Use of interpreting services in palliative care: does it improve the outcome of admissions?

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Communication is an essential component of palliative care. In multicultural Melbourne, the great diversity of languages and cultures often restricts the level and type of communication achieved between patients/families and their professional carers. At times, it is impossible to assess a patient without the assistance of an interpreter. Family are often called upon to help, a practice which some have criticised as being "unethical and uncivilised" (McAvo & Sayeed, 1990). Interpreters are available on request at most hospitals, but prior arrangements need to be made which is not always possible in emergency situations. In addition to differing languages, there are the associated differing priorities and attitudes towards care in the many cultural groups. This audit was carried out to review our clinical work with interpreters and the outcomes of interpreter interventions.

Caritas Christi, founded by Irish Sisters of Charity, is one of oldest hospices in Australia delivering palliative care for over 100 years. In April 1998, a major development occurred when Caritas opened a palliative care unit within St Vincent’s Hospital, Fitzroy, Melbourne, thus creating a palliative care ward within a major teaching hospital. Thirty-two percent of admissions to both sites of Caritas Christi (Kew and Fitzroy) are patients who are of a country of birth whose main language is other than English (LOTE). At the Fitzroy campus alone, in 1998, 191 of 351 (54%) admissions were LOTE. The major ethnic groups were Italian (62) Greek (32), Croatian (12), Polish (11) and Vietnamese (9).

Reasons for admission to the hospice remained as pain and symptom control, care of the dying patient, respite care for carers and palliative rehabilitation. The unit has close links with the acute hospitals, oncology centres, community-based palliative care services and other hospices. In addition, Caritas Christi provides a consult service to other inpatients within St Vincent’s Hospital.

Some of the important areas in which communication in palliative care plays a central role are as follows: initial assessment of patients on admission to the ward; discussion of their disease status, and responding to their questions about prognosis and further treatment options; eliciting patient preferences regarding end of life care (fluids, medications, withdrawal or withholding treatment), site of ongoing care and relevant arrangements for home-based terminal care, conducting counselling; exploring socioeconomic issues relevant to end of life care, contacting and supporting family carers and bereavement follow-up.

There are some frequently occurring issues, which arise in relation to the cultural differences between professional carers and patients/families. These include the prominence of family role differentiation and the different attitudes towards autonomy versus community responsibility; the attitudes towards certain medications, particularly opioids; the differing concepts of cancer as an illness; the attitudes towards disclosure of diagnosis and to whom; issues of Diaspora in which family
members may be widely dispersed; issues of trust in regard to host-culture health practices and preference for traditional methods of treatment; attitudes towards acceptance of incurability and ongoing attempts at curative treatment (Spruyt, 1999). With respect to disclosure, even when patients express a wish to be told the diagnosis, there can be misunderstanding about the degree of disclosure they expect and examples of severe distress and disbelief when actually told.

In view of the high proportion of patients of LOTE groups, we conducted this audit in part to raise awareness within the hospice of the importance of employment of professional interpreting services in delivery of care and to monitor the impact of interpreters on the quality of interviews.

The audit was conducted prospectively, with all interpreter interventions documented by the resident, specifying the reason for interview, who interpreted, and a subjective impression by the resident of the impact of the interpreter on the interview. A particular effort was made to use interpreters for all significant interviews during this audit period.

The audit was carried out during November 1998 and January 1999, by the then ward resident doctor, herself a first generation Australian of Korean/Vietnamese background. The residents rotate frequently through the palliative care service; this particular resident was there for a total of 10 weeks, with an interruption of one month (December) during annual leave. A good outcome was defined as clarification of previously unrecognised issues, achievement of more open communication with patient and / or family, achievement of practical outcomes such as effective discharge planning, better clinical diagnosis and symptom control. Rating was done by the resident herself. The rating is therefore only from the perspective of the treating team and we did not assess the views of the patient or carers independently.

During the audit period, 17 patients of LOTE were interviewed with a professional interpreter. The languages were Italian (8), Greek (4), Vietnamese (2), Hakkan (2), Turkish (1). The telephone interpreting service was not used during this audit. Interpreters used were Italian (6) -professional, 3 -medical; Vietnamese (2) -medical; Greek(2 )-professional, 1- professional, non-medical, Hakkan (2) -professional, Turkish (1)- professional. Family members interpreted on 6 occasions. LOTE patients accounted for 24 of 44 admissions over the two month period (54%). Interpreter interviews occurred with 70% of these patients. The reasons for interview were: discharge planning (6), admission assessment (10) ,ward round (2), review of patient’s deterioration (2) and clinical examination and review during admission (5), with a total of 25 interviews.

In 15 of the 17 patients, the outcome was improved by the intervention of using interpreter services for critical interviews. Several involved clarification of expectations of the outcome of the admission, be it terminal care or discharge planning for home based care. Families could be certain that their wishes were known and respected in regard to disclosure and ongoing treatment. Symptom control (pain, nausea, compliance with medications) were all improved when interpreters were used, with adjustments made in opioid doses after several interviews. Discharge planning was particularly assisted, with the patient able to participate in the planning, rather than a complete reliance on family members for such decisions and organisation.
Patients generally appreciated being part of the arrangements and learning about the plans for home-based follow-up by community palliative care.

Problems arose with use of interpreters in four patient/family groups. In the first, a Turkish speaking patient, two hospital interpreters were used in the one day, the first to assist in the admission evaluation and assessment of competency, and the second in the afternoon to assist in the family meeting. The patient felt uncomfortable about having to discuss his management with two interpreters. Conflict arose when an Italian family wished to protect their mother from bad news. However, when she developed a complication that required surgical management, she required more detail of her illness progression, in order to give informed consent to the operation. The patient was told with the help of the hospital interpreter and coped well with the news, gave consent and recovered well from her surgery, returning to hospice for terminal care some weeks later. Poor outcomes were documented in two cases. In one case, the patient was delirious and unable to be interviewed, with or without an interpreter. For the auditing resident, the most unsatisfactory outcome came in relation to a Greek speaking patient and family. Both the interpreter and family expressed concerns about disclosure of prognostic information. The resident felt that she had let the patient down by not being truthful about the team's expectations of terminal care rather than convalescence and improvement. The doctor's perception of personal dishonesty was a source of concern and a subsequent barrier to her caring for this patient and family.

Discussion

Professional interpreters were used for critical interviews. Clinicians felt that they improved the outcome of management in most instances, but recognised the areas of resistance and potential conflict which may arise. The sensitivity of issues arising in the palliative care context demands a high standard of care and communication in which interpreting services play a major part.

The impact of interpreting in such interviews on interpreters themselves needs more attention. In the palliative care team, there is considerable focus on mutual support and discussion of difficult clinical issues. Interpreters do not have immediate access to such team support. They may be identified by the patient as allies and so carry a significant burden of care. Strategies need to be developed to provide support and opportunities to participate in multidisciplinary meetings and other team activities designed to debrief staff. By such participation, staff awareness of cultural issues would also be heightened.

Conducting an interview through an interpreter is a particular communication skill. Staff have little or no training in this leading to considerable vulnerability for all concerned. Encountering resistance to the use of interpreters from patients or their families is not uncommon. The reasons for this reluctance need to be discussed and if possible, overcome, given the usual positive outcome when interpreters are used. Small communities may fear a lack of confidentiality. Patients may have had personal acquaintance with the interpreter socially. Close family units may express a preference to be self-reliant as a group. Families may have previously encountered expectations of health professionals that the family members act as the interpreters. These are all reasons for refusal of allowing a professional interpreter in the palliative care setting. Open discussion with key family members may reassure them of the benefits to the patient and themselves. Conflict may arise if the family continue to
refuse and patient care appears to be compromised as a result. This is rare and requires time and patience to address. Ultimately, professionals are accountable to the patient but the final judgement about the best approach may not be clear cut and indisputable. Respecting the family's need to have an easy mind after the patient has died is an important factor in decision making in this scenario.

References