

Interpreters Learning!

 Maine Medical Center **Interpreter & Cross-Cultural Services**

Narrative-Based Medicine: Questions and Silence

"What can you tell me about your health over the years?"

Every health care provider has his or her own method for gathering information for patients' medical histories. Some ask long series of questions that expect short answers; others ask open-ended questions that invite patients to tell stories about their health.

The second method, narrative-based medicine, has gained a following because some experts believe that patients appreciate the opportunity to express their perspectives on illness. One study, detailed in *Family Medicine* in May 2002, showed that the more open style of interviewing requires little extra time but increases patient satisfaction and results in "significant sharing of new information." Some providers say this improves disease outcomes.

"Let me see if I understand..."

Providers who use narrative-based methods will often rephrase patients' statements to be sure that they understand concerns. They may also ask the patient for clarification about something — asking, for example, what a patient's pain felt like — or simply remain silent, waiting for the patient to speak.



Some providers use narrative techniques to gather information for patient records.

Narrative-based medicine can be more challenging for interpreters because open-ended questions may elicit long, detailed answers. Interpreters need to be especially careful to:

-Interpret questions accurately so that they encourage

the narrative or short replies that the provider expects.

-Serve as cultural brokers if patients describe treatments or situations unfamiliar in the United States.

-Avoid filling silences or awkward pauses. Silence can have many reasons, including fear.

-Interpret everything, even if it seems unimportant. If the patient speaks for a long time without stopping and you

weren't able to interpret everything, explain that to the provider, then ask the patient to repeat what s/he said after the last interpreted point.

-Remain calm if the patient becomes emotional.

-Listen as carefully as possible, noticing the patient's mood and emotions so that you can make the best possible word choices to convey the patient's concerns. ★

Tips for Good Listening

- ★ If you're not sure you understand what someone said, repeat the person's utterance in your own words.
- ★ Observe body language. Your own body language — including nods and eye contact — should reflect that you are listening.
- ★ Respect silence. Allow providers and patients time to consider what they want to say. Don't hurry them.
- ★ When patients speak at length about their symptoms or illnesses, simultaneous interpretation often works best.
- ★ Focus completely on what clients say. Don't just listen for words: feel their content and the sentences they form. Then interpret, capturing the words and feel of your clients' languages. ★

This issue of *Interpreters Learning!* includes:

From Dana's Desk: Cultural Competence	2
Filing Your Taxes	2
Scripts: Encouraging Narrative and Listening	3
Inside Story: Children at the Center	4
-Your Income and Taxes -Case Study: HIPAA	6
-My Story: Sandrine Chabert -News Updates	7
ICCS Message Board	Back cover

MMC News: From Nasiriyah to Portland

Five-year-old Noor Abd Al-Hady Hassan came to Portland from Nasiriyah, Iraq, in February for heart surgery. Noor was born with a ventricular septal defect, a hole in her heart, that strained her heart, limiting her breathing and growth.

Dr. Reed Quinn of Maine Heart Surgical Associates patched two holes in Noor's heart with Dacron during a three-hour operation in February. Dr. Quinn, MMC, and two MMC interpreters, Dr. Osman Hersi and Dr. Abdel Moneim Ali, provided services at no charge. Pacific

Interpreters donated free telephone interpreter services for Noor. A foundation established through Dr. Quinn's surgical group covered the costs of travel for Noor and her father, Abdul Al-Hady Hassan Hesab.

Dr. Ali's services went beyond medical interpreting: he also brought local Arabic-speaking children to play with Noor, who spent time visiting with a number of local families. Dr. Ali's wife, Amal, said that Noor enjoyed visiting a local school, where she drew, wrote, and played outside. Amal said that

Noor's father was especially happy to see Noor run.

Noor came to Maine after her father, who works as a security guard at a school in Nasiriyah, asked the 115th Engineering Group of the Utah Army National Guard where to find help for his daughter.

Dr. Quinn donates his time to operate on six to eight children each year from various countries. ★

Visit <http://www.maineheartsurgical.com/foundation.html> for information on the Maine Foundation for Cardiac Surgery. If you'd like to support the Foundation, please contact Rick Morrone at 773-8161, x 48.

From Dana's Desk, by Dana Farris Gaya, Manager, Interpreter & Cross-Cultural Services

Dear Medical Interpreters:

Increasingly, medical interpreters are reporting cases of people who are afraid to seek the medical care they need. For example, a woman fails to return for an appointment to discuss an abnormal pap smear. A man leaves the emergency room because too many questions are asked of him. A woman attends her first prenatal visit only one week before her baby's delivery. An interpreter is called at home by someone seeking medical advice. These cases are illustrative of how some in our community are avoiding preventive services and treatment for illnesses – until their condi-

tions escalate into emergency situations.

Medical Interpreters should reassure patients that our questions about race, ethnicity, and primary language spoken at home offer staff important information that helps them to ensure that all patients get the best possible care. Further, the hospital's use of patient photos for the electronic medical recording system is only to verify the patient's identity during the process of diagnosis, treatment, and care at MMC. However, if patients hesitate to come into the hospital for care, offer them "I Speak" cards and the option to

call MMC providers or staff using the Language Access Line at 1-800-236-6875.

Maine Medical Center firmly opposes using doctors, nurses, and care staff as immigration inspectors. A proposed law in the Maine State Legislature, LD 1079, includes of the following language: *If a member of a public or private organization that receives state funds has contact with a person that member believes to be an undocumented illegal alien, that member or that organization shall notify the United States Department of Homeland Security, United States Citizenship and Immigration Services, or a*

successor organization. On April 7, 2005, the Legislature debated LD 1079, which is called "An Act To Require Publicly Funded Entities To Report Undocumented Illegal Aliens to Federal Immigration Authorities." The hospital submitted testimony against the measure, stating that Maine Medical Center serves "all people regardless of age, health status, income, ethnicity, residency or any other characteristic. We serve anyone in need."

Documents for LD 1079:

<http://www.mainelegislature.org/legis/bills/LD.asp?LD=1079>

Administrative Reminders: Did You Forget April 15th?**What If You Missed Tax Day?**

Deadline. The U.S. Internal Revenue Service (IRS) expected to receive your 2004 tax return in mid-April — all tax documents should have been postmarked on or before midnight April 15, 2005. What if you missed the deadline? Here is information adapted from the IRS Website.

Filing a Late Return. The IRS wants all taxpayers to send tax returns. If you owe money to the IRS and are late to file, you

may have to pay a penalty. Some late filers qualify for payment plans, though, and there is no penalty for late filing if you are receiving a refund. Refunds, though, may only be claimed within three years of the expected tax return due date. Self-employed taxpayers should file within three years of due dates to receive Social Security credit for retirement.



Repeat Offenders. People who repeatedly fail to file tax returns may be subject to enforcement measures.

Getting Local Help. The IRS has an office in South Portland (220 Maine Mall Road, 879-4683) that offers a variety of services, including tax forms, answering tax questions, and arranging for payment plans. For other sources of free help, visit <http://www.irs.gov/newsroom/article/0,id=105128,00.html>

Two Crucial Tax Forms:

-Form 1040, with Schedule C to document self-employment income (reported on 1099 forms) and business expenses.

-1040-ES — Estimated Tax for Individuals to make necessary prepayments on self-employment income.

Helpful Internet Links:

U.S. Internal Revenue Service: <http://www.irs.gov/>

Maine Revenue Service: <http://www.state.me.us/>

Medical Terminology: Words Related to This Month's "Inside Story"

Blood Sugar — Testing the level of sugar (glucose) in the blood indicates whether or not someone has diabetes. High levels of blood sugar, also known as hyperglycemia, indicate diabetes. Diabetics should monitor their blood sugar to determine if medications, diet, and other treatments are effective.

C-section (Cesarean section) — A surgical procedure in which the abdominal wall and uterus are cut to extract a baby.

Down Syndrome — A genetic condition caused by having an extra Chromosome 21 that comes from either the mother or father. Down syndrome causes varying degrees of mental retardation and can be diagnosed before birth with amniocentesis or at birth based on physical characteristics.

Genetic Testing — Genetic tests look at an individual's DNA and search for sequences that indicate a predisposition for mutations and irregularities linked to or known to cause diseases.

Gestational Diabetes — Diabetes with onset during pregnancy.

Insulin — A drug injected by Type 1 diabetics to control blood sugar levels. Insulin moves glucose from the blood to cells for cell function.

Prenatal Care — Health care that monitors the condition of a mother and her baby.

Natural Childbirth — A variable term: labor and childbirth without medication for pain, invasive procedures, and/or surgery.

TransVaginal Ultrasound — A diagnostic imaging procedure in which a transducer (hand-held probe) is inserted into the vagina. The transducer gathers images of the genital tract and, if the woman is pregnant, her fetus.

Vaginal Birth — Giving birth through the vagina rather than by C-section. ★



Using Direct Speech Instead of Reported Speech

No More "He Said, She Said"

Sometimes it feels strange to interpret in the first-person form. Using the pronoun "I" to interpret directly a patient's words — as in "I feel sick after I eat" — might not feel natural, particularly if you've never experienced the patient's medical difficulties.

But interpreting the words of patients and providers in the first-person is the most accepted interpreting method. It may be inappropriate in certain cases — with young children, for example — but it reinforces the fact that appointments are essentially meetings between providers and patients. The interpreter's role is to facilitate that meeting and try to convey the mood and nuances of the patient's and provider's speech when rendering their words into another language.

A Bit of Grammar. When you interpret a patient's statement as "I feel sick after I eat," you are using

direct speech because you interpret the patient's words directly. If, instead, you say "he said that he feels sick after he eats," you are using *indirect speech*. Indirect speech presents several difficulties. First, it requires you to transform "I" statements to "s/he" statements as you also translate words. It also distances the patient from the conversation because you and the provider are talking about the patient rather than conversing with him/her. Finally, the rules of indirect speech require you to transform tenses, too, making it even more complex.

An In-Between Version. First-person interpreting doesn't work in all situations. Some patients may feel unnerved if they speak some English and understand that you are speaking as "I" for them. A combination form often works well. You could tell the provider "He said 'I feel sick after I eat.'" ★

Why Interpret Using Direct Speech?

★ Most interpreting standards recommend using the "I" form of verbs to reinforce the idea of communication between patient and provider.

★ Many patients know enough English to understand the difference between "I" and "she." In American etiquette, many people consider it rude to talk about someone in the third person when the person is present.

★ Direct speech is easier to use: you can make a faster, more direct interpretation of what the patient or provider says without transforming an "I" statement into a "he" or "she" statement. ★

Now It's Your Turn!

✓ *Script 1: At the beginning of appointments, tell the patient and provider how you'll interpret:*
"I will interpret in the first-person, 'I' form."

✓ *Script 2: If you see that a client is uncomfortable with your interpreting in the first-person, tell both clients that you'll try another method:*
"It seems that using first-person interpretation is a bit confusing for Mr. Ivanov, so

I'm going to use a slightly different method. I'll say 'Mr. Ivanov said "I feel sick after I eat."'"

✓ *Script 3: If you want to change to simultaneous interpreting, tell the provider and patient:*
"Mr. Park is speaking in long paragraphs, so I'll interpret simultaneously so that I don't interrupt his thought process by asking him to stop for me to interpret."

Learning about Biology, Pregnancy, and Childbirth

Many of the medical topics raised by the Children at the Center case are complicated. Here is background on some of the conditions, diseases, and other topics that the group mentioned:

Down Syndrome Facts — <http://www.nads.org/pages/facts.htm> Genetic information on Down syndrome. Other pages include resources and stories about people with Down syndrome.

A Brief Primer on Genetic Testing — <http://www.genome.gov/page.cfm?pageID=10506784> Dr. Francis Collins, Director of the National Human Genome Research Institute, outlines the basics of genetic testing.

American Diabetes Association — <http://www.diabetes.org/home.jsp> Broad information about diabetes diagnosis, treatment, diet, and research.

Gestational Diabetes on FamilyDoctor.org — <http://familydoctor.org/075.xml> A description of gestational diabetes.

March of Dimes — <http://www.marchofdimes.com/> Basics on pregnancy, newborns, and birth defects. Subjects include nutrition, breastfeeding, and childhood illnesses.

Childbirth Options — http://www.findarticles.com/p/articles/mi_m1264/is_3_32/ai_76512965 An article from *Essence*. ★

The Inside Story: Children at the Center

The Case Under Discussion

In December 2004, a group of providers, plus Dana Gaya of ICCS and Clinical Ethicist David Nyberg, gathered at a Children of the Center session to discuss a medical case. Some group members met again in February 2005 to discuss Dr. Nyberg's suggestion that providers use a narrative approach to gather medical histories.

Some of the patient's decisions were perceived by providers as problems, but not all outcomes were negative:

-Patients: a non-English speaking woman who gave birth, by C-section, to a baby with Down syndrome.

-Prenatal care: did not include genetic testing. The mother had gestational diabetes and missed many prenatal appointments.

-The Baby: is reported to be doing well, though the family does not take advantage of all available Down syndrome services.

-Down syndrome referrals from MMC's Patient & Family Services typically include information on Social Security's Supplemental Income, home nursing visits, Maine's Child Development Services, and other resources. ★

Children at the Center: There Are Miracles All the Time

Suneela Nayak, RN, Staff Development Specialist, coordinates Children at the Center. The program's interdisciplinary patient care rounds explore difficult cases at MMC that involve children.

Nayak says, "I always look for cases that challenge us as providers to work outside our normal patterns, that stretch to extend our expertise, our communication, our policies or procedures, and our interaction to new boundaries so that patient care is optimized. I look for a child at the center of each case. But there are miracles all the time." ★

Most interpreters wonder why health care providers ask certain questions or act in unexpected ways with patients. While discussing a challenging case (see left), Children at the Center talked about various approaches to taking medical histories and looked at a few of the challenges of providing care to diverse patients.

Editor's note: This article combines comments from the February Children at the Center meeting with comments gathered by e-mail, telephone, and in meetings.

Who's Who:

Suneela Nayak, RN, Staff Development Specialist

Beth Bejeck, RN, Lactation Consultant

Emmy Hunt, RN, MSN, OB-GYN Clinic

Janet Oliver-Palanca, RN, Family Birth Center

David Nyberg, Ph.D, Ethicist
Patti Rickards, RN, Nurse Manager, Family Center, Prenatal Center, and Newborn Nursery

Using Narrative Techniques

During the December session, Dr. Nyberg suggested that providers gather medical history information by asking open-ended questions that elicit narrative answers rather than asking questions to be answered with "Yes" or "No."

Beth: I thought that some of David's suggestions were phenomenal, especially some of the things that he brought up in terms of how to interview people. I think it's so true that we don't do that here. We basically come at taking histories from our viewpoint, from "How do we get what needs to be done?" as opposed to "What do they see as being important to be done?" After the December session I went back and changed a form of ours, to try to engage people in more conversation about how they're doing or what they think is important. To hear their story.

Patti: If you've got the time, with any patient, sitting and

hearing a story is wonderful.

Janet: Maybe it's not having the time but making the time, especially in a difficult circumstance.

Suneela: David's suggestion was to allow for an open conversation without the need to hurry up and get the information in the admissions record or whatever. He suggested that if we just sit and listen, then we would gather whatever information we need anyway, and he cited a study that said that you'd actually get [information you need] in less time. Emmy went on to actually try this with one of her newer patients... She said "All right, we'll see."

Emmy: I have to be really blunt: I felt like I positively did not like the ethicist's approach. I tried it with a patient identified as a

I figured I can't possibly tell her anything, so I'd better ask her.

challenging woman with pre-existing Type 2 diabetes and who had been 100% noncompliant with any pre-pregnancy intervention about her diabetes. I figured I can't possibly tell her anything, so I'd better ask her. I honestly didn't know what else to do with her, so I started out by asking her how long she had had diabetes and whether she even thought she had it. Then I just left it open to her and asked her to tell me everything that she thought about it, having it, or not having it.

Patti: But how do you guide it? "Tell me your story?" is pretty broad. Do you need everything?

Beth: But you can say "Tell me about your..." or "How are you doing with this?" or "Is this a problem for you?" or "What do you think?" or "How does it affect your life?" That way it's not "I was born on this day..."

Janet: You can also say "Tell me what childbirth is like in your country or hometown. What

happens?" And that narrows the focus from "Tell me a story" to "Tell me a story around something that we're discussing or that is important to both of us." The patient's in the OB clinic, let's talk about things and then as it progresses, what does the town, what does the community do for you? How are family involved, so you can get other information that I would love to hear from her.

Emmy: I narrowed [the new patient] down to diabetes. I didn't let her tell me the whole story of her country... narrowing down to the topic of being pregnant with diabetes helped her to focus on stuff: like everyone in her family has diabetes... She talked to me, we understood each other, and she agreed to begin treatment.

Sitting Down With Patients

Some providers prefer to sit, not stand, during appointments.

Beth: It's amazing how you can get a lot more information by sitting down because you know that you're not going to run off. I might spend five or ten minutes with someone, but their perception is that I've been there for half an hour. I try to make my body language more open.

Janet: I think I get more conversations from intrapartum patients when I sit. I'll pull up a chair and say "Mind if I sit?" And I'm convinced they tell me more than if I were standing up and checking it off because they tell me personal things.

Suneela: There was a study published in the early '80s, a behavioral study that looked at providers wearing lab coats who had a clipboard or a chart or something. They would come to a patient's room and talk to the patient. They would do one of two things: sit down or remain standing. The length of time they stayed, what they presented with when they first walked in — "Hello, I'm so and so" — and everything else was consistent. The only variable

Discusses a Cross-Cultural Case Study

was sitting down or standing up. The surveyor went back and asked patients what their perception was of how long the provider had been in the room. That was the only question. And those that sat down were perceived by the patient as having been there significantly longer.

The Relativity of "Problems"

If a patient doesn't perceive a health issue as a problem, will s/he follow providers' advice?

Beth: What we consider a problem, the patient might not consider a problem, and if they don't consider it a problem, you know, maybe it's not. Maybe some things are, obviously, but...

Suneela: That's exactly right because no matter who you are or what your cultural background, if you don't think it's a problem, you're not going to do a whole lot about it.

Beth: You're not going to change your behaviors.

Suneela: The work needs to begin with clarifying "Why is this an issue?" And "What's in it for you?" or "What's in it for your baby?"

Emmy: If a patient has a really big barrier, it's probably because we're trying to force them into some sort of regime that's either foreign to them, that they don't believe in or that's threatening them in some way. I told [the second patient] that I knew that a lot of people from her country did not like a lot of intervention or a lot of blood tests and shots and highly scientific stuff... I told her that I wanted to have her pregnancy be the way that she could do it, the best she could do it and how she wanted it, but for her to please listen to what we were saying and then she could tell us how she could either take it on or reject it.

Coming to Terms With Cultural Differences

Providers, who often work with

people from many countries, sometimes struggle to find culturally acceptable ways to work with diverse patients and their beliefs.

Janet: You always have to be careful about looking at people or not looking at them. Is sitting down too intimate or... can you sit down but make sure that you're a safe distance away? Or do you need to come in closer because if you're far away you're perceived as distant? I'm sorry, but you can drive yourself nuts thinking about things like that!

Beth: I also think about height. I try not to be taller because then you're perceived as authoritarian.

Janet: At the end of the presentation in December I kind of felt like what I had done in the labor and delivery area was good care culturally and that... I had not harassed the patient into doing something that she didn't want to do. I felt our relationship was safe and respectful. There was a bad outcome and I feel bad for the family, but the care I delivered to her was not negligent of her cultural beliefs. That's a big jump for me.

David: I'm glad you made it! I don't know why this comes to mind right now but one of the best physicists in history, Niels Bohr, once said that the opposite of a correct statement may well be an incorrect statement, but the opposite of a profound truth may very well be another profound truth. And when we're talking about getting cultures right, doing the best we can, I think understanding this sense of opposites being profound truths from different points of view can be more useful than merely being correct or incorrect in what kind of medical choices we make or what kind of personal choices we make.

We live in a world where values clash inevitably. They are attached to truths and the best

we can do, I think, is to try to understand that and use the means of listening to get it so that when we can see we have an opposition of profound truth we can live with that. You can choose to do something that

We live in a world where values clash inevitably.

medically speaking would not seem like the optimal thing to choose to do, but if it serves a patient's well being, which is encapsulated by this profound truth about life and death and the rest of it, then that's really okay. Medically incorrect from one point of view might match a profound truth from another point of view, and that's a better service to a patient than insisting on the medically correct thing to do. I don't know exactly why all this came to mind right now, except that it might be relevant to the experience you just mentioned.

The Uncertainty Principle & Practicing Medicine

A useful physics metaphor is Heisenberg's Uncertainty Principle. Health care providers and interpreters are inherently imprecise instruments trying to quantify and understand patients' health.

David: The principle of uncertainty refers to the measurement of electron mass and speed or mass and location. Because of the types of instruments that we have for measuring these things, we cannot know at the same time an electron's mass and its velocity or its location. We can know either one alternately, but we cannot know them both at the same time.

David: Your instruments actually influence what it is that you're trying to measure. And it's not only true at this level of work, but it's true in psychologically interviewing people. You become the instrument. And that's one reason why listening is so important: because it's the least obtrusive way to use your instrument. Everything's connected. ★

Why Physics? Some Background...

Danish physicist **Niels Bohr** once said that "The opposite of a correct statement is a false statement. But the opposite of a profound truth may well be another profound truth."

Bohr won the Nobel Prize in Physics in 1922 for studying the structure of atoms and the radiation they emit. Bohr helped develop the atomic bomb in Los Alamos, NM, during World War II.

Information on Bohr: <http://www.pbs.org/wgbh/aso/databank/entries/bpbohr.html>

The German physicist **Werner Heisenberg** founded quantum mechanics, which observes the motion of electrons, atoms, and molecules. His Uncertainty Principle is an inherent principle of quantum mechanics. Heisenberg realized that it is impossible to simultaneously know both the momentum and position of a nuclear particle with absolute certainty. Measurement interferes with the system that the scientist is investigating, resulting in imprecision.

Heisenberg headed the nuclear energy program in Nazi Germany, but there is controversy over his role.

Heisenberg's Uncertainty Principle: <http://www.aip.org/history/heisenberg/>

Heisenberg and Bohr worked together in the 1920s. In 1941 Heisenberg visited Bohr; playwright Michael Frayn wrote the play "Copenhagen" about that meeting. "Copenhagen" parallels Heisenberg's uncertainty theory with the indeterminacy of human thinking.

Bohr and Albert Einstein debated Heisenberg's uncertainty principle for several years. ★

Understanding Your Pay & Tax Responsibilities: Part 1 of 2

Note: Tax laws and procedures are very complex. The information in this article is intended only as a general guideline. It is not meant to replace advice from qualified accountants or government tax officials.

Most interpreters at MMC earn money in different places, working as regular employees and/or independent contractors for multiple companies and clients.

It's important for people with mixed income to look carefully at how their clients and employers pay them. Understanding your sources of income will help you to prepare your tax documents properly for the Internal Revenue Service (IRS).

The IRS & Your Money

The IRS asks taxpayers to report different types of income using different tax forms.

Two Main Types of Income

If you are considered an em-

ployee at a company, your employer will send you W-2 form, usually in January, telling how much you earned during the previous year.

If you worked as an *independent contractor*, any client that paid you at least \$600 in the last year is supposed to send you a 1099 form summarizing your previous year's income.

Reporting Income to the IRS

In general, if you earned only income that employers reported to you on W-2 forms, you may file any type of tax form with the IRS: a 1040EZ, 1040A, or 1040.

If you only earned money as an independent contractor, you must file a 1040 with the IRS and include a Schedule C form that details your profit or loss from your business.

If you earned money reported on W-2 and 1099 forms, you should file a Form 1040 and a Schedule C. Be sure to record your W-2 income on the main 1040 form and 1099 income (with contractor income) on Schedule C.



Tax forms aren't always easy to work with.

An exception: If you worked as a *statutory employee* and earned money recorded on a W-2 form with a "statutory employee" box checked, report that income on Schedule C.

Filing a Form 1040 Schedule C

Schedule C also asks you to list your business expenses. You don't have to pay taxes on money that you spend to keep your business running—those expenses are called deductions. Keep records of your expenses: business mile-

age, postage, office supplies and equipment, telephone and Internet, business registration, professional dues, subscriptions, and home offices used only for business. ★

Greg Recommends

Greg Figaro, President & CEO of CultureSmart, spoke to interpreters in March about self-employment income. Here is some of his advice:

- Separate your work and personal finances by opening a bank account for your business.
- Make quarterly estimated tax payments to the IRS.
- Keep records of all income and expenses.
- Hire a professional accountant or use computer programs that record your expenses and/or file tax documents with the IRS.
- Register your business in your town or city.
- Don't forget that every client is your paying customer! ★

Case Study: Privacy & Records

Interpreters should keep records that show how much money they earn during assignments. But privacy laws dictate that interpreters not keep records with patient names. ★

-You have just finished a busy day: you interpreted for five patients in several clinics and offices at MMC.

-You decide to visit ICCS to turn in your timesheets.

-Before you hand in the papers, you ask if you can use the copier to make copies of your timesheets.

-ICCS tells you that you may not copy the timesheets because they contain your patients' names, which are confidential information.

-You protest that you've always kept records that list

your interpreting hours and patient names so that you can track your earnings.

-ICCS tells you that this is no longer allowed: the hospital has a legal obligation under the Health Insurance Portability and Accountability Act (HIPAA) to protect patient information.

-HIPAA requires that you not reveal patient name, medical condition, finances or other information. Don't discuss patient information in public places within or outside the hospital. ★

Keep records properly and observe HIPAA regulations:

1. Turn in timesheets through MMC interoffice mail, the lockboxes outside the cafeteria and in the ED, or directly to ICCS.
2. Never copy timesheets with patient names. To keep a record of interpreting income, write down the date, time, and place of the appointment, and the total hours that you worked. Do not include patient names.
3. If you write patient initials in a datebook, do not carry the book with you or let anyone in your household have access to the book. When appointments pass, use an eraser, black marker, or correction fluid to delete names.
4. If you store patient initials in an electronic calendar, remove them after appointments. Nobody but you should have access to them; you should not carry devices with patient information.
5. Never discuss patients' identities or information with family members, friends, or community members who ask you if you know certain patients. ★

Now It's Your Turn!



My Story: «Mon histoire» by Sandrine Chabert

Bonjour!

My name is Sandrine Chabert and I was born in Marseilles, France. I've been living in the U.S. for almost six years and I really enjoy Portland. Because of its cultural diversity, it reminds me of Marseilles, which, as a port on the Mediterranean, harbors an extremely diverse population from Africa and Asia.

After spending two years in Tunisia teaching elementary school children, I taught French as a Second Language to young people and adults visiting France, and this is how I met my future husband, who was one of my students!

When I arrived in the U.S., I first attended an intensive English as a Second Language program at the University of Southern Maine, then I got a teaching job at a high school in Buxton. Two years later, I started working for Catholic Charities Maine as a French interpreter/translator and for eight months now, I've been part of the MMC interpreters pool.

Having had the opportunity over the past years to witness the way the U.S. health care system works, I have come to realize the huge difference there is between this one and the one I had been used to all my life. Back when I was in France, I never worried about getting sick or injured because the cost of health care is extremely affordable for everyone, being either very low or free, and consequently assuring everyone has equal access to treatment. Most prescription drugs are 80% or 100% reimbursed by Social Security, and nobody is seen crossing the border to Italy or Germany to get their medication!

Setting aside the financial aspects, the U.S. health care system has a lot to offer and the opportunity to be part of it as an interpreter has brought me great satisfaction. So far, my best experience has been interpreting for a delightful and touching lady who suffered from glaucoma. Seeing her joy when the doctor told her, two months after her surgery, that the pressure in her eye had dramatically dropped and that she could go back to work was precious. ★

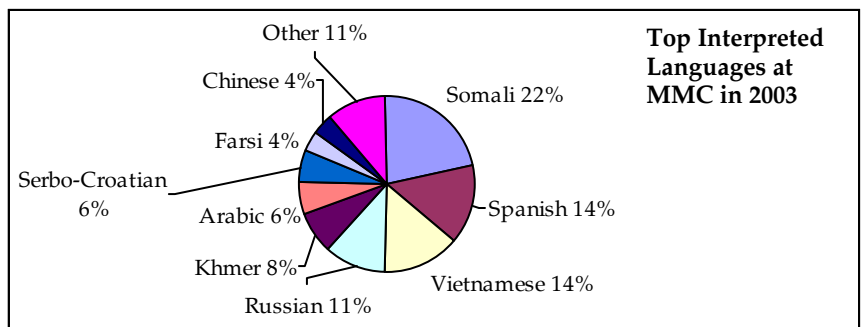


“First, Do No Harm?”

Most people know that new doctors take a Hippocratic Oath in medical school and promise to uphold high standards of medicine and ethics. But few know that the Oath, which Hippocrates wrote around 400 BC, does not include the famous line “First, do no harm.” His treatise “Epidemics” came closer, advising doctors to help patients and try not to harm them.

New doctors in the 21st century take revised oaths that differ greatly from Hippocrates's, which asked doctors not to practice abortion or euthanasia. Many medical schools administer an oath written in the 1960s.

To read two versions of the Oath and learn why the Oath is controversial, visit http://www.pbs.org/wgbh/nova/doctors/oath_today.html ★



Interpreting & The Law

ProEnglish Update

A federal court judge in San Diego, California, dismissed a lawsuit filed by ProEnglish, a national organization that supports making English the official language of government operations, and the Association of American Physicians and Surgeons. The ProEnglish suit challenged the U.S. Department of Health and Human Services policy of requiring translations and interpreters for patients with limited English proficiency (LEP).

The policy arose as the result of a 2000 executive order signed by President Bill Clinton requiring all doctors and hospitals that receive federal funding to provide interpreters for LEP patients. Under the executive order, failing to provide interpreters would violate Title VI of the 1964 Civil Rights Act. ProEnglish contends that the policy incorrectly interprets civil rights law to include language. ProEnglish also believes that the policy is expensive for doctors and limits their rights of free speech.

ProEnglish: <http://www.proenglish.org/>

Association of American Physicians and Surgeons:
<http://www.aapsonline.org/>

Bills to Roll Back the Executive Order

Two bills in the U.S. Congress would, if passed, nullify President Clinton's executive order and prohibit spending federal funds on interpreters for LEP patients. Representative Peter King of New York introduced legislation to the House of Representatives in January 2005. Senator Tom Coburn of Oklahoma has introduced a similar bill in the Senate. ★

Internet Links About Narrative Medicine

- Amednews.com article about doctors gathering patient history information: <http://www.ama-assn.org/amednews/2003/06/23/hll20623.htm>
- The journal *Family Medicine* focused on patient-physician communication in May 2002: <http://www.stfm.org/fmhub/fm2002/may02/toc.html>
- This abstract of a paper given at an oncology conference shows that patients prefer doctors who sit: http://www.asco.org/ac/1,1003,12-002636-00_18-0023-00_19-00101805,00.asp ★



Interpreter & Cross-Cultural Services Message Board

Questions about Medications? Billing? Appointment Times?

Tell patients about the Language Access Line! Patients with limited English language proficiency can call **1-800-236-6875** to receive free interpreter help in their native languages when calling MMC.

ICCS has "I speak" cards — which include the LAL number — available for distribution to patients.



New eLearn Screening Tests This Spring

All interpreters will be asked to take a new eLearn screening test during May and June 2005. The test will include new questions covering anatomy, ethics, procedures and policies, as well as medical terminology, treatments, and diagnostics. Interpreters who score well on the test will have an opportunity to be enrolled in a 40-hour medical training course conducted by the Harvard Pilgrim Health Care Institute.



Watch Out for Sharps!

Sharp medical waste, such as used needles, is dangerous and can carry diseases like hepatitis and HIV. If you see a sharp object that was not properly thrown away, tell medical personnel immediately.

Tuberculosis Education

The Centers for Disease Control have established a website that lists educational materials about tuberculosis in many languages. You will need to make a search to get materials: enter a language or a general word like "treatment." Materials are linked.

<http://www.findtbrsources.org/scripts/index.cfm>

Hand Hygiene

Cleaning your hands before and after patient visits by washing them with soap and warm water or rubbing them with waterless alcohol hand sanitizer gel is the most important thing you can do to prevent the spread of infection.



Interpreter Training in New England

The Harvard Pilgrim Health Care Foundation's Institute for Linguistic and Cultural Skills will offer interpreter training courses this year. All will be in New England.



Medical Interpreter Training Program

40 hours of training spread over five eight-hour days: Thursdays in Quincy, MA, starting June 23 or October 13; Tuesdays in Wellesley, MA, starting September 13. Topics cover ethics, patient culture, medical vocabulary in the target language, communication, and the U.S. health care system. Cost: \$475.00.

Training Skills for Trainers

June 6-10, 2005. 8.30-5.00 pm. Training for experienced trainers who want to deliver the Medical Interpreter Training Program to non-profit health care organizations. Cost: \$1,500.

Please contact ICCS if you're interested in either opportunity.

Wet Cleaning Discount!

Sandrine Chabert, a French interpreter, and her husband, Jason Wentworth, own The Washboard Laundry. Through May 10, 2005, The Washboard is happy to offer a 10% discount on its wet cleaning services to MMC employees who show badges.



Wet cleaning is an alternative to dry cleaning that uses water and detergent in sophisticated washers that clean delicate clothing without harsh chemicals; it costs the same as dry cleaning. The Washboard, Portland's first "eco laundry," also uses solar panels, energy- and water-efficient laundry machines, recycles materials, and hosts fundraising events for local organizations.

207 Danforth Street, Portland.
774-5778. Open daily, 8 a.m.-8 p.m.

Mental Health Interpretation

The Cross Cultural Communication Institute will present an eight-hour workshop, "Refreshing Your Skills in Mental Health Interpretation," on April 30th and May 21st, 9-5. Call Vonessa at (781) 729-3736 x.110 for details.

New Dietary Recommendations

The U.S. Department of Agriculture issued new dietary recommendations in January 2005. The new guidelines include advice on:

- weight management and exercise,
- food groups to eat more of,
- fats to limit,
- sodium/salt,
- alcoholic beverages,
- and food safety.



The recommendations are available on the Internet at:

<http://www.health.gov/dietaryguidelines/dga2005/recommendations.htm>

May Is National High Blood Pressure Education Month



To learn more about the diagnosis, prevention, and treatment of high blood pressure, visit the National Heart Lung, and Blood Institute of the National Institutes of Health:

<http://www.nhlbi.nih.gov/about/nhbpep/>

High blood pressure, also called hypertension, is especially common among African Americans. The heart has to work harder to maintain high blood pressure, which can cause stroke, heart attacks, kidney and eye problems, and death. Know your blood pressure and how diet, exercise, and other methods can help keep it healthy!

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[HTTP://www.mmc.org](http://www.mmc.org)

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