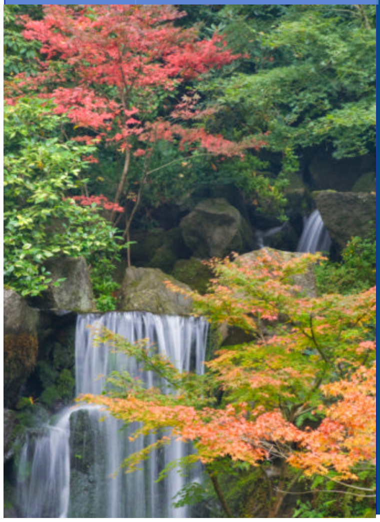
MEDICAL DIVISION

CONTENT: Part One

ANNUAL CONFERENCE ISSUE



Fall / Winter 2010

Caduceus is a quarterly publication of the Medical Division of the American Translators Association, a non-profit organization dedicated to promoting the recognition of translating and interpreting as professions.

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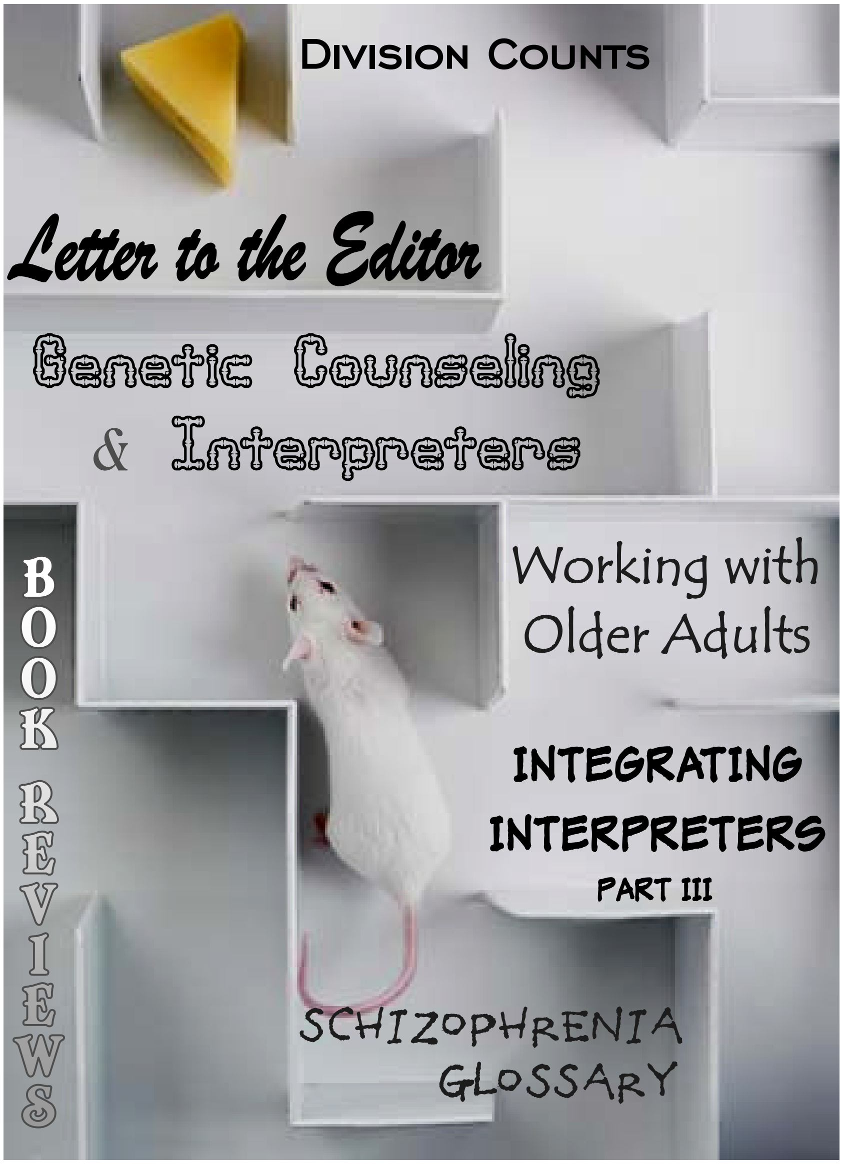


Instructions to Authors

Submissions for publications must be sent electronically in Word format. The deadline for submissions for the Spring/Summer issue of ***Caduceus*** is 1 March, 2011.

by Patricia Thickstun

DENVER WELCOMES YOU

The annual conference in Denver provides several networking opportunities for the Medical Division. On Wednesday evening immediately after the welcome reception, plan to attend the Division Open House, where you will meet members of the Medical Division as well as the other 15 Divisions.

The 2010 ATA Conference Denver has many sessions of interest to Medical Division members. While you're perusing the preliminary conference program, look for the pre-conference seminars and conference sessions on pages 3 and 4.

Friday is a busy day for the Medical Division. In the morning, join Division Members at the Medical Division Networking Breakfast (at no additional cost). In the afternoon, attend the Annual Division Meeting where we will have our annual business meeting, hold a panel discussion on mentoring, and develop a wish list of topics for future newsletter articles and next year's ATA Conference.

For updates on seminars, conference session, and networking activities, check the MD Listserv as well as the ATA conference website at http://www.atanet.org/conf/2010/byspecial.php

See you in Denver!

by Patricia Thickstun

SESSION	DESCRIPTION	SPEAKER
October 27, Wednesday (Pre-Conference)		
SEMINAR G: *Biomedical Translations*	Characteristics of biomedical language and common pitfalls in English>Spanish biomedical translation as well as useful resources.	Damián Vázquez, MD (Spanish)
SEMINAR H: *Introduction to Medical Terminology*	With language specific breakfast sessions in: German . . . . French . . . . Portuguese . . . . Spanish	 Maria Rosdolsky Patricia Thickstun Zanita-Araugjo-Lane Armando Ezquerra Hasbun
October 28, Thursday		
Where Right Brian Meets Left: *Translating for Medical and Pharmaceutical Marketing and Promotion*	Make translations more engaging and work within a brand framework	Erin M. Lyons (English)
Bioethical Issues in Translation: Informed Consent	Identify informed consent ethical issues and describe best practices for informed consent translation	Eric S. Bullington (English)
October 29, Friday		
Interpreter Quality Assurance and Professional Development Through Mentorship	Implement Interpreter QA through professional development opportunities and a mentorship program	Jucelei Pereira (English)
Heard It Through the Medical Grapevine	Find reliable health information and determine the validity and reliability of online resources	Rebecca Brown (English)
Medical Division Annual Meeting	Meet, network, and provide input and feedback for the newsletter as well as for the next annual conference. Listen to panelists share their experiences with mentoring	Suzanne Couture and Patricia Thickstun (English)

by Patricia Thickstun

OCTOBER 30, SATURDAY		
SESSION	**DESCRIPTION**	**SPEAKER**
Don't Miss the Bus! Best Practices for Medical Interpreters Working is School Settings	Identify best practices and terminology for medical encounters in the school environment	Fabio Torres (English)
Medical Terminology Challenges in the Southwest	Develop medical terminology associated with conditions, symptoms, and medications for linguists supplying Spanish translation and interpreting services to clients in the Southwestern US	Patrick J. O'Connor and Marcia Resler (English and Spanish)
The Ins and Outs of Managing Hospital Interpreters	Identify hospital interpreter staff management challenges and opportunities, review LEP patient services, professionalization of staff interpreters, in-house training, and requirements for new interpreters.	Elena Langdon (English)
When Your Limited English Proficient is an Older Adult	Improve skills for medical interpreting services to elders. Mr. Lenarduzzi has authored an insightful article that provides strategies for serving this population for this issue of ***Caduceus***	Ariel Lenarduzzi (English)
Language Services Management: The Next Piece of the Puzzle	Learn the fundamentals of healthcare interpreter management, including the interview process and training development.	Rashell LeCaptain (English)
Stress Busters for Interpreters	Learn and practice techniques to change your stress responses before they become a problem and can be empowered to care for yourself.	Julie P. Burns (English)

by Suzanne Couture

As temperatures get cooler, our thoughts turn to the many fall activities that lay ahead, including the ATA Annual Conference in Denver this October. We hope to meet many of you there!

To start us off, Administrator Patricia Thickstun highlights the Medical Division sessions offered at this year's conference. Next, we include articles from new contributors Lindsay Langford, who explains the role of genetic counselors and how it applies to interpreters, and Ariel Lenarduzzi, who discusses strategies for interpreters and providers working with older adults who have limited English proficiency. To round out this issue, Monica Guelman and Steven Becerra complete their three-part series on medical interpreting, with attention to cultural competency and integrating medical interpreters into the healthcare team.

This edition also includes two book reviews: the first regarding Marguerite Sechehaye's *Autobiography of a Schizophrenic Girl* submitted by Maria Rosdolsky, and the second a review of Beverley Henderson and Jennifer Lee Dorsey's *Medical Terminology for Dummies* submitted by Carmen Cross. Maria Rosdolsky also shares a glossary of schizophrenia terminology in English and German. Lastly, we end this issue with feedback from Leon McMorrow on Maria Rosdolsky's article "Back Translation of Medical Documents", which appeared in the Spring/Summer 2010 newsletter.

As always, your feedback and submissions are greatly appreciated. Please send your articles, comments or suggestions to caduceusnewsletter@gmail.com.

* * *

Suzanne Couture is a medical interpreter and ATA-certified Spanish>English translator based in Milwaukee, WI. She currently teaches medical translation as part of New York University's Certificate in Translation program. Suzanne is also an avid gardener and novice equestrian.

Caduceus
A PUBLICATION OF THE MEDICAL DIVISION OF ATA

GENETIC COUNSELORS AND INTERPRETERS |

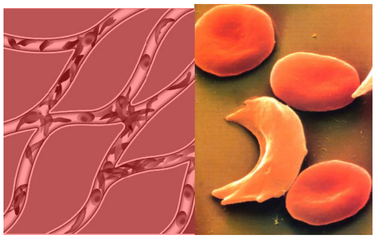
by Lindsay Langford

The rapidly expanding field of genetics has dramatically changed the way we think about health and medicine. Researchers have discovered the specific **genes** associated with thousands of genetic conditions, and more and more each day, we are learning how genes and environmental factors work together to cause common complex or **multifactorial diseases**, such as diabetes, asthma, heart disease, mental illnesses, and some cancers. Although there is still much to learn, the mapping of the whole human genome (the complete set of DNA in humans) has helped us explore our diversity and has helped us understand how changes in our DNA can affect our development and well being.

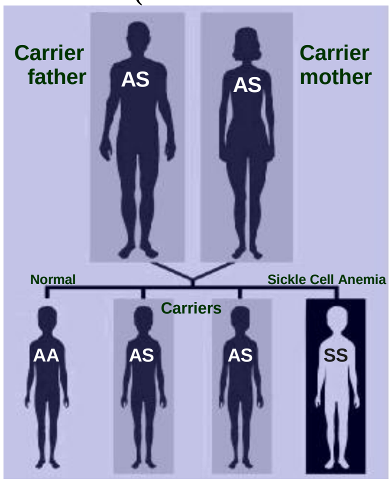
As our understanding of genetics has grown, so has the need for genetic experts such as **geneticists** and **genetic counselors**. These professionals are trained to recognize genetic conditions and help those who are impacted by genetic disease. Clinical geneticists are medical doctors who specialize in genetics, while genetic counselors are professionals (sometimes nurses) with Master's degrees in Genetic Counseling, including training in both medical genetics and counseling. Genetic counselors play an important role in reviewing family medical histories (**pedigrees**) and identifying at-risk individuals, providing genetic education, offering appropriate genetic tests, facilitating informed decision-making, and helping patients adapt to a diagnosis of a genetic condition.

Genetic counselors can work in a variety of settings, including hospitals, genetic centers, private offices, and laboratories, and clinical genetic counselors can work with many different kinds of patients. They may see couples for preconception or prenatal counseling to determine the chances of genetic conditions or birth defects in the couples' future children. They may also work in a pediatric setting, seeing children with known or suspected genetic conditions. Finally, genetic counselors can work with adult patients and/or those with suspected or diagnosed hereditary cancer in their families. Some genetic counselors focus on just one main type of genetic counseling (preconception/prenatal, pediatric, or adult/cancer), while others see patients in a combination of these settings or even specialize in a specific type of genetic condition (i.e. muscular dystrophy). Genetic counseling sessions generally last about one hour, but they may be longer or shorter depending on the complexity of the case and the number of questions the patient has.

In the United States, Limited English Proficiency (LEP) individuals are at a particular disadvantage when it comes to access to health care, including genetic counseling. As in other health-oriented settings, interpreters facilitate communication in genetic counseling sessions between genetic counselors and LEP patients. To get a better idea of what an interpreter might expect in a genetic counseling session, let us review the following example of a prenatal case to discuss the chance that a patient's unborn baby could have sickle cell anemia (or **sickle cell disease**).



Sickle cell disease is a fairly serious blood disorder that affects hemoglobin, the part of the red blood cells that carries oxygen and iron. Those with sickle cell disease make a different kind of hemoglobin, and as a result, they can have anemia, frequent infections, and pain crises (episodes of intense pain). The condition occurs when a person has a ***mutation*** *(change) in the DNA of both copies of the genes that code for hemoglobin. In the context of sickle cell disease, mutations in* *hemoglobin genes are often referred to as hemoglobin "traits," with sickle cell trait being one type of hemoglobin trait. If a person only has one hemoglobin trait, they are said to be* ***carriers****. Carriers of sickle cell disease (those who have a trait) usually do not have any symptoms of the condition. However, if their partner also has a hemoglobin trait, each of their children has a 1/4 chance of* ***inheriting*** *the traits of both parents and being affected with sickle cell disease. Sickle cell disease commonly affects individuals of African ancestry, although it can occur in other populations in countries where Africans have immigrated (including parts of Central America and the Caribbean).*



Antonio and Linda A. have recently moved to the US from the Dominican Republic, and Linda is 14 weeks into her first pregnancy. The couple has been referred to genetic counseling by Linda's obstetrician because a blood test revealed that she is a carrier for sickle cell disease – she has sickle cell "trait." Linda's obstetrician sent the couple to a genetic counselor, Sarah, to discuss what it means to be a carrier of sickle cell disease, the testing options that can determine if Antonio may be a carrier, and the chances that the couple's baby may be affected with sickle cell disease.

Before the counseling session with Mr. and Mrs. A., Sarah meets with the interpreter, Jaime, to introduce the reason for the visit and to inform him of the main points she wants the couple to understand. She acknowledges that she will be using some advanced medical terminology and promises to explain the meanings of highly technical words. Jaime explains that he will interpret the utterances of both the couple and Sarah as accurately as possible, requesting clarification when needed. He reminds Sarah to address the clients directly, unless she is requesting clarification from him.

Jaime goes out to the waiting room to introduce himself to Mr. and Mrs. A. He informs them that he will interpret all that is spoken and reminds the couple to speak directly to Sarah. Sarah calls Mr. and Mrs. A. from the waiting room, and Jaime starts interpreting when she invites them to enter her office and be seated. Sarah then introduces herself and starts by asking what Mr. and Mrs. A. understand about the reason for their appointment. Linda reports that her obstetrician told her that she had sickle cell disease. Sarah explains that she has seen Linda's test result and understands that Linda was referred to genetic counseling because she has sickle cell trait, not sickle cell disease. Sarah reassures her that the result means she is a carrier and that one would not expect her to have any symptoms of sickle cell disease or for her health to be affected. Sarah says she will explain sickle cell trait and what it may mean for the couple's children. She also says she wants to inform the couple of the options for testing and to take a family history. Antonio questions the need for testing since he is healthy and no one on his side of the family has sickle cell disease. Sarah tells him that many people have sickle cell trait and never know it because they do not have any health problems, and people are only affected with sickle cell disease when both of their parents are carriers, each having one hemoglobin trait that was passed on to the child. After having his questions answered, Antonio says that he wants to learn more.

Sarah starts by drawing the pedigree (family tree), asking detailed questions about the health of Mr. and Mrs. A. and each side of the family, looking for clues that might indicate sickle cell disease or other genetic conditions occurring in the family. Antonio reveals that he has a cousin with a type of **congenital** defect (birth defect) called cleft lip, which he says was caused by an eclipse. Sarah says she does not understand what Antonio means, so Jaime clarifies that in some cultures, people believe that if a pregnant woman goes outside during an eclipse, her baby might have birth defects. Sarah says she will talk about the case of cleft lip in the family after she finishes the pedigree and explains about sickle cell disease. There are no other reports of individuals with other birth defects or symptoms of sickle cell disease on either side of the family. Sarah finishes the pedigree by asking questions about the pregnancy, making note of any complications, hospitalizations, or exposures to potentially harmful substances.

Sarah then explains sickle cell disease to the couple, reviewing the associated health problems and how the condition is inherited from both parents who have a hemoglobin trait. She uses diagrams to show Mr. and Mrs. A. all the possible combinations of hemoglobin traits for each pregnancy for couples in which both partners are carriers and when only one parent is a carrier. Next, Sarah explains Antonio's options for carrier testing for sickle cell disease. She shares that since Antonio's family is from the Dominican Republic, there is a 1/9 chance, based on his ancestry alone, for him to have sickle cell trait. If Antonio does carry sickle cell trait or another hemoglobin trait, there is a 1/4 chance the baby could have inherited both Linda's and Antonio's trait and would be affected with sickle cell disease. If Antonio does not have a hemoglobin trait, the baby would not be at risk to have sickle cell disease. Doing carrier testing for Antonio would reveal the baby's chances of having sickle cell disease. Sarah mentions that if Antonio also has sickle cell trait, Linda could have **amniocentesis** to collect amniotic fluid for testing the baby's DNA. Then, they could be certain about whether or not the baby would have sickle cell disease. Cells collected during amniocentesis can also be used to test for **chromosome** conditions like Down **syndrome**, associated with heart defects, intellectual disability, and characteristic facial features. Sarah adds that all babies born in the US are screened for sickle cell disease at birth as part of a newborn screening program.

Sarah asks Antonio and Linda if they have understood everything thus far, and Antonio answers that they have. Linda, however, is silent and is looking at the floor. Sarah wants to make sure she is involved in the session and that she knows her thoughts are important, so Sarah asks Linda to verbalize what she has understood from the discussion they have been having.

Satisfied that Linda has understood the risks and benefits of her testing options, Sarah asks Linda and Antonio if they are interested in pursuing the sickle cell carrier testing for Antonio, and if so, how they would use the information they learn. Linda seems torn and replies that she does not know. Sarah shares that some couples want the carrier testing because they feel it would put their minds at ease, while others are comfortable with their chances and do not want to pursue any testing. After a few moments, Antonio says he wants the test, and Linda nods in agreement. Linda says she would worry if she did not know Antonio's status and that she would wait for the results to decide if she wanted to have amniocentesis. She explains she would be nervous about amniocentesis because of its risk for miscarriage, but adds that she wants more children and would take the carrier testing results into consideration in her family planning.

Sarah returns to the discussion of Antonio's relative with a cleft lip, which he said was caused by an eclipse. Sarah says that cleft lip can occur even when there is not an eclipse, so there may be other causes, such as a problem in the baby's development early in the pregnancy. She explains that an isolated instance of cleft lip in a family may be due to the combined effects of many genes and environmental factors. Since Antonio's cousin has no other birth defects and is the only family member with a cleft lip, Sarah reassures the couple that the chance of their baby having this birth defect is not likely to be greater than that of the general population (~1/700) and that a targeted ultrasound at four to five months in the pregnancy could screen for cleft lip in her baby. Linda comments that she would feel more relaxed if they could look for a cleft lip on ultrasound; Sarah says that she will mention the recommendation for ultrasound in her report to Linda's obstetrician. Thanks to Jaime's skillful interpreting, Sarah is confident that Mr. and Mrs. A. understand what has been covered in the genetic counseling session, so she goes over the consent form for sickle cell disease carrier testing and makes arrangements with Mr. and Mrs. A. to deliver the test results.

Resources

National Society of Genetic Counseling's frequently asked questions page http://www.nsgc.org/about/faq.cfm

Genetic Alliance's *Guide to Genetic Counseling* http://www.geneticalliance.org/sites/default/files/ksc_assets/publications/guidetogcfinal.pdf

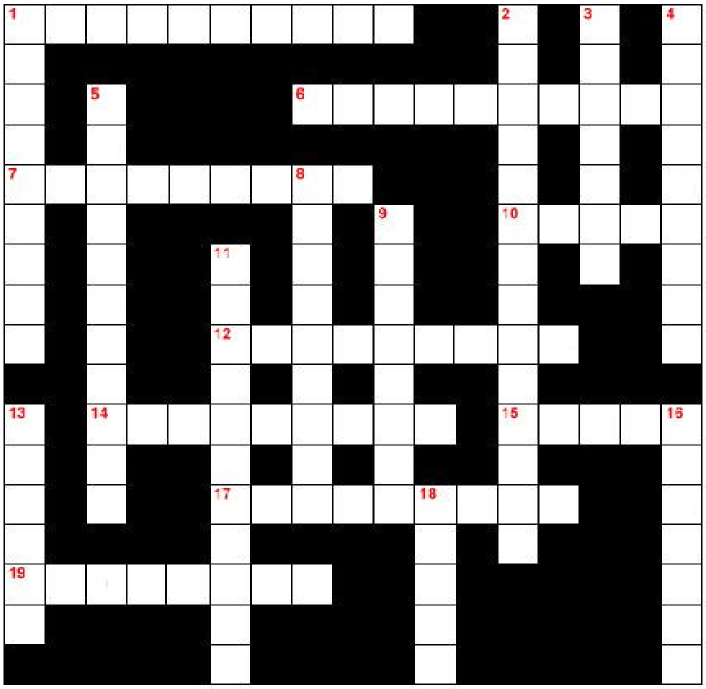
March of Dimes description of genetic counseling in English http://www.marchofdimes.com/pnhec/4439_15008.asp
and in Spanish http://www.nacersano.org/centro/9259_9705.asp

March of Dimes newborn screening information in English http://www.marchofdimes.com/professionals/14332_1200.asp and in Spanish http://www.nacersano.org/centro/9388_9944.asp

Lindsay Langford is a senior genetic counseling student at the University of South Carolina. She is a 2009 graduate of the South Carolina Honors College at USC and holds a BS in Biology and Spanish. Lindsay is conducting a study of medical interpreters as part of her Master's thesis.

ACROSS
1. Conducting nerve impulses in a direction opposite to normal (10)
6. Located outside the alimentary tract (10)
7. Filled with vascular sinuses and capable of becoming distended and rigid as a result of being filled with blood (9)
10. Make a great effort at a mental or physical task (5)
12. Capable of responding to stimuli (9)
14. Especially of muscles, drawing away from the midline of the body or from an adjacent part (9)
15. A medicine that strengthens and invigorates (5)
17. Moving of a body part away from the central axis of the body (9)
19. Filled with vascular sinuses and capable of becoming distended and rigid as the result of being filled with blood (8)

DOWN
1. Drawing a limb towards the body (9)
2. Maintaining a generally constant physiological state in a cell or organism (14)
3. Supplied with oxygen by respiration (7)
4. Controlled by individual volition (9)
5. Controlled by the autonomic nervous system; without conscious control (11)
8. Not supplied with oxygen (9)
9. Of two or more muscles; having equal tension (8)
11. The effect of a stimulus (on nerves or organs etc.)
13. Without volition or conscious control (6)
16. Regulation or maintenance of a function or action or reflex, etc.
18. Of sexual organs; stiff and rigid (5)



GLOSSARY

English Term	English Definition	Spanish Term
gene	The basic physical unit of inheritance. Genes are made up of DNA and are packaged inside the chromosomes in each cell. Humans have over 20,000 pairs of genes in every cell. Genes contain instructions for cell function, development, and hereditary traits.	el gen
multifactorial/ complex trait	A trait caused by the interaction of multiple genes and/or environmental factors.	un rasgo multifactorial
genetic counseling	The professional interaction between a healthcare provider with specialized knowledge of genetics and an individual or family. The genetic counselor assesses whether a condition in the family may be genetic, estimates the chances that another relative may be affected, offers and interprets genetic tests, and provides genetic education and psychological counseling to help families adapt to their condition or risk.	el consejo genético
pedigree	A diagram of a family tree that indicates medical history. Genetic counselors and geneticists use pedigrees to determine if a trait or condition may be inherited through several generations.	el pedigrí el linaje el árbol genealógico el heredograma
sickle cell disease	An inherited blood disorder that affects hemoglobin (the protein in red blood cells that carries oxygen and iron). Those who have sickle cell disease may have anemia, a predisposition to infection, and “pain crises,” or periods of intense pain. It most commonly affects individuals of African ancestry, but it can occur in other populations where Africans have immigrated (including Central America and the Caribbean). Sickle cell disease occurs when a person inherits two mutations (or traits) in their genes for hemoglobin. People who are carriers for sickle cell disease have only one hemoglobin trait, but usually do not have any symptoms.	la enfermedad de células falciformes la drepanocitosis
mutation	A change in a DNA sequence of a gene that can be inherited.	la mutación
carrier	An individual who carries and is capable of passing on a gene or trait for a genetic condition. For some genetic conditions, carriers may not display disease symptoms.	el portador la portadora
inherited trait	A genetically determined trait that is passed from parent to child.	un rasgo heredado
congenital	Present from birth.	congénito/congénita
amniocentesis	A procedure to draw a sample of amniotic fluid that surrounds a developing fetus. The fluid sample is used to test for specific genetic conditions and birth defects.	la amniocentesis
chromosome	A package of genes found in the nucleus of the cell. There are usually 23 pairs of chromosomes in every cell. The 23rd pair of chromosomes determines sex; males have an X and Y chromosome pair, while females have two X chromosomes.	el cromosoma
syndrome	A collection of recognizable traits or features that tend to occur together and are associated with a specific condition or disease.	el síndrome

Adapted from the National Human Genome Research Institute’s glossary of genetic terminology in English http://www.genome.gov/glossary/ and in Spanish http://www.genome.gov/10506935

A Parent’s Guide to Newborn Screening http://www.savebabies.org/library/HandoutAParentsGuidetoNBS.pdf

The Medical Interpreter with the Mac "Ruby Woo" Lipstick: Working with Older Adults who have Limited English Proficiency

by Ariel Lenarduzzi

On a typical (or not so typical) Monday morning I walked into my office to find one of my Senior Interpreters applying a thick layer of red lipstick to her lips. Our Interpreter Services office, a mini United Nations, can be a chaotic place at times, where dozens of languages and cultures come together under one roof for one purpose only: to help our patients and providers communicate. I have seen interpreters dressed in traditional attire from African countries; smelled the aroma of exotic foods from far away lands; gazed at magazine covers from all over the world and heard spirited discussion as to the best way to interpret a "simple" word into regional Spanish.

Until that Monday morning, I had not seen any of our interpreters apply lipstick in the office, *an act that I consider personal in nature and best suited for the privacy of the bathroom, changing room or crowded subway platform of the number 6 train during rush hour.*

As I walked into the office, the interpreter said to me, "I am on my way to my next case, a very special case and I must put on my top secret weapon, Mac "Ruby Woo" lipstick."

The interpreter must have seen the confusion, even slight displeasure on my face, when she pulled me aside and explained why this case needed "special primping" in the form of an *extra layer of her favorite designer brand lipstick.*

"My patient refuses to use assistive listening devices. He is hard of hearing and is in his seventies." This description did not seem unique to me.

"He can only understand me. Other interpreters have attempted to interpret for him but were not successful," the interpreter added.

Puzzled, I asked for additional information.

"The patient needs to see my lips when I speak in order to understand what is being said and red lips make it easier for the patient to see and follow the movement of my mouth," concluded the interpreter.

The lipstick shade, *an intense red*, was pivotal in helping with the communication between the providers and patient. The case began to make sense to me. By positioning herself in front of the patient, the patient was able to "read" the interpreter's lips and match the sound of the words to the movement of the crimson-stained mouth of the interpreter. Curious, I asked if other interpreters had tried to work with this patient.

Three other interpreters had attempted to work with the patient: a male interpreter, who had to withdraw from the case because the patient could not understand him, and two female interpreters, who followed the advice of the Senior Interpreter and positioned themselves in front of the patient, but the patient was not able to work with them either. Their lipstick shades of choice were not as vivid as the Mac "Ruby Woo" worn by the Senior Interpreter. Their lips did not "pop" and the patient had a difficult time focusing on their mouth. A change in position and a layer of designer lipstick coupled with professional experience was the answer for this unique case.

Insights often come from unusual situations. Days later, I was still thinking about this case: how sometimes something as simple as the color or shape of someone's lips can be a barrier or a bridge to communication. Inspired by the case, I sat down and took to the Internet to research the topic of communicating with older adults, specifically older adults with Limited English Proficiency (LEP).

According to the CDC, the number of older Americans will have more than doubled to 70 million, or one in every five Americans, by 2030, and the National Institute on Aging reports that the number of older people in the U.S. has increased ten-fold since 1900. Today, an estimated 35 million people, 13 percent of the population, are age 65 and older. People age 85 and above are currently the fastest growing segment of the older population; the growth of this group is particularly important for anticipating health care and assistance needs because these individuals tend to be in poorer health and require more services than people below age 85. *This gave me a sense of history and current and future trends*.

In 2000, the United States Census Bureau Report revealed that about 7 percent of persons 65 years or older did not speak English, and in some ethnic populations, over 70% of elders speak little or no English. *This was my call to action.* Medical interpreters are faced daily with the task of assisting older LEP clients; this is a need that will not go away and will continue to grow. I wanted to explore how older adults might differ from other groups of clients we encounter at the hospital. What sets them apart?

The first step was to huddle with my interpreter team and listen to what they had to say; focus on their successes and challenges. As a group, we brainstormed as to how an older LEP client might differ from other clients, always keeping in mind that our list did not reflect all older patients.

We concluded that some clients might experience:

- ☞ Multiple *comorbidity*
- ☞ Cognitive changes
- ☞ Mental Status changes
- ☞ Social Isolation
- ☞ A change in the quality of their voice
- ☞ Psychological, social and environmental changes

The next step took some contemplation; I reviewed and evaluated notes from workshops, educational initiatives and conferences, and determined that in many instances the way I was instructing interpreters and providers to work with each other and their patients might not be suitable for some older patients. While it is true that flexibility is one of the most important qualities of a medical interpreter, I wanted to be more exact. I wanted to develop concrete strategies that could be implemented when working with older LEP adults in certain situations.

The challenge is to remain faithful to the classic model of the interpreter as a conduit, clarifier, cultural broker and advocate and at the same time develop strategies to not only help guide the interpreter and provider but to ultimately improve communication between providers and older LEP adults. From this process, these are the strategies that have emerged.

STRATEGIES

Use third person - The client might not understand that you are the provider's voice and become confused as to who is talking.

Adjust pacing - Speak a little slower than usual and enunciate.

Give your client time to process information - Take a small pause between information exchanges.

Write /draw concepts - Ask for permission to "record" concepts. Once the encounter is finished, destroy paper in front of clients.

Pre-session imperative - Introduce yourself and explain your role as an interpreter.

Keep the client in the conversation - In family meetings, for example, the older adult might be the only one who does not have a command of the language. Make sure they are not only heard but understand everything that is being said. Advocate for the client's full participation.

Respect client's autonomy - Remember the client has the right to make his or her own decisions.

Be vigilant of boundaries - Don't let personal emotions and experiences guide your decisions.

Adjust positioning - Consider hearing and vision loss when positioning yourself to interpret. Seek "good lighting."

Be aware of tone/pitch of voice - Certain tones/pitches work best with certain clients. You might not be the best match for your client.

Make more gestures - Consider vision loss.

Accept that not everything will be understood and focus on key points - Advocate for take home points or "essence" of the interaction, summarization.

If not clear the first time, repeat as said - Do not assume that the way something was said was problematic. Avoid confusing the patient with new "interpretation."

Do not use baby talk or incorrect English - Advocate for client's "self-respect."

Pronounce some words as the LEP client does - Mimic the pronunciation of the client especially when talking about medications, proper names and medical exams.

Inquire about client history prior to session - Ask provider for an overview of the case and any special conditions that might affect communication prior to the encounter.

Consider cultural background and issues - How are elders seen in the client's culture? Is the provider/interpreter's gender/age "problematic or a barrier"?

Consider original literacy versus adopted literacy - The client might have higher literacy in native/main language.

Limit background noise - Turn down televisions, radios or change rooms when possible.

Maintain eye contact - If culturally appropriate, do "connect" visually with your client.

Consider the effects of stress and fatigue - Advocate for a break if you sense "information overload."

Remain faithful to consecutive mode - Avoid simultaneous interpretation. "Voice layering" might confuse patient.

Withdraw if necessary - Consider if you are the best match for the case; if not, withdraw.

Be sensitive to individual needs - Do not stereotype; each client is their own communication expert; be open to looking at a situation through the eyes of another "culture."

Circling back to the interpreters, I shared these strategies with them.

Although many of the strategies seemed obvious and intuitive in nature to the group, we all agreed that these strategies are not only practical but have the potential to improve patient safety, patient satisfaction, heighten cultural awareness and at the same time improve job satisfaction for the medical interpreter.

A final thought: never underestimate the importance of a touch of Mac "Ruby Woo" lipstick; sometimes crimson color lips are the best strategy to bridge communication between the patient and provider.

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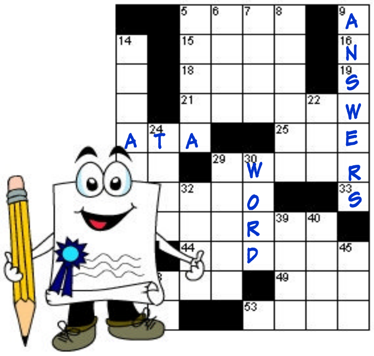

1 A	N	T	I	D	R	O	M	I	C	■	■	2 A	■	3 A	■	4 V
D	■	■	■	■	■	■	■	■	■	■	■	U	■	E	■	O
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7 C	A	V	E	R	N	O	8 U	S	■	■	■	R	■	T	■	N
T	■	O	■	■	■	■	N	■	9 I	■	■	10 E	X	E	R	T
I	■	L	■	■	11 S	■	A	■	S	■	■	G	■	D	■	A
N	■	U	■	■	T	■	E	■	O	■	■	U	■	■	■	R
G	■	N	■	■	12 I	R	R	I	T	A	B	L	E	■	■	Y
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13 R	■	14 A	B	D	U	C	T	I	N	G	■	15 T	O	N	I	16 C
E	■	R	■	■	L	■	E	■	I	■	■	I	■	■	■	O
F	■	Y	■	■	17 A	B	D	U	C	18 T	I	O	N	■	■	N
L	■	■	■	■	T	■	■	■	■	U	■	N	■	■	■	T
19 E	R	E	C	T	I	L	E	■	■	M	■	■	■	■	■	R
X	■	■	■	■	O	■	■	■	■	I	■	■	■	■	■	O
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