TOOLS FOR ANTICIPATING CULTURAL NEEDS

Remember at all times, that patients are members of cultural communities, not representatives of them. There are several cues that should sensitize you to cultural needs without leading to stereotyping.

Reliable vs. Unreliable Cues for Anticipating Cultural Need

Race is NOT a Reliable Cue of Cultural Need

- In attempting to anticipate the cultural needs of patients it is important to remember that the least reliable cue is race

*For Example...* African–American appearance characterizes corporate attorneys, surgeons, bankers and truck drivers who speak English, French, Arabic, Portuguese and Spanish. East Asian and South Asian features as well are no indication of education, religion, social class or language.

- Health care institutions have defined cachement areas and draw patients from the surrounding neighborhoods. The staff generally has some familiarity with patients from these communities. But the point is, never assume

*For Example...* An African-American man wearing a plaid workshirt could be a Choctaw lawyer from Mississippi. Midwesterners are surprised to see a young Asian man in a football uniform. Hawaiians are not

Country of Origin as a Potential Cue to Cultural Need

- Among U.S.-born people of diverse racial backgrounds, useful information might include:
  - Growing up in rural, suburban or urban settings
  - Social class
  - Primary language
  - Education
  - Religious beliefs

- How do you know? ASK the patient. Take a few minutes to find out exactly where they were born and grew up
- When people are ill, their thoughts often return to happier times and thoughts of home, and they will share this

*For Example...* In Chicago, many elderly African Americans migrated from the Deep South as teen-agers. Home to them is the South, and taking an elderly relative home is an important goal for such families.

Current Occupation vs. Educational Level

In minority and immigrant communities, current occupation is not a good indicator of educational level

*For Example...* Elderly African-Americans grew up in severely segregated, stratified society. The Pullman porters’ labor union constituted an important political force in early civil rights actions in part because the Pullman porters were on the whole college educated men. A few of these men are still alive, although they are quite elderly. You may be fortunate enough to meet one. Conversely, the women who clean offices at night may have been influential journalists at home in Bosnia.

Recognizing When Language is a Barrier

- Language barriers can be overcome. But first, it is important to recognize that the barrier exists
- Some potential cues that language is a problem include:
  - If you have trouble understanding the patient's (or the caregiver's) English, you can assume that they have trouble with yours
  - If the patient (or caregiver) seems to be getting as impatient as you are, to make you go away
If the patient never speaks on the phone, but someone else always calls for appointments or to report problems:

- Asking, “DO YOU UNDERSTAND?” is generally not a reliable cue. People nearly always say yes so as not to appear ignorant or to inconvenience you
- ASK if you will need an interpreter to speak with the patient. For home hospice it is not always possible to provide a professional medical interpreter. As we will discuss, a family interpreter has some good and some bad features.

Guidelines for Using Interpreters

Interpretation vs. Translation: What’s the Difference?

- Translation is static. He said. She said
- Furthermore, particularly for emotional states and evaluative statements, direct translation from English may actually distort the intended meaning
- Interpretation is interactive; it includes checks on meaning and understanding

What’s so Special about Medical Interpretation?

- Medical interpretation is a specialty, with national standards for certification. Most large cities have accredited training programs in medical interpretation
- Medical interpretation involves not only a specialized vocabulary, but also an interpreter who is empathic to suffering and comfortable in handling intimate and emotional content
- Interpreters generally charge between $18 and $30/hour

When a Medical Interpreter is Not Available

- A bilingual hospital worker or a primarily business translator is an alternative only if a professional medical interpreter is not available
- The xculture site also a short and long glossary of medical terms in several languages at www.xculture.org
- A final source is the AT&T language bank, but keep in mind that:
  - These interpreters are not trained in medical interpretation
  - Because they are on the phone, they do not have access to the visual information in the setting

The AT&T language bank (LanguageLine) can be reached at 1-800-752-0093 ext. 196, or visit their website at www.languageline.com

Anticipating and Planning the Need for Interpreters

- This is good care. It is also the law. DHHS Office of Civil Rights requires health care providers to furnish interpretation service at no expense to the patient
- Know that just language is not sufficient

  For Example... If the patient’s daughter says, “He speaks Chinese.” Ask which Chinese. Mandarin and Cantonese are not mutually intelligible. Russian is not Polish. Ethiopian can be Amharic, Somali, or Tigrean. Although there are easily discernible regional differences in Spanish, fortunately, the dialects are close enough for easy communication.

- ASK if the patient prefers a male or female interpreter. In general, middle-aged women are the best accepted. They are old enough to deal with matters of intimacy and they are perceived as maternal and caring
- If you know that a large number of your patients come from a particular language community, develop a relationship with a few trusted on-call interpreters
- Advocate for your institution to hire bilingual professional staff or maintain full-time interpreter services. Pulling housekeepers or food workers away from their duties is not fair to the worker and may insult the patient if they are of higher social status
Family Members as Interpreters

- Using family members to interpret is sometimes preferred by the patient, and in home settings may be the only alternative.
- Remember that the family member is also stressed, may not understand medical terminology and may have another agenda that interferes with direct communication with the patient. This is especially true if the family member is of a different gender (e.g. men interpreting for mothers and wives) or generation (children interpreting for parents). There are things women will not say in front of male relatives. There are things parents should not say in front of children.
- If families members must be used, firmly distinguish when you are asking them interpret and when you are asking for their own views. This distinction may be difficult.

For Example... In some conservative Muslim families, husbands and sons speak for their wives and mothers; however, the women’s private views may only be expressed to another woman, a daughter or sister.

- Defining the gender of the setting is important. If an adult relative is present, the context is male. If no men are present, the context is female. The sex of the hospice worker and interpreter therefore both have to be considered.

Helpful Hints When Speaking through an Interpreter

In Working With an Interpreter, You are Speaking to the Patient

- Spend a few minutes with the interpreter (whether professional or family) before you begin to plan the conversation.
- When you speak with the patient, position yourself facing the patient, with the interpreter to the side where she can see both your face and the patient’s.
- Speak in straightforward declarative sentences.
- Avoid, as you think about what to say, the use of qualifying phrases and dependent clauses, however much you may feel that you are being more precise.
- Avoid complex sentence structures. You can say it simply.
- Avoid utilizing polysyllabic terminology. Use short words.
- When you have to use a technical term, define it.

For Example... “We are going to insert a catheter in your bladder to relieve the obstruction.” versus “Your urine is blocked. It can’t come out. The nurse has a small plastic tube she can put in here. It will drain the urine. Then you won’t feel the pressure here.”

- Try to speak in blocks of no more than 20-30 words so the interpreter can cover everything you say. Otherwise the interpreter has to summarize or select what they think is important. Also ask questions.
- If family members interject in a disruptive manner, apologize for your limitations; explain that you can only talk to one person at time through the interpreter.

An Experienced Interpreter Will Ask Questions Before Interpreting

- In many languages there are no words for diseases, body parts, or procedures other than the English and the interpreter may need to clarify with you.
- In most non-English languages it takes more words to say the same thing, so the interpreter may seem to be saying more than you did.
- Ask the interpreter what words they anticipate using for body parts, diseases and procedures so you recognize them in the stream of translation. Also, it will help you have a sense of the “meaning” being conveyed.
- If the only word for cancer is The Horrible Death, negotiate an alternative with the interpreter.

For Example... There is no Japanese word for cancer. The Japanese word is borrowed from English. In Vietnamese the word for breast is crude, comparable to “tits.” The polite form is “vu,” something like “flower”. An American-born Vietnamese may not know this distinction. Sometimes interpreters adopt the English since it has no connotation.
• Be aware that patients may be very reluctant to name genital body parts

  For Example... They may say “my stomach” when they could mean any body part below the rib cage that is not a leg. They may say “my back” when they mean rectal pain. The interpreter may not know either. ASK the patient to touch or point to where it hurts. ASK what it is called “in your language” so the interpreter will have a guide in the future.

• Body parts also mean different things in different cultures

  For Example... Westerners locate sadness and depression in the heart (a broken heart, a heavy heart.) Cambodians locate such feelings in the head, “thinking too much” and headaches may indicate depression. Amharas from Ethiopia, however, may localize sadness to the stomach; it is “too wide.”

Whether there is bodily discomfort or whether it is a figure of speech is less important than whether the palliative care worker correctly identifies the problem

When Interpreting for the Patient, the Interpreter Should be Using the First Person

• “I am worried about the pain in my side.” Not, “She thinks the pain in her side is the cancer coming back.”
• The interpreter may say, “Doctor, I think you might have to explain about the biopsy again” as a cue to you go over difficult concepts
• In general though the interpreter should strive to be invisible
• If the patient can read, the interpreter could assemble a list of useful words and phrases (with a pronouncing guide) so that a patient with no or very limited English can at least point to what they want as a guide to the nurses who care for them

It is Always Correct to Be Formal with Adults

• In the United States informality is perceived as friendliness. But even as close as Canada it is perceived as rudeness
• It is always correct to address the patient as Mr. or Mrs. unless they ask to be called something else

  For Example... Chinese women traditionally do not change their surnames when they marry. If Wang Shu-Mai is married to Chen Shi-Ming, her name is Wang but she understands that she is Mrs. Chen in English.

• The use of first names is rude unless the patient asks that you use another name that Mr. Or Mrs. Or Ms. They may accept using your first name. But it may also make them uncomfortable. They are more comfortable calling you Miss Smith than Geraldine. The formality of conferring higher status on the health care professional may engender confidence. Formality and intimacy are not as mutually exclusive as many young Americans have come to believe.

National Cancer Institute grant (R25 CA76449) to Sara J. Knight, Ph.D., at the Robert H. Lurie Comprehensive Cancer Center provided the funding for the development of this program.