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The CATIE Center at St. Catherine University is funded from 2010-2015 by the U.S. Department of Education, Rehabilitation Services Administration, grant #H160A100003.

Part of the CATIE Center’s work is to enhance resources and training for interpreters working in healthcare settings. To this end the CATIE Center has developed the following resources:

- **Body Language online modules**, designed to guide both novice interpreters and experienced practitioners in working with the common discourse of medical appointments, and building use of classifiers and space to convey anatomy, physiology, common procedures and diseases in ASL. Seven modules are offered, covering healthcare discourse, the cardiac system, the digestive system, the respiratory system, the muscular/skeletal system, diabetes, and heart disease.

- **Concept Map for Mental Health/Medical Interpreter Education.** This curriculum guide is useful to educators planning how to incorporate healthcare interpreting into coursework.

- **Healthcare Interpreting Fellowship.** A supervised field induction for certified interpreters looking to expand their practice in healthcare settings. Fellows work with real patients in actual clinical settings under the supervision of experienced staff interpreters.

- **Interpreting in Healthcare Settings Annotated Bibliography.** This resource, organized by the Medical Interpreting ASL-English Domains and Competencies, identifies relevant and useful articles to both interpreters interested in interpreting in healthcare settings, as well as those more experienced with interpreting in healthcare settings.

- **Medical Interpreting Immersion.** A face-to-face program that incorporates use of classifiers and space to convey medical concepts accurately, discussion of common issues in ASL, ethical decision making, and a tour of a local hospital.

More information about these resources can be found at stkate.edu/catie and healthcareinterpreting.org.
Deaf people surveyed in a national needs assessment identified healthcare as the setting in which it is most difficult to get qualified interpreters (NCIEC, 2008). However, there are very few educational programs to prepare interpreters to work in these settings. Interpreters who do work on these settings most often work alone, and experience many challenges related to logistics, role and ethics. This manual seeks to assist interpreters in developing decision-making skills in handling these challenges. It also can be used by interpreters not yet working in healthcare, as well as student interpreters, to anticipate dilemmas they may face and to strategize the kinds of responses that may be the most effective.

The cases included here have all come from real situations that healthcare interpreters have experienced, although some details have been changed to protect confidentiality. These cases were analyzed in consultation groups, run by facilitators that the CATIE Center prepared. Facilitators used the Demand Control Schema approach as outlined by Dean and Pollard, including the process of identifying Demands/Controls/Consequences/Resulting Demands (DCCRD).

The case studies are grouped under the following themes:

- Logistics
- Role boundaries
- Responding as humans
- The need for advocacy and education

You will note that while the main demand relates to the section theme, many cases present concurrent demands that may also fit under a different theme.
HOW TO USE THIS MANUAL

This resource was designed to be used with the Demand Control Schema as presented in Dean and Pollard’s textbook The Demand Control Schema: Interpreting as a Practice Profession. Before beginning your work, we encourage you to read the two examples in the beginning of this manual that illustrate how this process can be used. You will also find questions that relate to the DC-S framework following the cases to help you get started.


Readers should also refer to the Medical Interpreting ASL-English Domains and Competencies and the Interpreting in Healthcare Settings Annotated Bibliography. These resources are useful for identifying the demands presented, as well as for additional professional development resources related to ethical decision making. This is available from www.stkate.edu/catie.

It is not a requirement to analyze the case studies in the order presented. Rather, read through them and select the ones that seem most challenging and most engaging.

Finally, we encourage you to work on these case studies with others. Get a group together and pick a case study to analyze (either independently or as a group) and discuss.

ACKNOWLEDGEMENTS

The development of this resource was led by Karen Malcolm, with additional support from Debra Russell, Marty Barnum, and Richard Laurion. Thank you for your dedication to advancing healthcare interpreter education.

QUICK GUIDE

- Review the sample case studies with analyses on pages 5-8.
- Choose case studies from the manual that interest you.
- Apply the Demand-Control Schema to analyzing each case study.
- Use the questions provided at the end of the cases as a guide.
- Work with other interpreters to enhance discussion and analysis.
DISCUSSION

This is an example of one of the simpler cases presented in this manual. The main demand presented is the interpreter’s knowledge of how the Deaf woman often reacts, and the upheaval this can cause for the clinic personnel. There may be an element of an Intrapersonal demand for the interpreter; as a hearing person, she may strongly feel that screaming is upsetting and disruptive.

The next step is to list the possible controls that the interpreter could exercise, such as:

- Saying nothing, letting the woman have whatever reaction she has and the staff having their reaction(s).
- Telling the lab technician that the woman may scream and asking the technician to alert the other staff members.
- Talking to the woman in advance, mentioning that the screaming may startle hearing people, and asking her permission to alert the staff.
- Doing the above, but telling her you will alert the staff, rather than asking her permission.
- Saying nothing in advance, but if she screams, quickly speaking loudly, “It’s okay! It’s not a problem,” to alert the staff.

From the list, choose the control that you are most likely to exercise. In a group discussion, you may want to vote on which control the majority prefers, and work with that control. Next, begin to delineate the consequences for this choice. For the purpose of illustration, let’s choose the option of talking to the Deaf woman in advance and asking her permission to alert the staff. If she agrees, the positive consequence could be that she is grateful to be consulted and agrees that the interpreter can prepare the staff. This would also address the interpreter’s discomfort. A negative consequence could be that she is embarrassed to realize that her screams have upset hearing personnel. She could also feel resentful that the comfort of hearing people takes precedence over her needs. She could wonder why the interpreter, who has worked with her for many previous appointments, didn’t talk to her about this previously.

If the patient disagrees, the interpreter may still feel uncomfortable. This creates a resulting demand for the interpreter, but she may then exercise a different control, such as saying something to reassure the staff as soon as the woman screams.

Even if the woman agrees to the interpreter forewarning the staff, some of the consequences may
still lead to resulting demands, but that does not mean that the selected control was necessarily ineffective. The interpreter may, for example, need to explain her reasons for not having mentioned the scream at previous appointments, and reassure the patient that it is her right to express pain.

Continue to work with this case, and choose a different control while working through the consequences and resulting demands.
CASE STUDY SAMPLE: EYE CLINIC

The interpreter receives information that this is a follow-up appointment at an eye clinic. A different interpreter worked the initial appointment.

The patient is knowledgeable about working with interpreters, with no obvious language or cognitive deficits. The patient has a Deaf friend accompanying him in the waiting room.

The interpreter’s first realization that there is more going on than she initially expected occurs when they are escorted back to the room. The doctor enters and immediately wants to know the patient’s decision on the procedure.

The interpreter has no information about what the “procedure” is or what was communicated in the previous appointment. She realizes that she needs more information to be able to interpret the question.

The doctor is impatient, saying that all this information had been given at the previous appointment. The patient seems very anxious and decides to consult his Deaf friend in the waiting room. The interpreter accompanies him to the waiting room. The friend supports doing the procedure immediately. The patient is very stressed and nervous; his hands are shaking. Once back in the procedure room the patient says to go ahead with the procedure. The interpreter asks for the doctor to walk the patient through what will happen. The doctor complies quickly and the procedure begins.

The procedure is fairly fast, done in the office with no special clothing or protective equipment required. At the end, the patient has temporary blindness. The doctor leaves the room and the nurse says, “He’ll be unable to see for about two minutes.” The patient is in hysterics, clenching the interpreter’s hands, unable to see. The interpreter tries to reassure him by attempting tactile sign language. This seems to only further agitate the patient. The interpreter realizes that by trying to communicate using tactile signs, she may have inadvertently reinforced the patient’s thought that he was blind.

Soon, the patient regains his vision. He is visibly embarrassed, signs, “I’m sorry” to the interpreter while hugging her and thanking her, and leaves.

DISCUSSION

This case offers multiple points where demands arise, and where an interpreter choosing a different control earlier in the scenario may have prevented the demands that arise later. There also may be post-assignment controls that the interpreter needs to employ.

Near the beginning, the interpreter realizes that there is more going on than she initially expected. The doctor talking about a procedure makes her realize that she is unaware of what is going to take place. This may be a time to talk about pre-assignment controls: the interpreter perhaps should have sought more information when accepting this “follow-up” appointment, or should have talked with the Deaf person more in the waiting room (if he was amenable to doing so).

The next point where a DCCRD could be conducted is when the interpreter asks the doctor about the procedure, and he responds impatiently while the patient is demonstrating a great deal of anxiety. The main demand is that the interpreter does not have enough information to interpret accurately. Concurrent demands are the doctor’s impatience and the patient’s anxiety.

Possible controls include:

- Asking the doctor for more information, and explaining the reason for needing the information.
• Requesting a 10-minute break to talk with the Deaf patient to understand the procedure, and what his anxiety is about.
• Continuing to interpret as best she can, hoping that the nature of the procedure will become clearer to her as they proceed.

Choosing the option of requesting the 10-minute break and talking with the Deaf patient would have the positive consequence of gaining more details about the procedure, and learning that the anxiety concerns the patient's fear of damaging his sight. The interpreter could potentially gather enough information to ask the doctor targeted questions, so that the temporary blindness could be explained prior to the procedure. A negative consequence could be the doctor's increasing impatience, which then feeds the patient's anxiety. It could also be that the Deaf patient doesn't really understand the procedure.

Other discussion points in this case include the patient's temporary blindness and his upset reaction, and then his embarrassment upon completion. Some post-assignment controls that the interpreter might exercise at the end of this case include:

• Assuring the patient that his reaction was natural and understandable.
• Talking to the doctor and/or nurse to educate them about the need to explain temporary blindness to a Deaf person in advance.
• Approaching the booking agency to let the agency know that more information is required for a follow-up appointment.

For more detailed information on the Demand Control-Schema, refer to the Dean and Pollard textbook.
UNEXPECTED TIME CONSTRAINTS

A 60-year-old deaf woman, who is a wife, mother and grandmother, is with her deaf husband and their four adult hearing children in a hospital room talking with a surgeon prior to a surgical biopsy.

This doctor refers to the biopsy area as “a very concerning tumor,” “the suspicious mass,” and “the area of concern.” He never uses the word “cancer.”

The deaf couple have had little to say as the doctor speaks. The eldest daughter among the children is the only one to ask any questions. She seems the most visibly concerned. She also does not use the word “cancer” when talking to the doctor and appears to actively use the term “concern,” “complication,” or “problem” when asking further questions. She also asks if her mother will need to stay in the hospital and if her mother’s Medicare insurance will cover all expenses.

As the daughter continues with her questions, neither she nor any of the children sign or interact with their parents. They are directly engaged with the doctor and defer to the interpreter for all signed communication. The doctor directs his attention to the daughter, as she is leading the conversation for the family. The doctor informs the family that once the biopsy is done, he will wait for the pathology report and then come talk to them about the results.

The interpreter realizes, as they wait for the surgery room to become available, that she has to go with the patient for pre-operation communication and instructions. The interpreter begins to consider what communication issues may emerge during pre-op. It is also not clear who will interpret for the husband while the interpreter is with the patient. Observing the family dynamics thus far, it is not clear how the family typically communicates. The anesthesiologist is still due to see the patient, and there is not enough time in the interpreter’s schedule to work beyond pre-op; this means she is not available to interpret the discussion of the pathology report with family or interpret for the patient during recovery. She is concerned about communication continuity.
The interpreter has a private discussion with the nurse about the scheduling complications and her limited availability. She lets the nurse know that she may not be able to stay for the post-surgery discussion and that she definitely cannot work with the patient and the husband while both are in two locations. She adds that she is exploring the options of adjusting her schedule. The nurse says that not having an interpreter would be okay because the doctor can talk to the children, who can then tell the patient what is happening. The nurse adds that the hospital has a video remote interpreting service they can use in recovery, and this same service can be provided to the husband in the family area.

**DISCUSSION QUESTIONS**

- What do you perceive to be the main demand in this scenario?
- What control(s) would you choose in this scenario?
- What concurrent demands might influence or be affected by the control choice(s)?
- What resulting demands could arise based on the choice of controls?
- Where would the controls you choose fall on the liberal-conservative continuum?
A 40-year-old Deaf woman has recently moved into the area. She is in the process of setting up all her first-time medical appointments, and after some research, has selected a local medical clinic. The appointment is with a new general practitioner (GP) doctor.

As the woman sits in the waiting room, the interpreter arrives. This is the first time they have met, and so they exchange many of the typical questions for a first-time meeting. The woman asks if the interpreter has Deaf parents, and wants to know more about the interpreter's background. She also asks the interpreter about the local community. The interpreter wants to get a sense of the woman's language use and make the woman confident that she will be understood, and so she answers appropriately. As they wait in the waiting room, the woman mentions that she is nervous about getting to know the new doctor and hopes she can establish a good rapport with him.

The nurse calls out the woman's name, and both the woman and interpreter are led into an examination room. The woman asks the interpreter to stay in the room as they wait for the doctor, and they make small talk. After about 10 minutes, the doctor knocks and enters the room. As the appointment starts, the doctor keeps saying to the interpreter, “tell her” and “ask her.” When the interpreter politely suggests that he address the patient directly, the doctor glares at the interpreter and appears to take great offense.

The Deaf patient looks startled and concerned about the doctor's sudden facial expression. After the appointment, the woman starts to leave with the interpreter following. The doctor walks out as well, behind the patient. As they walk down the hall, the doctor looks over at the interpreter and says, “I think I can communicate just fine with the patient. I don't think you need to come again.” The patient, walking ahead, is oblivious to this conversation taking place behind her.

**DISCUSSION QUESTIONS**

- What do you perceive to be the main demand in this scenario?
- What control(s) would you choose in this scenario?
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- Where would the controls you choose fall on the liberal-conservative continuum?
HOSPITAL INTERPRETER SEATING

A Deaf patient presents in the Emergency Department with suspicion of an acute reaction to a prescribed renal drug. An interpreter is called. After testing and consultation between physicians, the patient is admitted for observation overnight. The first interpreter, nearing the end of her shift, calls to arrange for a replacement interpreter. If the patient's condition changes, surgery may be necessary, requiring signed authorization and informed consent.

At 10 p.m., the replacement arrives and goes to the room. He expects to get a report from the first interpreter regarding the situation, how the interpreter has worked with the patient, the patient’s health status, what has taken place with the hospital personnel, and what plans might be in place for the evening.

He notices that the on-site interpreter is in the patient's room with books, laptop, water, etc., and is keeping herself occupied as the patient sleeps. No medical staff are in the room and the interpreter appears to have been in the room for some time. The replacement interpreter is surprised, in part because this is opposite of the standing policy between the hospital and interpreter service agency. The hospital has been concerned about liability issues and patient confidentiality as dictated by HIPPA, so interpreters are to stay outside patient rooms until their services are needed. When the interpreter sees the replacement interpreter, she quickly packs up all her stuff, expresses gratitude for her replacement, and leaves without providing a report.

The replacement interpreter pulls a chair into the hallway just outside the patient's room. A nurse approaches him and encourages him to move back into the room and stay “out of the way.” The interpreter respectfully declines, explaining that the hospital's policy is in place to avoid any liability issues and to ensure that any communication with the patient is done in a healthcare practitioner's presence. The nurse replies that she still thinks it is more effective, safer, and less of a distraction for the hospital staff if the interpreter stays in the room.

The interpreter again declines and remains sitting in the hallway.

DISCUSSION QUESTIONS

• What do you perceive to be the main demand in this scenario?
• What control(s) would you choose in this scenario?
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• Where would the controls you choose fall on the liberal-conservative continuum?
PLACEMENT OF INTERPRETER IN INPATIENT MENTAL HEALTH UNIT

The interpreter is called to a locked inpatient mental health unit in a large metropolitan hospital. Upon arrival, the interpreter is told that she is required to sit in the lobby past two locked doors and the nursing staff will come and call her when the group begins. The interpreter is uncomfortable with the arrangement and asks why she isn’t on the unit to be available for the patient to interact with hospital staff and patients. She is told that hospital policy allows only hospital staff interpreters to be behind the desk; agency interpreters must sit in the lobby. The interpreter wonders if part of the reason the hospital staff doesn’t want her on the unit is to decrease the amount of interaction the staff has with the patient. She has been at a different hospital where she was not allowed back, and where the patient had expressed the desire for the interpreter to be present, which staff ignored, so she is concerned that a similar situation is happening here.

Upon finally being called to interpret for one of the group sessions, the interpreter overhears staff saying that the Deaf patient had a phone call earlier but they took a message. The interpreter thinks this is a good example of why it would provide better service to the patient if she were able to access the unit prior to the start of group.

PATIENT TRYING TO COMMUNICATE DIRECTLY

The patient has an interpreter scheduled, and is using his limited spoken English to communicate. The interpreter wonders whether she is needed or not. She decides to stay as a backup for the doctor and patient. During the appointment the patient speaks in English sometimes, signs and talks sometimes, and sometimes only signs. The interpreter is trying to determine if the information that the patient is saying in English is clear to the provider. At times she interprets when the patient talks and signs at the same time. The doctor becomes confused between the patient’s use of the first person and the interpreter’s use of the first person, wondering who is answering. At times the doctor asks a question of the patient, then after listening to the patient’s response in English, the doctor responds to the patient’s comments with "Yes..." while looking at the interpreter puzzled. The interpreter thinks that the doctor is not sure he understood the patient completely. The patient is also trying to understand the doctor without the interpreter’s involvement. The interpreter tries to read the patient’s expressions and body language for clues that he does not understand and to determine when to interpret something. The interpreter leaves the session feeling dissatisfied with the way the appointment proceeded.
PEDiatrician Visit

A Deaf father and his son come to the pediatrics clinic as walk-ins. One of the staff interpreters who is at
another appointment receives the page from the scheduler. The interpreter is asked to go as soon as pos-
sible to the building’s walk-in pediatric clinic for an appointment just made. Since this is an immediate need,
the scheduler tries to emphasize that the interpreter should hurry as soon as her current appointment is
finished.

Unfortunately, the interpreter is still with a patient whose appointment is taking longer than expected. As
a result, the interpreter doesn’t arrive at the walk-in clinic for 20 minutes. When she approaches the desk
and identifies herself as the interpreter, the registration clerk hands her several forms and asks that she
have the Deaf father who is sitting in the waiting room fill them out.

The interpreter has not met the Deaf father previously, so walks up to him and introduces herself. The
father mentions that he had been there several times and he didn’t remember meeting her before. The
interpreter confirms that she has not interpreted for them before. She explains that there are three staff
interpreters and that she is the first one available to come to this unscheduled appointment. While chatting,
the father expresses frustration that it has taken 20 minutes to get an interpreter. He states that he has
been waiting too long. He tells the interpreter that when he and his son arrived and asked for an interpreter,
he was told that there were none available. Since his family has used this medical center many times, as
have other members of the Deaf community, he knew there were full time interpreters employed by this
facility and that all the front desk had to do was call. The interpreter acknowledges his frustration.

While getting to know the client, the interpreter learns that he is an Information Technology Specialist and
his wife, who is hearing, is a physician’s assistant and usually takes the children to the doctor. The father
seems very interested in knowing the English word for certain things; for example, he takes time and care
to spell the word “contagious,” asking the interpreter to confirm that it is spelled exactly right. He expresses
concern about his son’s health and whether he should be in daycare that day.

The father, child, and interpreter are put into a room and the nurse asks about the health concerns
that have brought him and his son here, which the father answers easily. The interpreter leaves when the
nurse does, and is greeted almost immediately by the doctor, so both go into the room. The doctor seems
rushed—he doesn’t wait for the father’s questions or comments to be completed before he starts talking
again. The interpreter attempts to interpret more quickly, to try to get a complete message conveyed, but
the overlapping and interruption continue.

After a quick examination, he diagnoses the problem and tells the father a long, Latin phrase. He explains
what it means and seems ready to leave. The father, however, wants to be sure he has the right spelling and the right information. He asks the doctor to spell it so he can write it down. The doctor dismisses this request and continues to tell the father the treatment plan. The father pushes for the information and asks the interpreter to write the diagnosis down.

**DISCUSSION QUESTIONS**

- What do you perceive to be the main demand in this scenario?
- What control(s) would you choose in this scenario?
- What concurrent demands might influence or be affected by the control choice(s)?
- What resulting demands could arise based on the choice of controls?
- Where would the controls you choose fall on the liberal-conservative continuum?
WAITING ROOM DILEMMA

A Deaf wife has brought her Deaf-Blind husband to see his GP. The interpreter meets the couple in the dimly-lit waiting room. The Deaf-Blind man can't see the interpreter. The wife starts providing information about the appointment to the interpreter, but doesn't make efforts to let her spouse know what she is saying. The interpreter suggests that they both move closer to the husband so he can follow their conversation, but the wife dismisses that suggestion. The interpreter feels this unfairly excludes the husband, but can't figure out how to include the husband without offending anyone.

The couple are taken into an examination room. The patient starts to tell the interpreter the reason for his visit. His wife interrupts him and tells him not to bother because the interpreter already knows. He looks confused and asks how the interpreter knows, and his wife responds that she told the interpreter. The husband gets angry; they start to argue just as the doctor arrives and asks them what brings them here today.

THERAPY APPOINTMENT

A young adult with cognitive delays, bipolar disorder, and PTSD was recently discharged from a psychiatric ward and is at a clinic to follow up with a therapist. His mother accompanies him.

The patient, mother, and interpreter are called into the therapist's office. After sitting down, the therapist asks how the patient is doing now that he is back at his group home. The patient does not answer, instead stating he needs to use the restroom. He excuses himself and the interpreter waits in the hallway. The interpreter sees herself as an integral part of the team and hears the therapist asks the mother how her son has been doing since his discharge. The interpreter wonders if this information is pertinent enough that she should stay in the room to hear, if she should continue to place herself in the hallway, or if she should ask if they feel comfortable with her staying to hear the discussion. The interpreter wants to align herself with the goal of the environment, but does not want to be seen as aligning solely with the therapist when the patient returns. Yet, with this person's cognitive disability, an update would assist her with the later points of the interpreted event.

DISCUSSION QUESTIONS

• What do you perceive to be the main demand in this scenario?
• What control(s) would you choose in this scenario?
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POTENTIAL ROLE CONFLICT

A private practice interpreter is called to interpret for an in-patient at the hospital. The interpreter learns the patient’s name and realizes that she has an appointment with the same patient at another facility later that day.

The interpreter arrives and steps into the patient’s room to let him know she is on-site. The patient quickly reminds the interpreter that his eye appointment is later that afternoon, but he wants it cancelled. The nurse enters and again the patient indicates that he wants to cancel his appointment. The nurse states she will cancel the appointment. She then administers medication and assesses him as the patient continues to express the importance of cancelling the appointment.

The interpreter is familiar with the patient’s health history and his need to avoid any anxiety, so she states to the nurse that the patient should be able to relax slightly once he knows she has called the optometrist. The nurse agrees and says she will do it soon. The nurse leaves the room and the patient says he is worried the nurse will forget to call. He asks the interpreter to call herself and cancel the appointment. The interpreter suggests him to call, with her interpreting. The patient becomes agitated and says he can’t do that. The interpreter goes to check with the nurse to see if she has called the office, but the nurse is nowhere to be seen.

DENTAL CLINIC

A Deaf patient has a lot of dental work needed, and is anxious about it. She specifically requests an interpreter she is friends with, who has experience as a dental hygienist. The interpreter accepts the appointment knowing that she is probably requested as much for emotional support as for her professional background. Based on her experience as a hygienist, she also knows how beneficial and less time-consuming it is if the patient is as relaxed as possible. During the appointment, the interpreter responds to the patient’s request to hold her hand and distract her during particularly painful moments. The interpreter feels comfortable with her ethical choices, but then the patient thanks her effusively and says she is going to tell all her friends about how supportive and friendly she has been. The interpreter begins to worry that others may question her professionalism or even expect that she would make the same choices in a different situation.
PATIENT WITH ACCOMPANYING CHILDREN

A staff interpreter has an appointment at the end of the day. By then, she is the only interpreter remaining in the office. She heads to the appointment and finds the patient and her two young children in tow. The interpreter learned at previous assignments that this patient aged out of the foster care system, is a new single mother, and is trying to hold down a full-time job in a new community.

The patient is scheduled for a quick temporal lobe scan for a cochlear implant. The interpreter is immediately concerned about who will watch the children as the scan takes place. The interpreter decides she will talk with the imaging staff to see how they normally handle such a situation. However, she realizes that if the imaging staff wants to reschedule because of the children's presence, it is likely that the scan will not happen because the patient previously indicated that she is new to the area and has no support.

The imaging staff is running behind. When they come to get the patient, they apologize for the delay and state that they don't have enough staff that afternoon. The interpreter is now even more uncertain as to what to do.

TRAUMATIC BRAIN INJURY

A Deaf man was involved in a head-on collision that killed his wife. He suffered a significant traumatic brain injury. His adult children wanted to be the ones to tell their dad what happened to their mother when he is lucid. When they told him, an interpreter was present. Some days he remembers and is sad, but on other days he asks for his wife.

A new staff member is interacting with the patient when he asks where his wife is. The employee says under his breath, “I don’t know if he has been told yet and what to say.” The lead physician has been encouraging staffers to reorient the patient any time there is confusion. The interpreter is unsure about what to say, because she knows the children have told their father. The patient, meanwhile, continues to ask where his wife is and begins to look upset about not getting a response. He starts asking the interpreter if she knows where his wife is. The staff member continues to seem undecided; he asks the interpreter if she has any information.
UNSUCCESSFUL TEAMING EXPERIENCE

You and an interpreting colleague are working in a team to provide interpreting services for a Deaf social worker who has Deaf clients who have additional disabilities. The social worker is engaged in clinical supervision with a consulting psychiatrist on a client’s mental health issues; this client has complex needs. Originally, you both understood that you would be working the regular staff meeting, but you learn about the psychiatrist consultation only 10 minutes before you go into the meeting. During the meeting, your colleague struggles to understand the ASL, and you provide support and feeds. The information is laden with medical terminology, medication names, and contextual information about changes in the client’s life circumstances.

The social worker and her non-deaf colleague are becoming increasingly frustrated with your team interpreter. Meanwhile, a hearing colleague, who can sign and has worked with the social worker for more than 10 years, is also participating in the meeting. This hearing colleague interrupts often to clarify information that the other interpreter has not interpreted accurately. Despite the challenges and the dynamics, you and your colleague continue to offer services in the way you agreed upon, which is switching every 20 minutes and supporting each other. After the appointment, you have some time to debrief as a team, with both of you acknowledging that the assignment was not very successful. You are also aware the co-interpreter has previously perceived you as more experienced and accomplished, and that has created some tension between you as a team. You attempt to raise the issue of the other interpreter not being able to convey the medically-based content. He deflects some of these comments, stating that there wasn’t time to prepare, and he is just getting over a cold and was not doing his best work. After several attempts to address the concerns, you decide to leave it alone.

One week later you are called back to interpret a different meeting for the same social worker and her colleague. At the end, they ask if they can speak with you in confidence; you agree. They share significant concerns about your team interpreter from last week, and how they do not want him to interpret again. However, they indicate they do not wish to speak with him about it.

DISCUSSION QUESTIONS

• What do you perceive to be the main demand in this scenario?
• What control(s) would you choose in this scenario?
• What concurrent demands might influence or be affected by the control choice(s)?
• What resulting demands could arise based on the choice of controls?
• Where would the controls you choose fall on the liberal-conservative continuum?
CONFLICTING NEEDS

A male patient accompanied by his wife is scheduled for a doctor’s appointment. Both are Deaf, although the husband can speak fairly clearly and seems to sometimes hear what is said. The interpreter has interpreted for this patient previously and knows that he benefits from having an interpreter. He says at this appointment that he doesn't need an interpreter, but each time he states this, his wife states that she needs one, and asks the interpreter to stay. The doctor enters the room, ready to start the appointment. The husband repeats that he doesn't need an interpreter. The interpreter voices what the husband is saying and the doctor replies to the interpreter, “That’s fine then, so I guess you can leave.” The wife doesn’t say anything but looks at the interpreter purposefully, which the interpreter takes to be a silent plea to not leave. The doctor stares at the interpreter, waiting for her to leave.

DISCUSSION QUESTIONS

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PATIENT LITERACY ISSUES

After interpreting several appointments with the same doctor and a 45-year-old Deaf female for high blood pressure and kidney problems, the interpreter has observed a pattern of responses to written information that leads her to suspect the patient struggles to comprehend English and might be illiterate. The patient has always forgotten her reading glasses and says she can’t see forms. Printed instructions from the previous appointment are frequently lost or not followed. The interpreter observes what appears to be the doctor’s frustration with this patient. Ongoing problems have emerged from the patient’s lack of compliance with preparation instructions prior to medical tests and procedures, confusion about prescription directions, and not showing up at specialist appointments that the patient had been notified of via a mailed letter.
A male interpreter, a relatively new hire at the hospital, is called to labor and delivery. There is a woman in labor who has no support person or family in the room. The interpreter, who is often unsure of protocol, is standing at the bedside where the support person typically stands. The physician is at the foot of the delivery bed, the delivery nurse is on the other side of the bed, and a medical student is immediately behind the physician. There usually is at least one more support nurse in the room, but the ward is short-staffed. The patient is having extremely strong and painful contractions.

Since there is no support person and limited options for a clear sightline, the interpreter stands close to the head of the bed and happens to have his hand on the handrail. During a contraction, the patient suddenly grabs and clutches the interpreter’s hand. The interpreter instantly faces a dilemma: should he retract his hand and stick to the “no physical contact with patient” etiquette, or accept the patient’s indirect plea for support?

**DISCUSSION QUESTIONS**

- What do you perceive to be the main demand in this scenario?
- What control(s) would you choose in this scenario?
- What concurrent demands might influence or be affected by the control choice(s)?
- What resulting demands could arise based on the choice of controls?
- Where would the controls you choose fall on the liberal-conservative continuum?
DEAF COUPLE CONFLICT

An interpreter is scheduled for a doctor’s appointment with a Deaf woman she has met before, but doesn’t know well. When the Deaf woman arrives, her Deaf husband is with her; he also has an appointment. The interpreter is fine with interpreting for each of them.

The doctor is a temporary replacement for their usual doctor. Neither of the couple has met him before. The doctor sees the woman first. Once in the examination room, she is very upset and says that her husband sexually assaulted her, and she wants the doctor to examine her to gather evidence so she can report her husband to the police. The doctor leaves her to get undressed, and goes with the interpreter into another examination room where the husband is.

Once there, the doctor tells the husband what the wife is alleging. The husband denies it, explaining that they had an argument this morning, and this is her way of trying to get back at him. The doctor states that he doesn’t want to get in the middle of a domestic dispute. He then proceeds to complete the appointment with the husband.

The doctor and interpreter go back to the room where the woman is. The doctor examines her, and then tells her there is no basis for her complaint, and she is being silly. The woman breaks down into tears. She gets dressed, and leaves with her husband.

INFORMATION ON DOMESTIC VIOLENCE

- Read more about what the American Medical Association has to say about medical professionals and reports of intimate partner abuse, as well as mandatory reporting requirements, at: www.virtualmentor.ama-assn.org/2007/12/oped1-0712.html

- To find additional information about domestic violence education within the Deaf community, visit: www.adwas.org/information/domesticviolence/
INPATIENT BEHAVIORAL UNIT

A male Deaf patient, from a Middle Eastern culture, is hospitalized in a behavioral health unit. The interpreter is asked to interpret a phone call between the patient and his parents. All patients are required to use a public phone, with a hospital staff member present during the call. The patient requests a pass to go off the unit to visit relatives, but his parents deny his request. The phone call evolves into a shouting match between the patient and his parents. As the conversation becomes more and more heated, the interpreter struggles to understand all the participants. The patient is so angry, and is signing rapidly. However, ASL is not his first signed language and he starts using signs in his native language. The parents’ English is heavily accented, and they continue to speak over the interpreter as she tries to interpret his comments. At the end of the phone call, the patient starts to berate the interpreter for not convincing his parents, and she begins to feel threatened. The staff member instructs the patient to cool off in his room, and he leaves. The interpreter is very shaken by the angry interchange and by the patient’s anger directed at her.

MEDICATION REFILL

An interpreter is called to an appointment at a walk-in medical clinic where a 30-year-old Deaf woman is waiting to be seen. The woman says she was in a car accident several months ago and injured her neck, and has ongoing pain. She wants to get a refill for her pain medication but couldn’t get in to see her regular doctor.

The appointment starts and the woman is crying and holding her neck, asking for the refill. The doctor asks her why she hasn’t gone back to her regular doctor, and the woman replies that his office is too far away and she needs the medication now. The doctor tells her he doesn’t believe her, that she is simply trying to get more drugs, and that he won’t write the prescription. The Deaf woman looks stunned and starts crying more, pleading for the medication. The doctor stands up and walks out of the office. The woman gets up and follows him, sobbing and pleading, with the interpreter following and voicing what she is saying. The doctor turns to the interpreter and says, “Tell her to leave and stop telling me what she’s saying. She is not getting that medication.”

DISCUSSION QUESTIONS

• What do you perceive to be the main demand in this scenario?
• What control(s) would you choose in this scenario?
• What concurrent demands might influence or be affected by the control choice(s)?
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• Where would the controls you choose fall on the liberal-conservative continuum?
**PAIN CONTROL**

A Deaf woman is hospitalized for extreme pain from advanced stage cancer. The physician and nurse want to create a palliative care plan for pain management with her. Hospital personnel talks with the patient and they agree that methadone would be the most effective pain control medication given her condition.

Her hearing husband arrives shortly thereafter, and objects to the plan. He is loud, dominating, and does not want his wife to have methadone. He states that methadone is used for heroin addicts, and his wife is not an addict. He adds that their religion believes that pain can be managed with prayer, and he will pray with his wife.

The on-call interpreter's shift has come to an end and she is replaced by another interpreter. The first interpreter lets the second interpreter know about relevant health information, including the husband's objections. As she prepares to leave, she wonders if she should say something to the nurse to encourage the staff to follow the patient's wishes, not the husband's.

**ULTRASOUND**

An interpreter is interpreting regularly for an expecting couple. At a regular visit, the expectant mother undergoes an ultrasound. At every appointment, both parents have been adamant that they do not want to know the baby's gender. At this particular appointment, however, the father is not present. In the small examination room, there is an ultrasound technician, the expectant mother, the interpreter, and other individuals whose roles are uncertain but they seem to be medical students, trainees, or residents.

The lead technician asks again if the mother would like to know the gender, and upon hearing the mother's response, turns the monitor away to prevent any accidental revelation. The mother comments that they have a son and are hoping for a girl this time.

As the medical personnel file out of the room allowing the expectant mother to gather her belongings, the interpreter takes a step back to allow them to pass. One of the “students,” grinning ear-to-ear, quietly states in passing to the interpreter, “They are not going to get what they want”—thus revealing the gender.
A 33-year-old Deaf woman, 24 weeks pregnant, is in the ICU. Eight days ago she awoke in the middle of the night with a tremendous headache. By the time her Deaf husband returned from asking the mother-in-law upstairs for help, she was unconscious on the floor. The doctors determined that she suffered an aneurysm and a significant brain bleed; she has been in a coma since then. The doctors have asked the family to attend a case conference with the hospital ethicist and ICU specialists who have been caring for the patient.

The interpreter has worked the eight days with the husband, and has also met the woman's two Deaf sisters. The husband is from Guatemala and his first signed language is Guatemalan Sign Language, and he is fluent in written Spanish. Although he is not yet fluent in English, he has a working knowledge of ASL. The wife and her family are Vietnamese immigrants, and the hearing family members speak Vietnamese and a little English, but are not fluent. The hospital has arranged for an English-Vietnamese interpreter for the meeting for the patient's parents, while the ASL interpreter provides interpreting services for the patient's husband and two sisters.

During the meeting, the doctors reveal that there is no brain stem activity and that to keep the patient alive for the sake of the fetus is a very problematic position, given that she has been in a coma. The Vietnamese interpreter begins talking with the family in very animated ways, and the ASL interpreter has no access to what is being said. The Deaf husband is very distraught and wants to know what to tell their two daughters and when to end life support. The two Deaf sisters are also very emotional and want to know what the interpreter and their parents are discussing.

When the doctor asks the Vietnamese interpreter to reveal what she is saying, she says she was sharing her experience of her mother, who was in a coma for 14 days. The mother awoke from the coma and was fine, and the interpreter states she is sharing this to help the family realize there is hope and to not disconnect life support. The ICU charge nurse interrupts the meeting to ask the ethicist to step out of the room to speak with another family. The two interpreters are in the room with the family members, another ICU
The Vietnamese interpreter begins speaking in English to the husband and sisters, providing advice about how they should not disconnect life support, that there is a chance the patient will live, and at the very least, the fetus might continue to grow in her body until there is a greater chance that the baby will live. She offers her opinion about Buddhist beliefs on life support. The Vietnamese interpreter’s beliefs are distinctly different than the husband’s Catholic beliefs, and he makes her aware of that in that moment. Amidst all of the high emotion as the ASL interpreter interprets for the Vietnamese interpreter, the ASL interpreter is aware that the parents have begun talking quietly with another doctor about removing life support at midnight, in keeping with their traditions, using their limited English to make the doctor aware of the family decision. They don’t appear to want to engage the husband in the conversation. The ASL interpreter knows the husband has not had any input into this decision, nor have the doctors asked him about his wishes.

**DISCUSSION QUESTIONS**

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The Need for Advocacy

LIPREADING

A Deaf senior citizen is admitted to the hospital for a small bowel obstruction. She is not eligible for a surgical procedure to remove the obstruction because of her age and health status. Instead, the doctors have inserted a tube through her nose and guided it to the obstruction in her small intestine in order to remove the blockage. If this procedure is successful, she will live.

The emergency on-call interpreter arrives and checks in at the unit desk. She asks if there are any precautions and finding there are none, goes to the patient's room to introduce herself and let the patient know interpreting services are available. Upon entering the room, the interpreter notices on the white board, written in large letters, “Patient can lipread.” She introduces herself to the patient, chats briefly to establish trust, and then informs the patient she'll be sitting in the hallway and available to interpret when the doctor arrives. She notes that the patient is using ASL, and understands ASL well. She wonders how comfortable the patient is with lipreading, and if she should say anything to the patient and/or the hospital staff.

PHYSICAL EXAMINATION OF DEAF-BLIND PATIENT

A 60-year-old Deaf-Blind man goes to his doctor with concerns about knee pain. He communicates using tactile signs, and the male interpreter is comfortable with this. He has met the patient several times in the past, but hasn't interpreted for him in this setting before. The patient has seen this doctor previously with different interpreters.

As the appointment progresses, the doctor wants the patient to perform a number of actions to identify where the pain is, and what seems to make it worse. The interpreter begins to interpret the instructions, but then the doctor physically grabs the patient and starts moving him into specific directions. The Deaf-Blind man looks startled, and the doctor's placement makes it impossible for the interpreter to reach the patient's hands.
VRI IN THE EMERGENCY ROOM

The interpreter works in a video relay service (VRS) setting that also receives video remote interpreting (VRI) calls. A VRI call comes and the interpreter sees a patient lying in bed, and a nurse. The male patient seems to be older and a bit frail. The interpreter introduces herself, and the nurse introduces the patient and then says, “We just want to know if he has any questions.”

The interpreter has no context to ask the question. From the room layout, it seems that the patient is in the emergency room, but there is no confirmation of this. The interpreter feels pressured to interpret and not ask questions, so she does this. The patient does not respond. The interpreter lets the nurse know that the patient is not responding and asks for clarification. The nurse says, “Well, the doctor wants to know if the patient has any questions.”

The interpreter wonders what happened previously. Was there another video interpreter? How did they communicate? Was it with pen and paper? Was a procedure done? A history taken? The patient seems very passive and as he watches the interpreter, he does not respond. The interpreter is unsure if he is heavily medicated and having difficulty understanding her, or if he has some kind of cognitive deficit. She is not sure how to ask this information with the patient watching everything. The nurse again asks if the patient has any questions, and states that if he doesn’t, she will leave.

The interpreter decides to try and get some context on what is going on. She asks the nurse, “Can you tell me what has happened so far?” The nurse responds that the doctor is reading the scan and wants to know if the patient has any questions.

The interpreter asks, “Was that a CT scan?” When the answer is affirmative, the interpreter tries asking the patient again with the added information about the CT scan. The patient still does not respond. After the interpreter notifies the nurse of this, the patient finally signs clearly, but weakly, that he is hungry and wants something to eat.

The nurse says, “Yes, I understand, but we have to wait for the doctor to read the scan to see if you can have anything to eat or drink.” The patient repeats what he wants, and the interpreter is voicing and signing this exchange. The nurse then asks, “Well, do you have any other questions?” The patient again does not respond to this. The interpreter tries to expand the question to see if she can get elicit any more of a response from the patient. After an extended time, the patient says, “No questions.”
OPERATING ROOM

A staff interpreter is scheduled to interpret for a surgery. The interpreter meets the patient at admitting and accompanies the patient to the pre-surgery area. This interpreter’s practice is to ask patients if they would like the interpreter to accompany them into the operating room until they are asleep. The operating room staff has always accepted and appreciated when interpreters accompany the patients. All of the staff interpreters know where the bunny suits are kept as well as the surgical caps and foot covers.

When asked about the interpreter accompanying him, the patient says "yes" without hesitation. A nurse assists the interpreter in getting prepped. The anesthesiologist comes in to review the routine pre-operation procedure and says to the patient, "You don't really need the interpreter to go in with you. She can introduce an unnecessary risk, such as an infection. I'm being serious here." The interpreter perceives the patient as feeling cornered into saying that he understands and will be fine without the interpreter, although he does not look completely comfortable.

The anesthesiologist looks at the interpreter and tries to get her to agree. This is not a new anesthesiologist; the interpreter has worked with him before. The interpreter is also feeling cornered, due to the strength of the anesthesiologist's statements. The anesthesiologist goes on to assure the patient that the interpreter is not even really needed in the operating room, and that she will be there in the recovery room when he wakes up.

DISCUSSION QUESTIONS

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PSYCHIATRIC ASSESSMENT

An interpreter is called to the emergency department, and told only that there is a Deaf patient there. When she arrives, she finds a Deaf man in his 40s. She starts a conversation with him, but he answers only with short responses, or else doesn't respond at all. Very quickly he is seen by hospital staff, and she discovers that he is being given a psychiatric assessment. The psychiatrist is working through a standard assessment. The patient often does not respond, but when he does, the interpreter has a difficult time understanding him. She considers three possibilities: that she does not have the language background to understand him, that he is not fluent in ASL, or that a mental health issue or medication is affecting his language. She tries to tell the psychiatrist this, and suggests that a CDI should be brought in. The psychiatrist says that he needs to do the assessment now, and she should just try to do her best.

PRENATAL ADVICE

A 25-year-old Deaf woman, originally from Turkey, has been in the country for five years. She has learned some ASL, but is not fluent in the language. She is shy and uncertain in interacting with Americans. Usually her Deaf husband, who is more fluent in ASL and more comfortable interacting, accompanies her, but he is unable to attend her prenatal appointment today. The interpreter has met the Deaf woman a few times and they have successfully communicated, so she feels qualified to interpret this appointment.

The woman has taken a home pregnancy test. She and her husband are delighted that she is pregnant with their first child. This is her first appointment with the doctor to discuss her pregnancy.

The doctor enters and begins to talk to her about genetic testing, and the risk of the baby being disabled. The woman begins to look very alarmed, and uncertain about what to do. He keeps talking about tests, disabilities, and the possible option of terminating the pregnancy. As the doctor continues to talk, the interpreter begins to get the sense that he is talking about the baby possibly being Deaf, although he never says this outright. The woman asks what could be wrong with her baby, but the doctor doesn't respond specifically to her question.

DISCUSSION QUESTIONS

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