Handouts

Handout #1
What Do You Know Already?

Circle the letter of the best answer to the question.

1. Which is the best definition of palliative care?
   a. An approach to health care aimed at keeping a patient comfortable at the end of life.
   b. A program to provide support for patients to die at home.
   c. An approach to health care aimed at treating symptoms instead of the cause of disease.
   d. An approach to managing pain.

In front of each term, write the letter of the best definition. Not all the definitions will be used.

2. ____ goals of care
3. ____ POLST
4. ____ chaplain
5. ____ quality of life
6. ____ respite care

a) A person who has been specially trained to offer support, prayer, and spiritual guidance to patients and their families.

b) An expression of the things that make life worth living for an individual patient.

c) A member of the clergy, such as a minister, a priest, a rabbi or a mullah.

d) A legal document that authorizes a particular person to make decisions for a patient if he or she cannot make them for him-or herself.

e) The degree to which a patient is free of pain.

f) A program that provides alternate care for a patient being cared for at home, in order to give the family caregivers a break.

g) A physician's order that specifies the limits to the types of interventions that a patient wants to have at the end of his or her life.

h) A patient or family's desired outcome from a course of care.

Handout #2
Why do we Need Palliative Care?

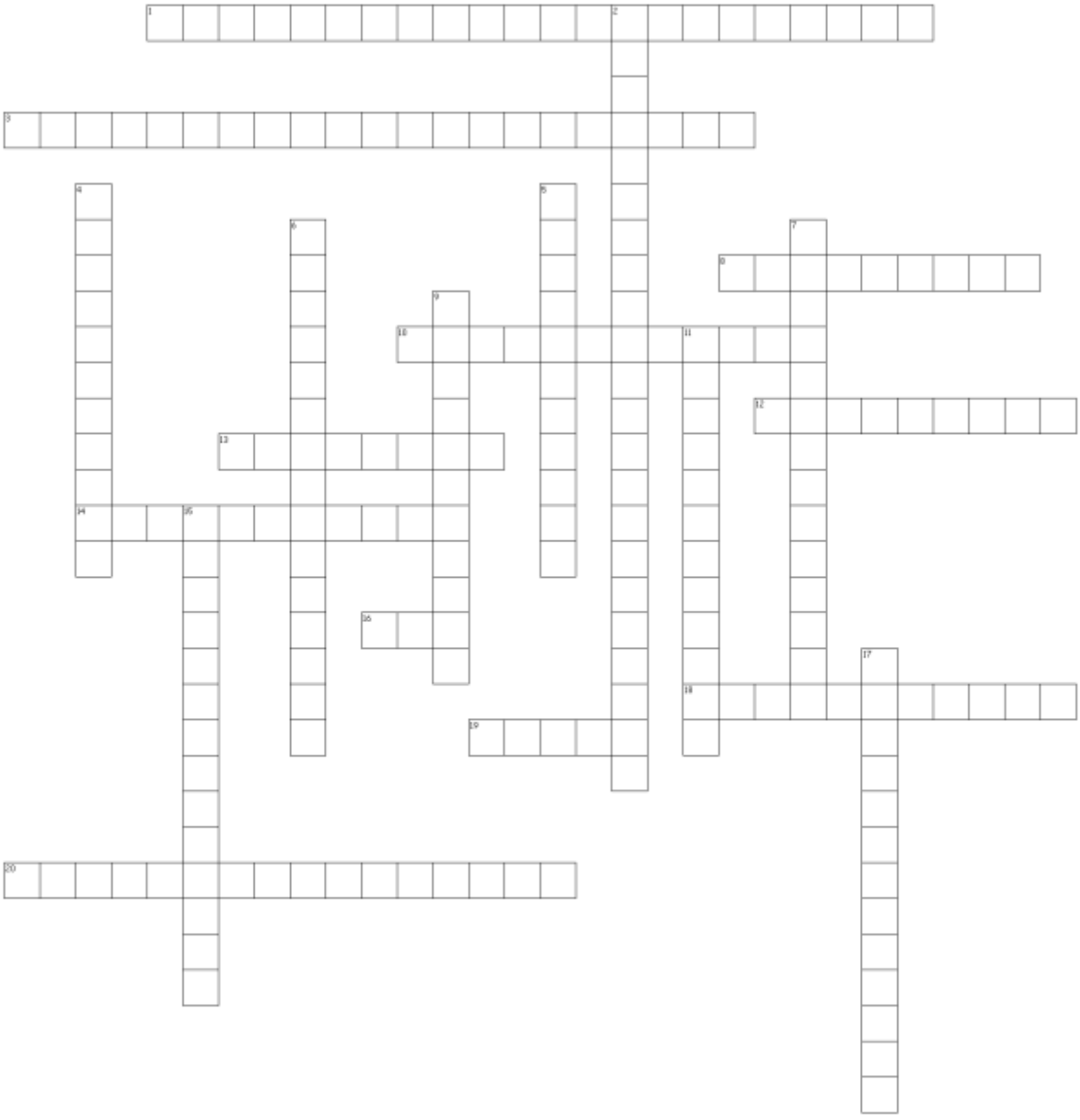
"It used to be that most people had a short illness and then died. Because there were no antibiotics, there were no cardiac cath labs, there was no angioplasty, if you had a heart attack, you died. You developed lung cancer, you died, within a relatively short period of time. You got pneumonia or meningitis or a bad urinary tract infection that spread to your blood stream, you died. People did not live to their eighties and nineties with chronic disease, even fifty or sixty years ago.

"But thanks to modern medicine, we have totally transformed the nature of what it is to be old, the nature of what it is to live with illness. Things that used to kill you quickly less than a hundred years ago, we now live with for years, sometimes decades, as chronic illnesses. So today, most of what medicine does is not cure; most of what medicine does is help you manage chronic disease. . . . . And that's cancer or heart disease or Parkinson's disease or dementia: things go on for a very long time."

"We've got to make those extra years worth having. Because if those extra years are completely miserable and disabled and stressful for everyone, you have to ask 'To what end?' So what we're saying is chronic disease management must include the skills of helping people live both as long as possible and as well as possible."

Dr. Diane Meyer, director of the Lillian and Benjamin Hertzberg Palliative Care Institute at Mt. Sinai, and of the National Center to Advance Palliative Care, speaking on THE OPEN MIND, 2/26/2011. To hear Dr. Meyer's entire speech, go to http://www.thirteen.org/openmind/health/palliative-medicine-care-versus-cure/2038/

Handout #3
Palliative Care Terminology
English Exercise #1



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Clues

Across

1. a person who may make health-related decisions on behalf of a patient who is not able to make decisions for himself
3. counseling to help deal with on-going sadness regarding a loved one who has died or who is dying
8. the likelihood of recovery from a disease or trauma
10. a healthcare facility that provides nursing care to patients over an extended period of time
12. a legal term referring to the person or persons most closely related by blood to an individual
13. an individual specially trained to offer support, prayer, and spiritual guidance to patients and their families
14. a program that sends temporary caretakers to a patient's home in order to give the principle caregiver a break
16. do-not-resuscitate order
18. examples of this: feeding tube, mechanical ventilation, dialysis
19. Physicians Orders for Life-Sustaining Treatment
20. This tells your doctor what kind of care you want if you should become unable to make medical decisions for yourself.

Down

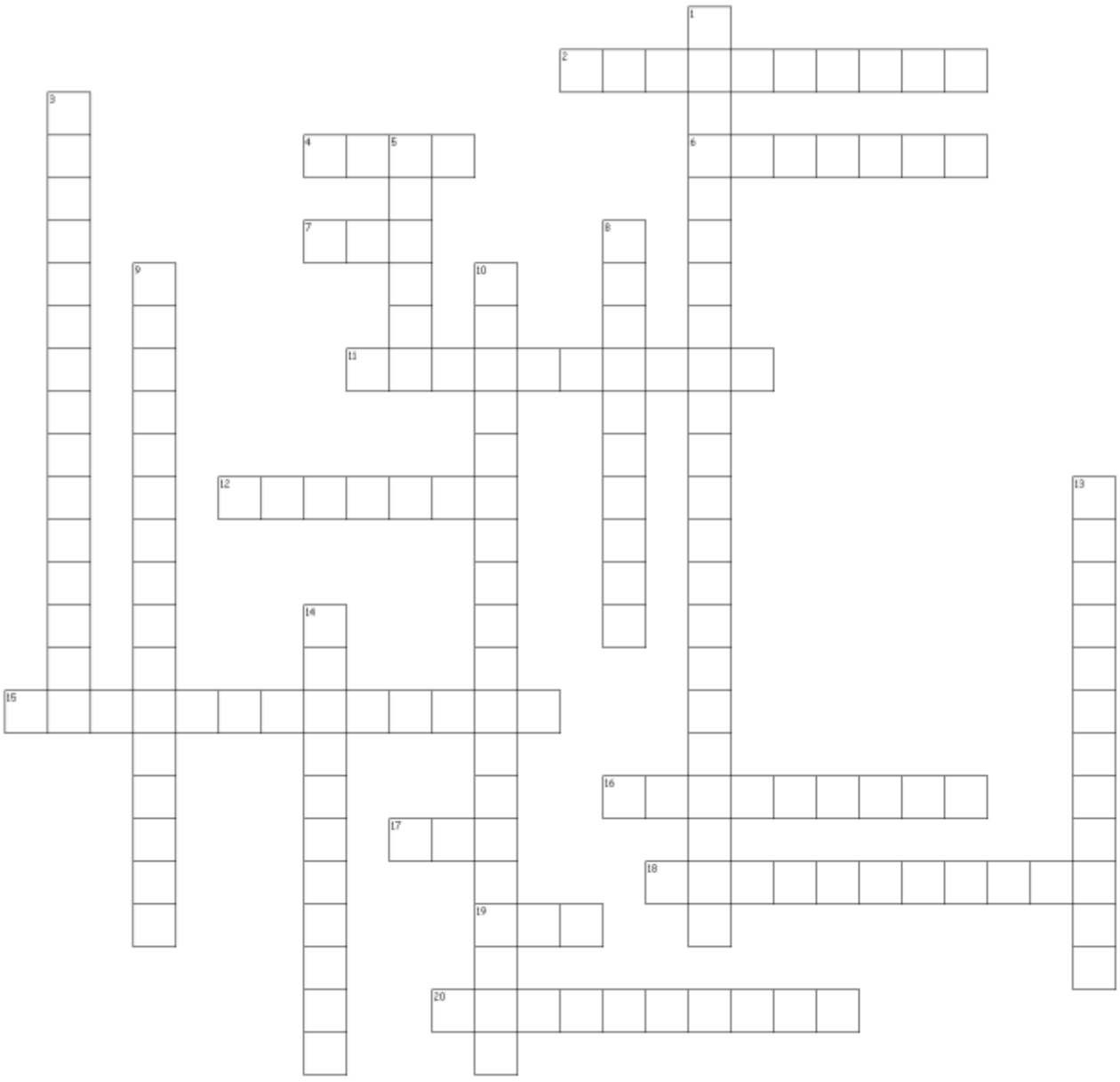
2. a residential facility that provides professional nursing care around the clock
4. the desired outcome from a specific treatment plan
5. a legal document in which an individual designates another person to make health care decisions if he cannot participate in medical decision-making, for any reason
6. a patient's closest relatives
7. a trained and certified healthcare worker who assists with personal hygiene and light housework for a homebound patient
9. a special way of caring for people during the last six months of life by meeting the patient's physical, emotional, social, and spiritual needs, as well as the needs of the family
11. the skills needed to emotionally handle difficult situations in life
15. care that focuses on improving a patient's quality of life and managing a patient's symptoms rather than on curing the cause of those symptoms
17. an expression of the actions, experiences, or feelings that make life worth living, for an individual patient

Answers

Across
1. surrogate decision maker
3. bereavement counseling
8. prognosis
10. a healthcare facility that provides nursing care to patients over an extended period of time
12. next-of-kin
13. chaplain
14. respite care
16. DNR
18. life support
19. Physicians Orders for Life-Sustaining Treatment
20. advance directive

Down
2. skilled nursing facility
4. goals of care
5. health proxy
6. immediate family
7. home health aide
9. hospice care
11. coping skills
15. palliative care
17. quality of life

Handout #4
Palliative Care Terminology
English Exercise #2



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Clues

Across

2. the insertion of an airway
4. a state of profound unconsciousness caused by disease, injury or poison
6. examination of the body in order to determine the cause of death
7. cardiopulmonary resuscitation
11. a machine that takes over breathing for the patient
12. a public official, usually elected, who investigates any death not due to natural causes
15. the giving of a patient's organs after his death for transplantation into another individual
16. anybody who provides direct care for a patient
17. intensive care unit
18. a tube placed into the stomach or small intestine to provide nutrition to a person who cannot eat or drink
19. persistent vegetative state
20. a condition in which even the most basic functions of the brain have stopped

Down

1. a legal document in which a patient designates a person to take legal action on his behalf in the case of an incapacitating medical condition
3. a qualified physician, appointed to the position, who investigates deaths not due to natural causes
5. an area where the body of the deceased is kept under refrigeration
8. the spread of a disease through the body
9. a machine that artificially takes over the function of the lungs and heart
10. the removal of all forms of life support
13. the inability to stay still
14. a commercial entity that prepares the deceased for burial or cremation and assists in preparing a funeral

Answers

Across
2. intubation
4. coma
6. autopsy
7. CPR
11. ventilator
12. a public official, usually elected, who investigates any death not due to natural causes
15. organ donation
16. caregiver
17. ICU
18. feeding tube
19. PVS
20. brain death

Down
1. durable power of attorney
3. medical examiner
5. morgue
8. metastasis
9. heart-lung machine
10. withdrawal of support
13. restlessness
14. funeral home

Handout #5, SP
Bilingual Glossary of Palliative Care Terms
English-Spanish

Term	***English Definition***	***Spanish Equivalent***
advance directive[i]	Advance directives are legal documents that describe a patient's treatment preferences and designate a surrogate decision-maker in the event that the person should become unable to make medical decisions for him or herself. Advance directives generally fall into two categories: those that designate surrogate decision makers (power of attorney for health care, healthcare proxy), and those that designate care instructions (living will, POLST, pre-hospital DNR).	directivas (f) médicas por adelantado declaración (f) de voluntades anticipadas
advance care planning	Decisions made by a patients about their wishes regarding interventions and care if a physical condition made it impossible them to communicate their wishes in the moment.	planificación (f) de cuidado anticipado
artificial nutrition and hydration	Means of life support providing calories, vitamins and minerals, either through feeding tubes or intravenously, to a patient who cannot eat or drink sufficiently by normal means.	hidratación (f) y nutrición (f) artificial
autopsy	An examination of the body in order to determine the cause of death, involving dissection of the remains.	autopsia (f)
bereavement counseling	Counseling to help deal with on-going sadness regarding a loved one who has died or who is dying.	consejería (f) por duelo
brain death	A clinical condition in which the most basic functions of the brain are gone, including basic reflexes and control of breathing, so that life can only be maintained through artificial means.	muerte (f) cerebral
caregiver	A person who provides direct care for a patient. Caregivers can be professionals, such as Home Health Aides, or simply caring individuals such as family and friends.	encargado(m) del cuidado

Term	*English Definition*	*Spanish Equivalent*
chaplain[ii]	An individual ordained or consecrated for religious ministry, specially trained to offer support, prayer, and spiritual guidance to patients and their families.	capellán (m) consejero (m) espiritual
coma	A state of profound unconsciousness caused by disease, injury or poison.	coma (m)
code status	A patient's "code status" tells providers whether a patient should be resuscitated or not should cardiac or respiratory arrest occur.	clave (f) de estado del paciente
comfort care	treatments that focus only on promoting comfort, not prolonging life artificially	cuidado (m) de confort
coping skills	The skills needed to emotionally handle difficult situations in life	destrezas (f) para afrontar a una situación difícil
coroner	A public official who investigates by inquest any death not due to natural causes. Coroners are usually elected officials, who may or may not possess any special training in investigating the cause of death.	official (m) de justicia que investiga los casos de muerte inexplicada
CPR (cardiopulmonary resuscitation)[i]	The emergency substitution of heart and lung action to restore life to someone who has ceased to breathe and whose heart is not pumping. The two main components of cardiopulmonary resuscitation (CPR) are chest compressions to force blood from the heart to the body, and artificial breathing by forcing air into the lungs (through mouth-to-mouth breathing or through medical equipment).	resucitación (f) cardiopulmonar
do-not-resuscitate order (DNR)[iii]	A doctor's written instructions not to attempt cardiopulmonary resuscitation (CPR) on a specific patient in the event of cardiac or respiratory arrest. The DNR order should be noted in a person's medical chart like any other medical order, and may be filed at hospitals, in private practice, with local emergency services, and with companies such as MedicAlert (which provides a bracelet to wear).	orden (f) de no resucitar

Term	*English Definition*	*Spanish Equivalent*
durable power of attorney[i]	A legal document in which a patient designates a specific individual to take legal action on his/her behalf in the case of an incapacitating medical condition. The general durable power of attorney allows an individual to make bank transactions, sign Social Security checks, apply for disability, or simply write checks to pay the utility bill while an individual is medically incapacitated. Compare with "durable power of attorney for health care."	poder(m) legal
durable power of attorney for health care	A legal document in which a patient designates a specific individual to make healthcare decisions on his or her behalf. A Durable Power of Attorney for Health Care does not allow the surrogate decision maker power over financial decisions. Note that when healthcare providers talk about a "durable power of attorney," they usually mean a durable power of attorney for health care.	poder (m) legal para cuidado de salud
feeding tube	A tube placed into the stomach or small intestine to provide nutrition to a person who cannot eat or drink.	sonda (f) de alimentación
funeral home	A commercial entity that prepares the deceased for burial or cremation and assists in preparing a funeral.	funeraria (f)
goals of care	A patient or family's desired outcome(s) from his or her medical care. In some cases, a complete eradication of a disease is the goal of care, while in others, the goal is to control pain, or to recover a degree of mobility.	objetivos del cuidado
health proxy[i]	A legal document in which an individual designates another person to make health care decisions if he or she cannot participate in medical decision-making, for any reason. This term also refers to the person who has been so designated. The health care proxy has, in essence, the same rights to request or refuse treatment that the individual would have if capable of making and communicating decisions.	documento (m) legal nombrando a un apoderado para decisiones médicas apoderado (m) para decisiones médicas

Term	***English Definition***	***Spanish Equivalent***
health status	The condition of an individual's health.	estado de salud
heart/lung machine	A machine that artificially takes over the function of the lungs and heart.	sistema (m) de circulación extracorporal
home health aide	A trained and certified healthcare worker who monitors a home-bound patient's condition and assists with personal hygiene and light housework.	asistente (m) del cuidado de salud en el hogar
hospice care[iii]	A special way of caring for people with terminal illnesses by meeting the patient's physical, emotional, social, and spiritual needs, as well as the needs of the family. The goals of hospice are to keep the patient as comfortable as possible by relieving pain and other symptoms; to prepare for a death that follows the wishes and needs of the patient; and to reassure both the patient and family members by helping them to understand and manage what is happening. To be eligible for hospice care, a physician must indicate that the patient is likely to die within six months.	programa (m) especial de cuidados paliativos para pacientes terminales cuyos doctores creen que van a morir dentro de seis meses
immediate family	A patient's closest relatives, usually considered to be parents, siblings, spouse and children.	familia (f) inmediata
intensive care unit (ICU)[iii]	A specialized part of the hospital designed for care of the critically ill whose conditions require constant monitoring.	unidad (f) de cuidados intensivos
intubation[i]	Endotracheal intubation is a procedure by which a tube is inserted through the mouth down into the trachea in order to enable mechanical ventilation, in a patient who cannot safely breathe on his or her own. Also referred to as "inserting an airway."	intubación (f)
life support	Equipment, material or treatment used to keep a seriously ill patient alive: e.g. artificial nutrition such as a feeding tube, mechanical ventilation, dialysis.	mantenimiento (m) artificial de la vida equipo (m) de prolongación de vida vida (f) artificial

Term	*English Definition*	*Spanish Equivalent*
living will[i]	A written document that specifies what types of medical treatments are desired under specific circumstances. The most common statement in a living will is to the effect that: If I suffer an incurable, irreversible illness, disease, or condition and my attending physician determines that my condition is terminal, I direct that life-sustaining measures that would serve only to prolong my dying be withheld or discontinued. More specific living wills may include an individual's desire for such services such as analgesia (pain relief), antibiotics, hydration, feeding, and the use of ventilators or cardiopulmonary resuscitation.	testamento (m) en vida
long-term care	A healthcare facility that provides nursing care to patients over an extended period of time.	cuidado (m) de largo plazo
Medical Examiner	A qualified physician, often with advanced training in forensic pathology (the application of medical knowledge to questions of the law), who investigates deaths not due to natural causes. Medical examiners are usually appointed to the position.	médico (m) forense
metastasis	The spread of a disease (usually cancer) from the initial site to another part of the body.	metástasis (m)
morgue	In a hospital, an area where the body of the deceased is kept under refrigeration until the funeral home can arrange for transport to the mortuary.	morgue (f) depósito (m) de cadáveres
next of kin	A legal term referring to the person or persons most closely related by blood to an individual. While not related by blood, a spouse is usually included as “next of kin.”	familiar (m) más cercano
organ donation	The act of giving permission for a patient’s organs to be harvested after his death for transplantation into another individual	donación (f) de órganos

Term	*English Definition*	*Spanish Equivalent*
palliative care	Care that focuses on improving a patient's quality of life and managing a patient's symptoms rather than on curing the cause of those symptoms. Palliative care is often used at the end of life, but it can also be used in conjunction with curative care. Palliative care usually involves a team of practitioners including physicians, nurses, social workers and chaplains; the care extends to a patient's family and will address spiritual and social concerns as well as physical problems.	cuidados(m) paliativos atención (f) paliativa
persistent vegetative state (PVS)[iv]	A clinical condition of complete unawareness of the self and environment. Even though PVS patients may exhibit sleep wake cycles, they show no evidence of response to or understanding of environmental stimuli. Unlike with a coma, there is no reasonable hope for recovery for those in a PVS. Although life expectancy for patients in a PVS is between two and five years, there are a number of cases where PVS patients are sustained on life support for decades. It has been estimated that there are somewhere between 15,000 and 35,000 PVS patients being sustained in the U.S. at any given time.	estado (m) vegetativo persistente estado (m) de coma
POLST	Physicians Orders for Life-Sustaining Treatment. A legal form, filled out by a patient with his or her physician, that instructs healthcare personnel as to what degree of interventional treatment the patient wants toward the end of his or her life.	órdenes (f) del médico para el tratamiento de mantenimiento artificial de la vida
pre-hospital DNR	A legal document, signed by a patient and his or her physician, whose purpose is to instruct Emergency Medical Services personnel NOT to resuscitate a patient if the patient's heart stops. The types of resuscitation covered in a DNR include chest compressions (as in CPR), assisted ventilation, endotracheal intubation, defibrillation, and medications that support resuscitation. The form does NOT affect treatment for any other kind of emergency medical condition such as bleeding, trauma or difficulty breathing.	órden (f) de no resucitar ortorgada antes de ingresar al hospital

Term	*English Definition*	*Spanish Equivalent*
prognosis	The likelihood of recovery from a disease or trauma, based on the normal course of the disease/condition or on the special circumstances of a particular case. When discussing terminal illnesses, some providers may use "prognosis" to mean "the estimated time remaining to live."	pronóstico (m)
quality of life	An expression of the actions, experiences, or feelings that make life worth living, for an individual patient.	calidad (f) de vida
respite care	A program that either sends temporary caretakers to a patient's home, or allows a patient to be admitted to a healthcare facility temporarily, in order to give the principle caregiver a break.	cuidado (m) temporal de reemplazo
restlessness	The inability to stay still, often involuntary	agitación (f)
skilled nursing facility[ii]	A residential facility that provides professional nursing care around the clock, usually along with rehabilitation	centro (m) de enfermería especializada
support	Actions and attitudes that help an individual or group. In palliative care, when providers talk about patient "support," they do not mean financial help but usually emotional and logistical help.	apoyo (m)
surrogate decision-maker	A person who may make health-related decisions on behalf of a patient who is not able to make decisions for himself. A surrogate may be designated verbally, by the patient, or legally, through a written Advance Directive or by the court.	sustituto (m) para la toma de decisiones
ventilator[ii]	A machine that takes over breathing for the patient, controlling the intake and expiration of air	respirador (m)
withdrawal of support	The removal of all forms of life support such as a ventilator, a feeding tube, or other treatment used to keep a seriously ill patient alive.	retiro (m) del mantenimiento artificial de la vida

[i] Definition from www.eMedicinehealth.com.
[ii] Definition from http://www.mywhatever.com/cifwriter/content/66/4620.html.
[iii] Definition from http://www.pbs.org/secondopinion/episodes/endoflife/medicalglossary.
[iv] Definition from http://www.dickinson.edu/endoflife/Glossary.html

Handout #5, MN
Bilingual Glossary of Palliative Care Terms
English-Simplified Chinese

Term	***English Definition***	***Simplified Chinese Equivalent***
advancedirective[i]	Advance directives are legal documents that describe a patient's treatment preferences and designate a surrogate decision-maker in the event that the person should become unable to make medical decisions for him or herself. Advance directives generally fall into two categories: those that designate surrogate decision makers (power of attorney for health care, healthcare proxy), and those that designate care instructions (living will, POLST, pre-hospital DNR).	医护服务事前指示书
advance care planning	Decisions made by a patients about their wishes regarding interventions and care if a physical condition made it impossible them to communicate their wishes in the moment.	**事前**护理计划
artificial nutrition and hydration	Means of life support providing calories, vitamins and minerals, either through feeding tubes or intravenously, to a patient who cannot eat or drink sufficiently by normal means.	**人工**营养和维持水分
autopsy	An examination of the body in order to determine the cause of death, involving dissection of the remains.	验尸
bereavement counseling	Counseling to help deal with on-going sadness regarding a loved one who has died or who is dying.	丧亲咨询
braindeath	A clinical condition in which the most basic functions of the brain are gone, including basic reflexes and control of breathing, so that life can only be maintained through artificial means.	脑死亡
caregiver	A person who provides direct care for a patient. Caregivers can be professionals, such as Home Health Aides, or simply caring individuals such as family and friends.	护理者

Term	***English Definition***	***Simplified Chinese Equivalent***
chaplain[ii]	An individual ordained or consecrated for religious ministry, specially trained to offer support, prayer, and spiritual guidance to patients and their families.	**牧**师[i]
coma	A state of profound unconsciousness caused by disease, injury or poison.v	**昏迷**
code status	A patient's "code status" tells providers whether a patient should be resuscitated or not should cardiac or respiratory arrest occur.	病者的维生决定
comfort care	treatments that focus only on promoting comfort, not prolonging life artificially	**舒适**护理
coping skills	The skills needed to emotionally handle difficult situations in life	应对技能
coroner	A public official who investigates by inquest any death not due to natural causes. Coroners are usually elected officials, who may or may not possess any special training in investigating the cause of death.	验尸官
CPR (cardiopulmonary resuscitation)[i]	The emergency substitution of heart and lung action to restore life to someone who has ceased to breathe and whose heart is not pumping. The two main components of cardiopulmonary resuscitation (CPR) are chest compressions to force blood from the heart to the body, and artificial breathing by forcing air into the lungs (through mouth-to-mouth breathing or through medical equipment).	**心肺**复苏术
do-not-resuscitate order (DNR)[iii]	A doctor's written instructions not to attempt cardiopulmonary resuscitation (CPR) on a specific patient in the event of cardiac or respiratory arrest. The DNR order should be noted in a person's medical chart like any other medical order, and may be filed at hospitals, in private practice, with local emergency services, and with companies such as MedicAlert (which provides a bracelet to wear).	**不施行心肺**复苏术医嘱

Term	*English Definition*	*Simplified Chinese Equivalent*
durable power of attorney[i]	A legal document in which a patient designates a specific individual to take legal action on his/her behalf in the case of an incapacitating medical condition. The general durable power of attorney allows an individual to make bank transactions, sign Social Security checks, apply for disability, or simply write checks to pay the utility bill while an individual is medically incapacitated. Compare with "durable power of attorney for health care."	**永久授**权书
durable power of attorney for health care	A legal document in which a patient designates a specific individual to make healthcare decisions on his or her behalf. A Durable Power of Attorney for Health Care does not allow the surrogate decision maker power over financial decisions. Note that when healthcare providers talk about a "durable power of attorney," they usually mean a durable power of attorney for health care.	**健康**护理永久授权书
feedingtube	A tube placed into the stomach or small intestine to provide nutrition to a person who cannot eat or drink.	胃管/给养管
funeral home	A commercial entity that prepares the deceased for burial or cremation and assists in preparing a funeral.	殡仪馆
goals of care	A patient or family's desired outcome(s) from his or her medical care.In some cases, a complete eradication of a disease is the goal of care, while in others, the goal is to control pain, or to recover a degree of mobility.	护理目标
healthproxy[i]	A legal document in which an individual designates another person to make health care decisions if he or she cannot participate in medical decision-making, for any reason. This term also refers to the person who has been so designated. The health care proxy has, in essence, the same rights to request or refuse treatment that the individual would have if capable of making and communicating decisions.	医护**代理人**

Term	*English Definition*	*Simplified Chinese Equivalent*
health status	The condition of an individual's health.	**健康状况**
heart/lung machine	A machine that artificially takes over the function of the lungs and heart.	**心/肺机**
home health aide	A trained and certified healthcare worker who monitors a home-bound patient's condition and assists with personal hygiene and light housework.	**家庭**保健助理
hospicecare[iii]	A special way of caring for people with terminal illnesses by meeting the patient's physical, emotional, social, and spiritual needs, as well as the needs of the family. The goals of hospice are to keep the patient as comfortable as possible by relieving pain and other symptoms; to prepare for a death that follows the wishes and needs of the patient; and to reassure both the patient and family members by helping them to understand and manage what is happening. To be eligible for hospice care, a physician must indicate that the patient is likely to die within six months.	临终护理
immediate family	A patient's closest relatives, usually considered to be parents, siblings, spouse and children.	**直系**亲属
intensive care unit (ICU)[iii]	A specialized part of the hospital designed for care of the critically ill whose conditions require constant monitoring.	**加**护病房/深切治疗部
intubation[i]	Endotracheal intubation is a procedure by which a tube is inserted through the mouth down into the trachea in order to enable mechanical ventilation, in a patient who cannot safely breathe on his or her own. Also referred to as "inserting an airway."	**插管**
life support	Equipment, material or treatment used to keep a seriously ill patient alive: e.g. artificial nutrition such as a feeding tube, mechanical ventilation, dialysis.	**生命**维持

Term	***English Definition***	***Simplified Chinese Equivalent***
livingwill[i]	A written document that specifies what types of medical treatments are desired under specific circumstances. The most common statement in a living will is to the effect that: If I suffer an incurable, irreversible illness, disease, or condition and my attending physician determines that my condition is terminal, I direct that life-sustaining measures that would serve only to prolong my dying be withheld or discontinued. More specific living wills may include an individual's desire for such services such as analgesia (pain relief), antibiotics, hydration, feeding, and the use of ventilators or cardiopulmonary resuscitation.	**生前**遗嘱
long-term care	A healthcare facility that provides nursing care to patients over an extended period of time.	长期护理
Medical Examiner	A qualified physician, often with advanced training in forensic pathology (the application of medical knowledge to questions of the law), who investigates deaths not due to natural causes. Medical examiners are usually appointed to the position.	验尸官
metastasis	The spread of a disease (usually cancer) from the initial site to another part of the body.	癌症转移
morgue	In a hospital, an area where the body of the deceased is kept under refrigeration until the funeral home can arrange for transport to the mortuary.	**停尸房**/陈**尸所**
next of kin	A legal term referring to the person or persons most closely related by blood to an individual. While not related by blood, a spouse is usually included as “next of kin.”	**最近**亲属/至亲
organ donation	The act of giving permission for a patient’s organs to be harvested after his death for transplantation into another individual	**器官捐**赠

Term	***English Definition***	***Simplified Chinese Equivalent***
palliative care	Care that focuses on improving a patient's quality of life and managing a patient's symptoms rather than on curing the cause of those symptoms. Palliative care is often used at the end of life, but it can also be used in conjunction with curative care. Palliative care usually involves a team of practitioners including physicians, nurses, social workers and chaplains; the care extends to a patient's family and will address spiritual and social concerns as well as physical problems.	**安宁**护理**/舒适**护理
persistent vegetative state (PVS)[iv]	A clinical condition of complete unawareness of the self and environment. Even though PVS patients may exhibit sleep wake cycles, they show no evidence of response to or understanding of environmental stimuli. Unlike with a coma, there is no reasonable hope for recovery for those in a PVS. Although life expectancy for patients in a PVS is between two and five years, there are a number of cases where PVS patients are sustained on life support for decades. It has been estimated that there are somewhere between 15,000 and 35,000 PVS patients being sustained in the U.S. at any given time.	**持**续性植物人状态
POLST	Physicians Orders for Life-Sustaining Treatment. A legal form, filled out by a patient with his or her physician, that instructs healthcare personnel as to what degree of interventional treatment the patient wants toward the end of his or her life.	维持生命治疗医嘱
pre-hospital DNR	A legal document, signed by a patient and his or her physician, whose purpose is to instruct Emergency Medical Services personnel NOT to resuscitate a patient if the patient's heart stops. The types of resuscitation covered in a DNR include chest compressions (as in CPR), assisted ventilation, endotracheal intubation, defibrillation, and medications that support resuscitation. The form does NOT affect treatment for any other kind of emergency medical condition such as bleeding, trauma or difficulty breathing.	**住院前**签署的**不做心肺**复苏术指示书

Term	*English Definition*	*Simplified Chinese Equivalent*
prognosis	The likelihood of recovery from a disease or trauma, based on the normal course of the disease/condition or on the special circumstances of a particular case. When discussing terminal illnesses, some providers may use "prognosis" to mean “the estimated time remaining to live."	预后
quality of life	An expression of the actions, experiences, or feelings that make life worth living, for an individual patient.	**生活素**质
respite care	A program that either sends temporary caretakers to a patient’s home, or allows a patient to be admitted to a healthcare facility temporarily, in order to give the principle caregiver a break.	暂缓护理
restlessness	The inability to stay still, often involuntary	**不安/心神不定**
skilled nursing facility[ii]	A residential facility that provides professional nursing care around the clock, usually along with rehabilitation	专业护理机构
support	Actions and attitudes that help an individual or group. In palliative care, when providers talk about patient “support,” they do not mean financial help but usually emotional and logistical help.	支撑/扶持
surrogate decision-maker	A person who may make health-related decisions on behalf of a patient who is not able to make decisions for himself. A surrogate may be designated verbally, by the patient, or legally, through a written Advance Directive or by the court.	**有**权做决定的代理人
ventilator[ii]	A machine that takes over breathing for the patient, controlling the intake and expiration of air	**呼吸机**
withdrawal of support	The removal of all forms of life support such as a ventilator, a feeding tube, or other treatment used to keep a seriously ill patient alive.	**撤走**维持生**命的**仪器

[i] Definition from www.eMedicinehealth.com.

[ii] Definition from http://www.mywhatever.com/cifwriter/content/66/4620.html.

[iii] Definition from http://www.pbs.org/secondopinion/episodes/endoflife/medicalglossary

[iv] Definition from http://www.dickinson.edu/endoflife/Glossary.html

Handout #5, MN
Bilingual Glossary of Palliative Care Terms
English-Traditional Chinese

Term	*English Definition*	*Traditional Chinese Equivalent*
advancedirective[i]	Advance directives are legal documents that describe a patient's treatment preferences and designate a surrogate decision-maker in the event that the person should become unable to make medical decisions for him or herself. Advance directives generally fall into two categories: those that designate surrogate decision makers (power of attorney for health care, healthcare proxy), and those that designate care instructions (living will, POLST, pre-hospital DNR).	醫護服務事前指示書
advance care planning	Decisions made by a patients about their wishes regarding interventions and care if a physical condition made it impossible them to communicate their wishes in the moment.	事前護理計劃
artificial nutrition and hydration	Means of life support providing calories, vitamins and minerals, either through feeding tubes or intravenously, to a patient who cannot eat or drink sufficiently by normal means.	人工營養和維持水分
autopsy	An examination of the body in order to determine the cause of death, involving dissection of the remains.	驗屍
bereavement counseling	Counseling to help deal with on-going sadness regarding a loved one who has died or who is dying.	喪親諮詢
braindeath	A clinical condition in which the most basic functions of the brain are gone, including basic reflexes and control of breathing, so that life can only be maintained through artificial means.	腦死亡
caregiver	A person who provides direct care for a patient. Caregivers can be professionals, such as Home Health Aides, or simply caring individuals such as family and friends.	護理者

Term	*English Definition*	*Traditional Chinese Equivalent*
chaplain[ii]	An individual ordained or consecrated for religious ministry, specially trained to offer support, prayer, and spiritual guidance to patients and their families.	牧師
coma	A state of profound unconsciousness caused by disease, injury or poison.v	昏迷
code status	A patient's "code status" tells providers whether a patient should be resuscitated or not should cardiac or respiratory arrest occur.	病者的維生決定狀態
comfort care	treatments that focus only on promoting comfort, not prolonging life artificially	舒適護理
coping skills	The skills needed to emotionally handle difficult situations in life	應對技能
coroner	A public official who investigates by inquest any death not due to natural causes. Coroners are usually elected officials, who may or may not possess any special training in investigating the cause of death.	驗屍官
CPR (cardiopulmonary resuscitation)[i]	The emergency substitution of heart and lung action to restore life to someone who has ceased to breathe and whose heart is not pumping. The two main components of cardiopulmonary resuscitation (CPR) are chest compressions to force blood from the heart to the body, and artificial breathing by forcing air into the lungs (through mouth-to-mouth breathing or through medical equipment).	心肺復甦術
do-not-resuscitate order (DNR)[iii]	A doctor's written instructions not to attempt cardiopulmonary resuscitation (CPR) on a specific patient in the event of cardiac or respiratory arrest. The DNR order should be noted in a person's medical chart like any other medical order, and may be filed at hospitals, in private practice, with local emergency services, and with companies such as MedicAlert (which provides a bracelet to wear).	不施行心肺復甦術醫囑

Term	*English Definition*	*Traditional Chinese Equivalent*
durable power of attorney[i]	A legal document in which a patient designates a specific individual to take legal action on his/her behalf in the case of an incapacitating medical condition. The general durable power of attorney allows an individual to make bank transactions, sign Social Security checks, apply for disability, or simply write checks to pay the utility bill while an individual is medically incapacitated. Compare with “durable power of attorney for health care.”	永久授權書
durable power of attorney for health care	A legal document in which a patient designates a specific individual to make healthcare decisions on his or her behalf. A Durable Power of Attorney for Health Care does not allow the surrogate decision maker power over financial decisions. Note that when healthcare providers talk about a “durable power of attorney,” they usually mean a durable power of attorney for health care.	健康護理永久授權書
feedingtube	A tube placed into the stomach or small intestine to provide nutrition to a person who cannot eat or drink.	胃管/給養管
funeral home	A commercial entity that prepares the deceased for burial or cremation and assists in preparing a funeral.	殯儀館
goals of care	A patient or family’s desired outcome(s) from his or her medical care.In some cases, a complete eradication of a disease is the goal of care, while in others, the goal is to control pain, or to recover a degree of mobility.	護理目標
healthproxy[i]	A legal document in which an individual designates another person to make health care decisions if he or she cannot participate in medical decision-making, for any reason. This term also refers to the person who has been so designated. The health care proxy has, in essence, the same rights to request or refuse treatment that the individual would have if capable of making and communicating decisions.	醫護代理人

Term	*English Definition*	*Traditional Chinese Equivalent*
health status	The condition of an individual's health.	健康狀況
heart/lung machine	A machine that artificially takes over the function of the lungs and heart.	心/肺機
home health aide	A trained and certified healthcare worker who monitors a home-bound patient's condition and assists with personal hygiene and light housework.	家庭保健助理
hospicecare[iii]	A special way of caring for people with terminal illnesses by meeting the patient's physical, emotional, social, and spiritual needs, as well as the needs of the family. The goals of hospice are to keep the patient as comfortable as possible by relieving pain and other symptoms; to prepare for a death that follows the wishes and needs of the patient; and to reassure both the patient and family members by helping them to understand and manage what is happening. To be eligible for hospice care, a physician must indicate that the patient is likely to die within six months.	臨終護理
immediate family	A patient's closest relatives, usually considered to be parents, siblings, spouse and children.	直系親屬
intensive care unit (ICU)[iii]	A specialized part of the hospital designed for care of the critically ill whose conditions require constant monitoring.	加護病房/深切治療部
intubation[i]	Endotracheal intubation is a procedure by which a tube is inserted through the mouth down into the trachea in order to enable mechanical ventilation, in a patient who cannot safely breathe on his or her own. Also referred to as "inserting an airway."	插管
life support	Equipment, material or treatment used to keep a seriously ill patient alive: e.g. artificial nutrition such as a feeding tube, mechanical ventilation, dialysis.	生命維持

Term	*English Definition*	*Traditional Chinese Equivalent*
livingwill[i]	A written document that specifies what types of medical treatments are desired under specific circumstances. The most common statement in a living will is to the effect that: If I suffer an incurable, irreversible illness, disease, or condition and my attending physician determines that my condition is terminal, I direct that life-sustaining measures that would serve only to prolong my dying be withheld or discontinued. More specific living wills may include an individual's desire for such services such as analgesia (pain relief), antibiotics, hydration, feeding, and the use of ventilators or cardiopulmonary resuscitation.	生前遺囑
long-term care	A healthcare facility that provides nursing care to patients over an extended period of time.	長期護理
Medical Examiner	A qualified physician, often with advanced training in forensic pathology (the application of medical knowledge to questions of the law), who investigates deaths not due to natural causes. Medical examiners are usually appointed to the position.	驗屍官
metastasis	The spread of a disease (usually cancer) from the initial site to another part of the body.	癌症轉移
morgue	In a hospital, an area where the body of the deceased is kept under refrigeration until the funeral home can arrange for transport to the mortuary.	停屍房/陳屍所
next of kin	A legal term referring to the person or persons most closely related by blood to an individual. While not related by blood, a spouse is usually included as “next of kin.”	最近親屬/至親
organ donation	The act of giving permission for a patient’s organs to be harvested after his death for transplantation into another individual	器官捐贈

Term	*English Definition*	*Traditional Chinese Equivalent*
palliative care	Care that focuses on improving a patient's quality of life and managing a patient's symptoms rather than on curing the cause of those symptoms. Palliative care is often used at the end of life, but it can also be used in conjunction with curative care. Palliative care usually involves a team of practitioners including physicians, nurses, social workers and chaplains; the care extends to a patient's family and will address spiritual and social concerns as well as physical problems.	安寧護理/舒適護理
persistent vegetative state (PVS)[iv]	A clinical condition of complete unawareness of the self and environment. Even though PVS patients may exhibit sleep wake cycles, they show no evidence of response to or understanding of environmental stimuli. Unlike with a coma, there is no reasonable hope for recovery for those in a PVS. Although life expectancy for patients in a PVS is between two and five years, there are a number of cases where PVS patients are sustained on life support for decades. It has been estimated that there are somewhere between 15,000 and 35,000 PVS patients being sustained in the U.S. at any given time.	持續性植物人狀態
POLST	Physicians Orders for Life-Sustaining Treatment. A legal form, filled out by a patient with his or her physician, that instructs healthcare personnel as to what degree of interventional treatment the patient wants toward the end of his or her life.	維持生命治療醫囑
pre-hospital DNR	A legal document, signed by a patient and his or her physician, whose purpose is to instruct Emergency Medical Services personnel NOT to resuscitate a patient if the patient's heart stops. The types of resuscitation covered in a DNR include chest compressions (as in CPR), assisted ventilation, endotracheal intubation, defibrillation, and medications that support resuscitation. The form does NOT affect treatment for any other kind of emergency medical condition such as bleeding, trauma or difficulty breathing.	住院前簽署的不做心肺復甦術指示書

Term	*English Definition*	*Traditional Chinese Equivalent*
prognosis	The likelihood of recovery from a disease or trauma, based on the normal course of the disease/condition or on the special circumstances of a particular case. When discussing terminal illnesses, some providers may use "prognosis" to mean “the estimated time remaining to live."	預後
quality of life	An expression of the actions, experiences, or feelings that make life worth living, for an individual patient.	生活素質
respite care	A program that either sends temporary caretakers to a patient’s home, or allows a patient to be admitted to a healthcare facility temporarily, in order to give the principle caregiver a break.	暫緩護理
restlessness	The inability to stay still, often involuntary	不安/心神不定
skilled nursing facility[ii]	A residential facility that provides professional nursing care around the clock, usually along with rehabilitation	專業護理機構
support	Actions and attitudes that help an individual or group. In palliative care, when providers talk about patient “support,” they do not mean financial help but usually emotional and logistical help.	支撐/扶持
surrogate decision-maker	A person who may make health-related decisions on behalf of a patient who is not able to make decisions for himself. A surrogate may be designated verbally, by the patient, or legally, through a written Advance Directive or by the court.	有權做決定的代理人
ventilator[ii]	A machine that takes over breathing for the patient, controlling the intake and expiration of air	呼吸機
withdrawal of support	The removal of all forms of life support such as a ventilator, a feeding tube, or other treatment used to keep a seriously ill patient alive.	撤走維持生命的儀器

[i] Definition from www.eMedicinehealth.com. [iii] Definition from http://www.pbs.org/secondopinion/episodes/endoflife/medicalglossary
[ii] Definition from http://www.mywhatever.com/cifwriter/content/66/4620.html [iv] Definition from http://www.dickinson.edu/endoflife/Glossary.html

Handout #5, VT
Bilingual Glossary of Palliative Care Terms
English-Vietnamese

Term	***English Definition***	***Vietnamese Equivalent***
advance directive[i]	Advance directives are legal documents that describe a patient's treatment preferences and designate a surrogate decision-maker in the event that the person should become unable to make medical decisions for him or herself. Advance directives generally fall into two categories: those that designate surrogate decision makers (power of attorney for health care, healthcare proxy), and those that designate care instructions (living will, POLST, pre-hospital DNR).	chỉ thị trước
advance care planning	Decisions made by a patients about their wishes regarding interventions and care if a physical condition made it impossible them to communicate their wishes in the moment.	lập kế hoạch chăm sóc trước
artificial nutrition and hydration	Means of life support providing calories, vitamins and minerals, either through feeding tubes or intravenously, to a patient who cannot eat or drink sufficiently by normal means.	truyền dinh dưỡng và nước nhân tạo
autopsy	An examination of the body in order to determine the cause of death, involving dissection of the remains.	khám nghiệm tử thi
bereavement counseling	Counseling to help deal with on-going sadness regarding a loved one who has died or who is dying.	tư vấn về việc mất người thân
brain death	A clinical condition in which the most basic functions of the brain are gone, including basic reflexes and control of breathing, so that life can only be maintained through artificial means.	chết não
caregiver	A person who provides direct care for a patient. Caregivers can be professionals, such as Home Health Aides, or simply caring individuals such as family and friends.	người chăm sóc

Term	*English Definition*	*Vietnamese Equivalent*
chaplain[ii]	An individual ordained or consecrated for religious ministry, specially trained to offer support, prayer, and spiritual guidance to patients and their families.	cha tuyên úy
coma	A state of profound unconsciousness caused by disease, injury or poison.	hôn mê
code status	A patient's "code status" tells providers whether a patient should be resuscitated or not should cardiac or respiratory arrest occur.	mã chỉ định hồi sinh
comfort care	treatments that focus only on promoting comfort, not prolonging life artificially	chăm sóc an ủi
coping skills	The skills needed to emotionally handle difficult situations in life	kỹ năng đối phó
coroner	A public official who investigates by inquest any death not due to natural causes. Coroners are usually elected officials, who may or may not possess any special training in investigating the cause of death.	nhân viên điều tra các vụ chết bất thường
CPR (cardiopulmonary resuscitation)[i]	The emergency substitution of heart and lung action to restore life to someone who has ceased to breathe and whose heart is not pumping. The two main components of cardiopulmonary resuscitation (CPR) are chest compressions to force blood from the heart to the body, and artificial breathing by forcing air into the lungs (through mouth-to-mouth breathing or through medical equipment).	hồi sức tim phổi
do-not-resuscitate order (DNR)[iii]	A doctor's written instructions not to attempt cardiopulmonary resuscitation (CPR) on a specific patient in the event of cardiac or respiratory arrest. The DNR order should be noted in a person's medical chart like any other medical order, and may be filed at hospitals, in private practice, with local emergency services, and with companies such as MedicAlert (which provides a bracelet to wear).	chỉ định không hồi sinh

Term	*English Definition*	*Vietnamese Equivalent*
durable power of attorney[i]	A legal document in which a patient designates a specific individual to take legal action on his/her behalf in the case of an incapacitating medical condition. The general durable power of attorney allows an individual to make bank transactions, sign Social Security checks, apply for disability, or simply write checks to pay the utility bill while an individual is medically incapacitated. Compare with "durable power of attorney for health care."	quyền đại diện dài hạn
durable power of attorney for health care	A legal document in which a patient designates a specific individual to make healthcare decisions on his or her behalf. A Durable Power of Attorney for Health Care does not allow the surrogate decision maker power over financial decisions. Note that when healthcare providers talk about a "durable power of attorney," they usually mean a durable power of attorney for health care.	quyền đại diện dài hạn về chăm sóc sức khỏe
feeding tube	A tube placed into the stomach or small intestine to provide nutrition to a person who cannot eat or drink.	ống nuôi ăn
funeral home	A commercial entity that prepares the deceased for burial or cremation and assists in preparing a funeral.	nhà tang lễ
goals of care	A patient or family's desired outcome(s) from his or her medical care. In some cases, a complete eradication of a disease is the goal of care, while in others, the goal is to control pain, or to recover a degree of mobility.	mục tiêu chăm sóc
health proxy[i]	A legal document in which an individual designates another person to make health care decisions if he or she cannot participate in medical decision-making, for any reason. This term also refers to the person who has been so designated. The health care proxy has, in essence, the same rights to request or refuse treatment that the individual would have if capable of making and communicating decisions.	ủy quyền chăm sóc sức khỏe

Term	***English Definition***	***Vietnamese Equivalent***
health status	The condition of an individual's health.	tình hình sức khỏe
heart/lung machine	A machine that artificially takes over the function of the lungs and heart.	máy trợ tim/phổi
home health aide	A trained and certified healthcare worker who monitors a home-bound patient's condition and assists with personal hygiene and light housework.	người hỗ trợ chăm sóc sức khỏe tại gia
hospice care[iii]	A special way of caring for people with terminal illnesses by meeting the patient's physical, emotional, social, and spiritual needs, as well as the needs of the family. The goals of hospice are to keep the patient as comfortable as possible by relieving pain and other symptoms; to prepare for a death that follows the wishes and needs of the patient; and to reassure both the patient and family members by helping them to understand and manage what is happening. To be eligible for hospice care, a physician must indicate that the patient is likely to die within six months.	chăm sóc cuối đời
immediate family	A patient's closest relatives, usually considered to be parents, siblings, spouse and children.	gia đình trực hệ
intensive care unit (ICU)[iii]	A specialized part of the hospital designed for care of the critically ill whose conditions require constant monitoring.	khoa chăm sóc tập trung
intubation[i]	Endotracheal intubation is a procedure by which a tube is inserted through the mouth down into the trachea in order to enable mechanical ventilation, in a patient who cannot safely breathe on his or her own. Also referred to as "inserting an airway."	đặt ống
life support	Equipment, material or treatment used to keep a seriously ill patient alive: e.g. artificial nutrition such as a feeding tube, mechanical ventilation, dialysis.	hỗ trợ sự sống

Term	*English Definition*	*Vietnamese Equivalent*
living will[i]	A written document that specifies what types of medical treatments are desired under specific circumstances. The most common statement in a living will is to the effect that: If I suffer an incurable, irreversible illness, disease, or condition and my attending physician determines that my condition is terminal, I direct that life-sustaining measures that would serve only to prolong my dying be withheld or discontinued. More specific living wills may include an individual's desire for such services such as analgesia (pain relief), antibiotics, hydration, feeding, and the use of ventilators or cardiopulmonary resuscitation.	di chúc sống
long-term care	A healthcare facility that provides nursing care to patients over an extended period of time.	chăm sóc dài hạn
Medical Examiner	A qualified physician, often with advanced training in forensic pathology (the application of medical knowledge to questions of the law), who investigates deaths not due to natural causes. Medical examiners are usually appointed to the position.	Nhân Viên Pháp Y
metastasis	The spread of a disease (usually cancer) from the initial site to another part of the body.	di căn
morgue	In a hospital, an area where the body of the deceased is kept under refrigeration until the funeral home can arrange for transport to the mortuary.	nhà xác
next of kin	A legal term referring to the person or persons most closely related by blood to an individual. While not related by blood, a spouse is usually included as “next of kin.”	người có quan hệ thân thuộc nhất
organ donation	The act of giving permission for a patient’s organs to be harvested after his death for transplantation into another individual	hiến tặng nội tạng

Term	***English Definition***	***Vietnamese Equivalent***
palliative care	Care that focuses on improving a patient's quality of life and managing a patient's symptoms rather than on curing the cause of those symptoms. Palliative care is often used at the end of life, but it can also be used in conjunction with curative care. Palliative care usually involves a team of practitioners including physicians, nurses, social workers and chaplains; the care extends to a patient's family and will address spiritual and social concerns as well as physical problems.	chăm sóc giảm đau / chăm sóc an ủi
persistent vegetative state (PVS)[iv]	A clinical condition of complete unawareness of the self and environment. Even though PVS patients may exhibit sleep wake cycles, they show no evidence of response to or understanding of environmental stimuli. Unlike with a coma, there is no reasonable hope for recovery for those in a PVS. Although life expectancy for patients in a PVS is between two and five years, there are a number of cases where PVS patients are sustained on life support for decades. It has been estimated that there are somewhere between 15,000 and 35,000 PVS patients being sustained in the U.S. at any given time.	trạng thái thực vật lâu dài
POLST	Physicians Orders for Life-Sustaining Treatment. A legal form, filled out by a patient with his or her physician, that instructs healthcare personnel as to what degree of interventional treatment the patient wants toward the end of his or her life.	Lệnh Bác Sĩ Điều Trị Duy Trì Mạng Sống
pre-hospital DNR	A legal document, signed by a patient and his or her physician, whose purpose is to instruct Emergency Medical Services personnel NOT to resuscitate a patient if the patient's heart stops. The types of resuscitation covered in a DNR include chest compressions (as in CPR), assisted ventilation, endotracheal intubation, defibrillation, and medications that support resuscitation. The form does NOT affect treatment for any other kind of emergency medical condition such as bleeding, trauma or difficulty breathing.	DNR trước khi nhập viện

Term	*English Definition*	*Vietnamese Equivalent*
prognosis	The likelihood of recovery from a disease or trauma, based on the normal course of the disease/condition or on the special circumstances of a particular case. When discussing terminal illnesses, some providers may use "prognosis" to mean “the estimated time remaining to live."	tiên lượng bệnh
quality of life	An expression of the actions, experiences, or feelings that make life worth living, for an individual patient.	chất lượng sống
respite care	A program that either sends temporary caretakers to a patient’s home, or allows a patient to be admitted to a healthcare facility temporarily, in order to give the principle caregiver a break.	dịch vụ chăm sóc thay tạm thời
restlessness	The inability to stay still, often involuntary	bất an
skilled nursing facility[ii]	A residential facility that provides professional nursing care around the clock, usually along with rehabilitation	cơ sở điều dưỡng chuyên môn
support	Actions and attitudes that help an individual or group. In palliative care, when providers talk about patient “support,” they do not mean financial help but usually emotional and logistical help.	hỗ trợ
surrogate decision-maker	A person who may make health-related decisions on behalf of a patient who is not able to make decisions for himself. A surrogate may be designated verbally, by the patient, or legally, through a written Advance Directive or by the court.	người ra quyết định thay thế
ventilator[ii]	A machine that takes over breathing for the patient, controlling the intake and expiration of air	máy hô hấp nhân tạo
withdrawal of support	The removal of all forms of life support such as a ventilator, a feeding tube, or other treatment used to keep a seriously ill patient alive.	rút lại sự hỗ trợ

[i] Definition from www.eMedicinehealth.com.
[ii] Definition from http://www.mywhatever.com/cifwriter/content/66/4620.html.
[iii] Definition from http://www.pbs.org/secondopinion/episodes/endoflife/medicalglossary/story436.html.
[iv] Definition from http://www.dickinson.edu/endoflife/Glossary.html

Handout #5, KR
Bilingual Glossary of Palliative Care Terms
English-Korean

Term	***English Definition***	***Korean Equivalent***
advance directive[i]	Advance directives are legal documents that describe a patient's treatment preferences and designate a surrogate decision-maker in the event that the person should become unable to make medical decisions for him or herself. Advance directives generally fall into two categories: those that designate surrogate decision makers (power of attorney for health care, healthcare proxy), and those that designate care instructions (living will, POLST, pre-hospital DNR).	사전의료지시서
advance care planning	Decisions made by a patients about their wishes regarding interventions and care if a physical condition made it impossible them to communicate their wishes in the moment.	사전의료계획
artificial nutrition and hydration	Means of life support providing calories, vitamins and minerals, either through feeding tubes or intravenously, to a patient who cannot eat or drink sufficiently by normal means.	인위적 영양 및 수분공급
autopsy	An examination of the body in order to determine the cause of death, involving dissection of the remains.	부검
bereavement counseling	Counseling to help deal with on-going sadness regarding a loved one who has died or who is dying.	사별 카운셀링
brain death	A clinical condition in which the most basic functions of the brain are gone, including basic reflexes and control of breathing, so that life can only be maintained through artificial means.	뇌사
caregiver	A person who provides direct care for a patient. Caregivers can be professionals, such as Home Health Aides, or simply caring individuals such as family and friends.	간병인

Term	*English Definition*	*Korean Equivalent*
chaplain[ii]	An individual ordained or consecrated for religious ministry, specially trained to offer support, prayer, and spiritual guidance to patients and their families.	성직자
coma	A state of profound unconsciousness caused by disease, injury or poison.v	혼수상태
code status	A patient's "code status" tells providers whether a patient should be resuscitated or not should cardiac or respiratory arrest occur.	코드 현황
comfort care	treatments that focus only on promoting comfort, not prolonging life artificially	완화의료
coping skills	The skills needed to emotionally handle difficult situations in life	대처기술
coroner	A public official who investigates by inquest any death not due to natural causes. Coroners are usually elected officials, who may or may not possess any special training in investigating the cause of death.	검시관
CPR (cardiopulmonary resuscitation)[i]	The emergency substitution of heart and lung action to restore life to someone who has ceased to breathe and whose heart is not pumping. The two main components of cardiopulmonary resuscitation (CPR) are chest compressions to force blood from the heart to the body, and artificial breathing by forcing air into the lungs (through mouth-to-mouth breathing or through medical equipment).	심폐소생술
do-not-resuscitate order (DNR)[iii]	A doctor's written instructions not to attempt cardiopulmonary resuscitation (CPR) on a specific patient in the event of cardiac or respiratory arrest. The DNR order should be noted in a person's medical chart like any other medical order, and may be filed at hospitals, in private practice, with local emergency services, and with companies such as MedicAlert (which provides a bracelet to wear).	심폐소생술 금지서

Term	*English Definition*	*Korean Equivalent*
durable power of attorney[i]	A legal document in which a patient designates a specific individual to take legal action on his/her behalf in the case of an incapacitating medical condition. The general durable power of attorney allows an individual to make bank transactions, sign Social Security checks, apply for disability, or simply write checks to pay the utility bill while an individual is medically incapacitated. Compare with "durable power of attorney for health care."	항구적 법적위임장
durable power of attorney for health care	A legal document in which a patient designates a specific individual to make healthcare decisions on his or her behalf. A Durable Power of Attorney for Health Care does not allow the surrogate decision maker power over financial decisions. Note that when healthcare providers talk about a "durable power of attorney," they usually mean a durable power of attorney for health care.	의료관련 법적위임장
feeding tube	A tube placed into the stomach or small intestine to provide nutrition to a person who cannot eat or drink.	급식관
funeral home	A commercial entity that prepares the deceased for burial or cremation and assists in preparing a funeral.	장의사
goals of care	A patient or family's desired outcome(s) from his or her medical care. In some cases, a complete eradication of a disease is the goal of care, while in others, the goal is to control pain, or to recover a degree of mobility.	의료 목표
health proxy[i]	A legal document in which an individual designates another person to make health care decisions if he or she cannot participate in medical decision-making, for any reason. This term also refers to the person who has been so designated. The health care proxy has, in essence, the same rights to request or refuse treatment that the individual would have if capable of making and communicating decisions.	의료관련 위임장 의료관련 대리인

Term	***English Definition***	***Korean Equivalent***
health status	The condition of an individual's health.	건강 상태
heart/lung machine	A machine that artificially takes over the function of the lungs and heart.	심폐기
home health aide	A trained and certified healthcare worker who monitors a home-bound patient's condition and assists with personal hygiene and light housework.	가정간호인
hospice care[iii]	A special way of caring for people with terminal illnesses by meeting the patient's physical, emotional, social, and spiritual needs, as well as the needs of the family. The goals of hospice are to keep the patient as comfortable as possible by relieving pain and other symptoms; to prepare for a death that follows the wishes and needs of the patient; and to reassure both the patient and family members by helping them to understand and manage what is happening. To be eligible for hospice care, a physician must indicate that the patient is likely to die within six months.	호스피스 간호
immediate family	A patient's closest relatives, usually considered to be parents, siblings, spouse and children.	직계 가족
intensive care unit (ICU)[iii]	A specialized part of the hospital designed for care of the critically ill whose conditions require constant monitoring.	중환자실
intubation[i]	Endotracheal intubation is a procedure by which a tube is inserted through the mouth down into the trachea in order to enable mechanical ventilation, in a patient who cannot safely breathe on his or her own. Also referred to as "inserting an airway."	삽관[i]
life support	Equipment, material or treatment used to keep a seriously ill patient alive: e.g. artificial nutrition such as a feeding tube, mechanical ventilation, dialysis.	생명유지 보조장치

Term	***English Definition***	***Korean Equivalent***
living will[i]	A written document that specifies what types of medical treatments are desired under specific circumstances. The most common statement in a living will is to the effect that: If I suffer an incurable, irreversible illness, disease, or condition and my attending physician determines that my condition is terminal, I direct that life-sustaining measures that would serve only to prolong my dying be withheld or discontinued. More specific living wills may include an individual's desire for such services such as analgesia (pain relief), antibiotics, hydration, feeding, and the use of ventilators or cardiopulmonary resuscitation.	사망선택 유언장
long-term care	A healthcare facility that provides nursing care to patients over an extended period of time.	장기요양원
Medical Examiner	A qualified physician, often with advanced training in forensic pathology (the application of medical knowledge to questions of the law), who investigates deaths not due to natural causes. Medical examiners are usually appointed to the position.	법의관
metastasis	The spread of a disease (usually cancer) from the initial site to another part of the body.	전이
morgue	In a hospital, an area where the body of the deceased is kept under refrigeration until the funeral home can arrange for transport to the mortuary.	시신안치소
next of kin	A legal term referring to the person or persons most closely related by blood to an individual. While not related by blood, a spouse is usually included as “next of kin.”	근친자 (부모, 자식, 형제, 자매, 배우자)
organ donation	The act of giving permission for a patient’s organs to be harvested after his death for transplantation into another individual	장기 기증

Term	***English Definition***	***Korean Equivalent***
palliative care	Care that focuses on improving a patient's quality of life and managing a patient's symptoms rather than on curing the cause of those symptoms. Palliative care is often used at the end of life, but it can also be used in conjunction with curative care. Palliative care usually involves a team of practitioners including physicians, nurses, social workers and chaplains; the care extends to a patient's family and will address spiritual and social concerns as well as physical problems.	완화의료
persistent vegetative state (PVS)[iv]	A clinical condition of complete unawareness of the self and environment. Even though PVS patients may exhibit sleep wake cycles, they show no evidence of response to or understanding of environmental stimuli. Unlike with a coma, there is no reasonable hope for recovery for those in a PVS. Although life expectancy for patients in a PVS is between two and five years, there are a number of cases where PVS patients are sustained on life support for decades. It has been estimated that there are somewhere between 15,000 and 35,000 PVS patients being sustained in the U.S. at any given time.	지속적 식물인간 상태
POLST	Physicians Orders for Life-Sustaining Treatment. A legal form, filled out by a patient with his or her physician, that instructs healthcare personnel as to what degree of interventional treatment the patient wants toward the end of his or her life.	POLST (생명유지치료에 대한 의사 지시서)
pre-hospital DNR	A legal document, signed by a patient and his or her physician, whose purpose is to instruct Emergency Medical Services personnel NOT to resuscitate a patient if the patient's heart stops. The types of resuscitation covered in a DNR include chest compressions (as in CPR), assisted ventilation, endotracheal intubation, defibrillation, and medications that support resuscitation. The form does NOT affect treatment for any other kind of emergency medical condition such as bleeding, trauma or difficulty breathing.	병원 전 DNR (심정지 시 응급요원에 의한 심폐소생술 금지서)

Term	*English Definition*	*Korean Equivalent*
prognosis	The likelihood of recovery from a disease or trauma, based on the normal course of the disease/condition or on the special circumstances of a particular case. When discussing terminal illnesses, some providers may use "prognosis" to mean “the estimated time remaining to live."	예후
quality of life	An expression of the actions, experiences, or feelings that make life worth living, for an individual patient.	삶의 질
respite care	A program that either sends temporary caretakers to a patient’s home, or allows a patient to be admitted to a healthcare facility temporarily, in order to give the principle caregiver a break.	일시적 위탁 프로그램
restlessness	The inability to stay still, often involuntary	안절부절증
skilled nursing facility[ii]	A residential facility that provides professional nursing care around the clock, usually along with rehabilitation	전문요양시설
support	Actions and attitudes that help an individual or group. In palliative care, when providers talk about patient “support,” they do not mean financial help but usually emotional and logistical help.	지지 (완화의료에서는 의료진의 정서적 지지나 관리적 지원을 의미한다)
surrogate decision-maker	A person who may make health-related decisions on behalf of a patient who is not able to make decisions for himself. A surrogate may be designated verbally, by the patient, or legally, through a written Advance Directive or by the court.	대리결정권자
ventilator[ii]	A machine that takes over breathing for the patient, controlling the intake and expiration of air	인공호흡기
withdrawal of support	The removal of all forms of life support such as a ventilator, a feeding tube, or other treatment used to keep a seriously ill patient alive.	생명유지장치 제거

[i] Definition from www.eMedicinehealth.com. [iii] Definition from http://www.pbs.org/secondopinion/episodes/endoflife/medicalglossary
[ii] Definition from http://www.mywhatever.com/cifwriter/content/66/4620.html. [iv] Definition from http://www.dickinson.edu/endoflife/Glossary.html

Handout #5, TG
Bilingual Glossary of Palliative Care Terms
English-Tagalog

Term	*English Definition*	*Tagalog Equivalent*
advance directive[i]	Advance directives are legal documents that describe a patient's treatment preferences and designate a surrogate decision-maker in the event that the person should become unable to make medical decisions for him or herself. Advance directives generally fall into two categories: those that designate surrogate decision makers (power of attorney for health care, healthcare proxy), and those that designate care instructions (living will, POLST, pre-hospital DNR).	maagang tagubilin
advance care planning	Decisions made by a patients about their wishes regarding interventions and care if a physical condition made it impossible them to communicate their wishes in the moment.	maagang pagpaplano ng pangangalaga
artificial nutrition and hydration	Means of life support providing calories, vitamins and minerals, either through feeding tubes or intravenously, to a patient who cannot eat or drink sufficiently by normal means.	artipisyal na nutrisyon at pagbibigay ng tubig
autopsy	An examination of the body in order to determine the cause of death, involving dissection of the remains.	awtopsiya
bereavement counseling	Counseling to help deal with on-going sadness regarding a loved one who has died or who is dying.	pagpapayo para sa pagdadalamhati
brain death	A clinical condition in which the most basic functions of the brain are gone, including basic reflexes and control of breathing, so that life can only be maintained through artificial means.	pagkamatay ng utak
caregiver	A person who provides direct care for a patient. Caregivers can be professionals, such as Home Health Aides, or simply caring individuals such as family and friends.	tagapag-alaga

Term	*English Definition*	*Tagalog Equivalent*
chaplain[ii]	An individual ordained or consecrated for religious ministry, specially trained to offer support, prayer, and spiritual guidance to patients and their families.	pari o pastor
coma	A state of profound unconsciousness caused by disease, injury or poison.v	pagkawalang-malay
code status	A patient's "code status" tells providers whether a patient should be resuscitated or not should cardiac or respiratory arrest occur.	kodigo ng kalagayan
comfort care	treatments that focus only on promoting comfort, not prolonging life artificially	pangangalagang pagbibigay-ginhawa
coping skills	The skills needed to emotionally handle difficult situations in life	mga kasanayan sa pagharap sa hirap
coroner	A public official who investigates by inquest any death not due to natural causes. Coroners are usually elected officials, who may or may not possess any special training in investigating the cause of death.	tagasiyasat ng dahilan ng pagkamatay
CPR (cardiopulmonary resuscitation)[i]	The emergency substitution of heart and lung action to restore life to someone who has ceased to breathe and whose heart is not pumping. The two main components of cardiopulmonary resuscitation (CPR) are chest compressions to force blood from the heart to the body, and artificial breathing by forcing air into the lungs (through mouth-to-mouth breathing or through medical equipment).	pagsisikap para maibalik ang paghinga
do-not-resuscitate order (DNR)[iii]	A doctor's written instructions not to attempt cardiopulmonary resuscitation (CPR) on a specific patient in the event of cardiac or respiratory arrest. The DNR order should be noted in a person's medical chart like any other medical order, and may be filed at hospitals, in private practice, with local emergency services, and with companies such as MedicAlert (which provides a bracelet to wear).	tagubilin ng doktor na huwag nang sikaping ibalik ang paghinga

Term	*English Definition*	*Tagalog Equivalent*
durable power of attorney[i]	A legal document in which a patient designates a specific individual to take legal action on his/her behalf in the case of an incapacitating medical condition. The general durable power of attorney allows an individual to make bank transactions, sign Social Security checks, apply for disability, or simply write checks to pay the utility bill while an individual is medically incapacitated. Compare with "durable power of attorney for health care."	dokumentong nagbibigay ng kapangyarihan sa isang kinatawan
durable power of attorney for health care	A legal document in which a patient designates a specific individual to make healthcare decisions on his or her behalf. A Durable Power of Attorney for Health Care does not allow the surrogate decision maker power over financial decisions. Note that when healthcare providers talk about a "durable power of attorney," they usually mean a durable power of attorney for health care.	dokumentong nagbibigay ng kapangyarihan sa isang kinatawan para sa pangangalagang pangkalusugan
feeding tube	A tube placed into the stomach or small intestine to provide nutrition to a person who cannot eat or drink.	tubo para sa pagpapakain
funeral home	A commercial entity that prepares the deceased for burial or cremation and assists in preparing a funeral.	punerarya
goals of care	A patient or family's desired outcome(s) from his or her medical care.In some cases, a complete eradication of a disease is the goal of care, while in others, the goal is to control pain, or to recover a degree of mobility.	mga hangarin ng pangangalaga
health proxy[i]	A legal document in which an individual designates another person to make health care decisions if he or she cannot participate in medical decision-making, for any reason. This term also refers to the person who has been so designated. The health care proxy has, in essence, the same rights to request or refuse treatment that the individual would have if capable of making and communicating decisions.	kinatawan ng pasyente sa paggawa ng desisyon sa paggamot

Term	***English Definition***	***Tagalog Equivalent***
health status	The condition of an individual's health.	kalagayan ng kalusugan
heart/lung machine	A machine that artificially takes over the function of the lungs and heart.	makinang nagsisilbing puso at baga
home health aide	A trained and certified healthcare worker who monitors a home-bound patient's condition and assists with personal hygiene and light housework.	katulong na pangkalusugan sa bahay
hospice care[iii]	A special way of caring for people with terminal illnesses by meeting the patient's physical, emotional, social, and spiritual needs, as well as the needs of the family. The goals of hospice are to keep the patient as comfortable as possible by relieving pain and other symptoms; to prepare for a death that follows the wishes and needs of the patient; and to reassure both the patient and family members by helping them to understand and manage what is happening. To be eligible for hospice care, a physician must indicate that the patient is likely to die within six months.	pangangalaga sa hospisyo
immediate family	A patient's closest relatives, usually considered to be parents, siblings, spouse and children.	malapit na kapamilya
intensive care unit (ICU)[iii]	A specialized part of the hospital designed for care of the critically ill whose conditions require constant monitoring.	yunit ng masusing pangangalaga
intubation[i]	Endotracheal intubation is a procedure by which a tube is inserted through the mouth down into the trachea in order to enable mechanical ventilation, in a patient who cannot safely breathe on his or her own. Also referred to as "inserting an airway."	paghinga sa pamamagitan ng tubo
life support	Equipment, material or treatment used to keep a seriously ill patient alive: e.g. artificial nutrition such as a feeding tube, mechanical ventilation, dialysis.	pangsuporta sa buhay

Term	*English Definition*	*Tagalog Equivalent*
living will[i]	A written document that specifies what types of medical treatments are desired under specific circumstances. The most common statement in a living will is to the effect that: If I suffer an incurable, irreversible illness, disease, or condition and my attending physician determines that my condition is terminal, I direct that life-sustaining measures that would serve only to prolong my dying be withheld or discontinued. More specific living wills may include an individual's desire for such services such as analgesia (pain relief), antibiotics, hydration, feeding, and the use of ventilators or cardiopulmonary resuscitation.	habilin sa nais na pangangalaga
long-term care	A healthcare facility that provides nursing care to patients over an extended period of time.	pangmatagalang pangangalaga
Medical Examiner	A qualified physician, often with advanced training in forensic pathology (the application of medical knowledge to questions of the law), who investigates deaths not due to natural causes. Medical examiners are usually appointed to the position.	Tagasiyasat ng Di-likas na Pagkamatay
metastasis	The spread of a disease (usually cancer) from the initial site to another part of the body.	pagkalat ng sakit sa katawan
morgue	In a hospital, an area where the body of the deceased is kept under refrigeration until the funeral home can arrange for transport to the mortuary.	morge
next of kin	A legal term referring to the person or persons most closely related by blood to an individual. While not related by blood, a spouse is usually included as “next of kin.”	pinakamalapit na kamag-anak
organ donation	The act of giving permission for a patient’s organs to be harvested after his death for transplantation into another individual	paghahandog ng bahagi ngkatawan

Term	***English Definition***	***Tagalog Equivalent***
palliative care	Care that focuses on improving a patient's quality of life and managing a patient's symptoms rather than on curing the cause of those symptoms. Palliative care is often used at the end of life, but it can also be used in conjunction with curative care. Palliative care usually involves a team of practitioners including physicians, nurses, social workers and chaplains; the care extends to a patient's family and will address spiritual and social concerns as well as physical problems.	pampaginhawang pangangalaga
persistent vegetative state (PVS)[iv]	A clinical condition of complete unawareness of the self and environment. Even though PVS patients may exhibit sleep wake cycles, they show no evidence of response to or understanding of environmental stimuli. Unlike with a coma, there is no reasonable hope for recovery for those in a PVS. Although life expectancy for patients in a PVS is between two and five years, there are a number of cases where PVS patients are sustained on life support for decades. It has been estimated that there are somewhere between 15,000 and 35,000 PVS patients being sustained in the U.S. at any given time.	patuloy na kawalan ng malay
POLST	Physicians Orders for Life-Sustaining Treatment. A legal form, filled out by a patient with his or her physician, that instructs healthcare personnel as to what degree of interventional treatment the patient wants toward the end of his or her life.	Mga Utos ng Doktor para sa Paggamot na Nagpapatuloy ng Buhay
pre-hospital DNR	A legal document, signed by a patient and his or her physician, whose purpose is to instruct Emergency Medical Services personnel NOT to resuscitate a patient if the patient's heart stops. The types of resuscitation covered in a DNR include chest compressions (as in CPR), assisted ventilation, endotracheal intubation, defibrillation, and medications that support resuscitation. The form does NOT affect treatment for any other kind of emergency medical condition such as bleeding, trauma or difficulty breathing.	bilin bago maospital na huwag nang sikaping ibalik ang paghinga

Term	*English Definition*	*Tagalog Equivalent*
prognosis	The likelihood of recovery from a disease or trauma, based on the normal course of the disease/condition or on the special circumstances of a particular case. When discussing terminal illnesses, some providers may use "prognosis" to mean “the estimated time remaining to live."	tinatayang kalalabasan ng sakit
quality of life	An expression of the actions, experiences, or feelings that make life worth living, for an individual patient.	kalidad ng buhay
respite care	A program that either sends temporary caretakers to a patient’s home, or allows a patient to be admitted to a healthcare facility temporarily, in order to give the principle caregiver a break.	pangangalagang pangrilyebo
restlessness	The inability to stay still, often involuntary	pagkabalisa
skilled nursing facility[ii]	A residential facility that provides professional nursing care around the clock, usually along with rehabilitation	pasilidad ng bihasang pangangalaga
support	Actions and attitudes that help an individual or group. In palliative care, when providers talk about patient “support,” they do not mean financial help but usually emotional and logistical help.	suporta
surrogate decision-maker	A person who may make health-related decisions on behalf of a patient who is not able to make decisions for himself. A surrogate may be designated verbally, by the patient, or legally, through a written Advance Directive or by the court.	kahaliling tagagawa ng desisyon
ventilator[ii]	A machine that takes over breathing for the patient, controlling the intake and expiration of air	makinang humihinga para sa pasyente
withdrawal of support	The removal of all forms of life support such as a ventilator, a feeding tube, or other treatment used to keep a seriously ill patient alive.	pagtanggal ng suporta sa buhay

[i] Definition from www.eMedicinehealth.com.
[ii] Definition from http://www.mywhatever.com/cifwriter/content/66/4620.html.
[iii] Definition from http://www.pbs.org/secondopinion/episodes/endoflife/medicalglossary/story436.html.
[iv] Definition from http://www.dickinson.edu/endoflife/Glossary.html

Handout #5, RS
Bilingual Glossary of Palliative Care Terms
English-Russian

Term	***English Definition***	**Russian Equivalent**
advance directive[i]	Advance directives are legal documents that describe a patient's treatment preferences and designate a surrogate decision-maker in the event that the person should become unable to make medical decisions for him or herself. Advance directives generally fall into two categories: those that designate surrogate decision makers (power of attorney for health care, healthcare proxy), and those that designate care instructions (living will, POLST, pre-hospital DNR).	Заблаговременное распоряжение
advance care planning	Decisions made by a patients about their wishes regarding interventions and care if a physical condition made it impossible them to communicate their wishes in the moment.	Заблаговременное планирование лечения
artificial nutrition and hydration	Means of life support providing calories, vitamins and minerals, either through feeding tubes or intravenously, to a patient who cannot eat or drink sufficiently by normal means.	Искусственное питание и поддержание водного баланса
autopsy	An examination of the body in order to determine the cause of death, involving dissection of the remains.	вскрытие
bereavement counseling	Counseling to help deal with on-going sadness regarding a loved one who has died or who is dying.	психологическаяпомощь в связи с переживанием утраты близкого человека
brain death	A clinical condition in which the most basic functions of the brain are gone, including basic reflexes and control of breathing, so that life can only be maintained through artificial means.	Смерть мозга

Term	*English Definition*	**Russian Equivalent**
caregiver	A person who provides direct care for a patient. Caregivers can be professionals, such as Home Health Aides, or simply caring individuals such as family and friends.	лицо, осуществляющее уход. Например, медреосонал, родственники или друзья
chaplain[ii]	An individual ordained or consecrated for religious ministry, specially trained to offer support, prayer, and spiritual guidance to patients and their families.	капеллан
coma	A state of profound unconsciousness caused by disease, injury or poison.v	кома
code status	A patient's "code status" tells providers whether a patient should be resuscitated or not should cardiac or respiratory arrest occur.	Статус кода (указания для проведения реанимационных мероприятий)
comfort care	treatments that focus only on promoting comfort, not prolonging life artificially	Симптоматическая терапия
coping skills	The skills needed to emotionally handle difficult situations in life	Навыки переживания трудных ситуаций
coroner	A public official who investigates by inquest any death not due to natural causes. Coroners are usually elected officials, who may or may not possess any special training in investigating the cause of death.	Судебный следователь
CPR (cardiopulmonary resuscitation)[i]	The emergency substitution of heart and lung action to restore life to someone who has ceased to breathe and whose heart is not pumping. The two main components of cardiopulmonary resuscitation (CPR) are chest compressions to force blood from the heart to the body, and artificial breathing by forcing air into the lungs (through mouth-to-mouth breathing or through medical equipment).	СЛР (сердечно-лёгочная реанимация)

Term	*English Definition*	**Russian Equivalent**
do-not-resuscitate order (DNR)[iii]	A doctor's written instructions not to attempt cardiopulmonary resuscitation (CPR) on a specific patient in the event of cardiac or respiratory arrest. The DNR order should be noted in a person's medical chart like any other medical order, and may be filed at hospitals, in private practice, with local emergency services, and with companies such as MedicAlert (which provides a bracelet to wear).	распоряжение «не проводить реанимационные мероприятия»
durable power of attorney[i]	A legal document in which a patient designates a specific individual to take legal action on his/her behalf in the case of an incapacitating medical condition. The general durable power of attorney allows an individual to make bank transactions, sign Social Security checks, apply for disability, or simply write checks to pay the utility bill while an individual is medically incapacitated. Compare with “durable power of attorney for health care.”	Доверенность продолжительного действия
durable power of attorney for health care	A legal document in which a patient designates a specific individual to make healthcare decisions on his or her behalf. A Durable Power of Attorney for Health Care does not allow the surrogate decision maker power over financial decisions. Note that when healthcare providers talk about a “durable power of attorney,” they usually mean a durable power of attorney for health care.	Долгосрочная доверенность на осуществление медицинского обслуживания
feeding tube	A tube placed into the stomach or small intestine to provide nutrition to a person who cannot eat or drink.	Зонд для искусственного кормления
funeral home	A commercial entity that prepares the deceased for burial or cremation and assists in preparing a funeral.	Похоронное бюро
goals of care	A patient or family’s desired outcome(s) from his or her medical care.In some cases, a complete eradication of a disease is the goal of care, while in others, the goal is to control pain, or to recover a degree of mobility.	Цели лечения

Term	***English Definition***	**Russian Equivalent**
health proxy[i]	A legal document in which an individual designates another person to make health care decisions if he or she cannot participate in medical decision-making, for any reason. This term also refers to the person who has been so designated. The health care proxy has, in essence, the same rights to request or refuse treatment that the individual would have if capable of making and communicating decisions.	Медицинская доверенность / лицо, уполномоченное принимать решения о медицинском обслуживании
health status	The condition of an individual's health.	Медицинский статус
heart/lung machine	A machine that artificially takes over the function of the lungs and heart.	Аппарат искусственного кровообращения (АИК)
home health aide	A trained and certified healthcare worker who monitors a home-bound patient's condition and assists with personal hygiene and light housework.	Медико-санитарная помощь на дому
hospice care[iii]	A special way of caring for people with terminal illnesses by meeting the patient's physical, emotional, social, and spiritual needs, as well as the needs of the family. The goals of hospice are to keep the patient as comfortable as possible by relieving pain and other symptoms; to prepare for a death that follows the wishes and needs of the patient; and to reassure both the patient and family members by helping them to understand and manage what is happening. To be eligible for hospice care, a physician must indicate that the patient is likely to die within six months.	лечение в хосписе
immediate family	A patient's closest relatives, usually considered to be parents, siblings, spouse and children.	Ближайшие родственники
intensive care unit (ICU)[iii]	A specialized part of the hospital designed for care of the critically ill whose conditions require constant monitoring.	Отделение интенсивной терапии

Term	***English Definition***	**Russian Equivalent**
intubation[i]	Endotracheal intubation is a procedure by which a tube is inserted through the mouth down into the trachea in order to enable mechanical ventilation, in a patient who cannot safely breathe on his or her own. Also referred to as “inserting an airway.”	интубация
life support	Equipment, material or treatment used to keep a seriously ill patient alive: e.g. artificial nutrition such as a feeding tube, mechanical ventilation, dialysis.	Поддержание жизненных функций
living will[i]	A written document that specifies what types of medical treatments are desired under specific circumstances. The most common statement in a living will is to the effect that: If I suffer an incurable, irreversible illness, disease, or condition and my attending physician determines that my condition is terminal, I direct that life-sustaining measures that would serve only to prolong my dying be withheld or discontinued. More specific living wills may include an individual's desire for such services such as analgesia (pain relief), antibiotics, hydration, feeding, and the use of ventilators or cardiopulmonary resuscitation.	«завещание о жизни»
long-term care	A healthcare facility that provides nursing care to patients over an extended period of time.	Долговременное лечение
Medical Examiner	A qualified physician, often with advanced training in forensic pathology (the application of medical knowledge to questions of the law), who investigates deaths not due to natural causes. Medical examiners are usually appointed to the position.	судебно-медицинский эксперт
metastasis	The spread of a disease (usually cancer) from the initial site to another part of the body.	метастаз
morgue	In a hospital, an area where the body of the deceased is kept under refrigeration until the funeral home can arrange for transport to the mortuary.	морг

Term	***English Definition***	**Russian Equivalent**
next of kin	A legal term referring to the person or persons most closely related by blood to an individual. While not related by blood, a spouse is usually included as “next of kin.”	Ближайшие родственники
organ donation	The act of giving permission for a patient’s organs to be harvested after his death for transplantation into another individual	Донорство органа
palliative care	Care that focuses on improving a patient’s quality of life and managing a patient’s symptoms rather than on curing the cause of those symptoms. Palliative care is often used at the end of life, but it can also be used in conjunction with curative care. Palliative care usually involves a team of practitioners including physicians, nurses, social workers and chaplains; the care extends to a patient’s family and will address spiritual and social concerns as well as physical problems.	Паллиативная терапия
persistent vegetative state (PVS)[iv]	A clinical condition of complete unawareness of the self and environment. Even though PVS patients may exhibit sleep wake cycles, they show no evidence of response to or understanding of environmental stimuli. Unlike with a coma, there is no reasonable hope for recovery for those in a PVS. Although life expectancy for patients in a PVS is between two and five years, there are a number of cases where PVS patients are sustained on life support for decades. It has been estimated that there are somewhere between 15,000 and 35,000 PVS patients being sustained in the U.S. at any given time.	Персистирующее вегетативное состояние
POLST	Physicians Orders for Life-Sustaining Treatment. A legal form, filled out by a patient with his or her physician, that instructs healthcare personnel as to what degree of interventional treatment the patient wants toward the end of his or her life.	Распоряжение для врача об искусственном поддержании жизни

Term	*English Definition*	**Russian Equivalent**
pre-hospital DNR	A legal document, signed by a patient and his or her physician, whose purpose is to instruct Emergency Medical Services personnel NOT to resuscitate a patient if the patient's heart stops. The types of resuscitation covered in a DNR include chest compressions (as in CPR), assisted ventilation, endotracheal intubation, defibrillation, and medications that support resuscitation. The form does NOT affect treatment for any other kind of emergency medical condition such as bleeding, trauma or difficulty breathing.	распоряжение DNR до госпитализации
prognosis	The likelihood of recovery from a disease or trauma, based on the normal course of the disease/condition or on the special circumstances of a particular case. When discussing terminal illnesses, some providers may use "prognosis" to mean "the estimated time remaining to live."	прогноз
quality of life	An expression of the actions, experiences, or feelings that make life worth living, for an individual patient.	Качество жизни
respite care	A program that either sends temporary caretakers to a patient's home, or allows a patient to be admitted to a healthcare facility temporarily, in order to give the principle caregiver a break.	Временный медицинский уход (за больными и инвалидами в период отдыха лиц, обычно осуществляющих за ними уход)
restlessness	The inability to stay still, often involuntary	возбуждение, беспокойство
skilled nursing facility[ii]	A residential facility that provides professional nursing care around the clock, usually along with rehabilitation	Учреждение квалифицированного медицинского ухода
support	Actions and attitudes that help an individual or group. In palliative care, when providers talk about patient "support," they do not mean financial help but usually emotional and logistical help.	поддержка

Term	***English Definition***	**Russian Equivalent**
surrogate decision-maker	A person who may make health-related decisions on behalf of a patient who is not able to make decisions for himself. A surrogate may be designated verbally, by the patient, or legally, through a written Advance Directive or by the court.	Уполномоченный распорядитель
ventilator[ii]	A machine that takes over breathing for the patient, controlling the intake and expiration of air	Аппарат искусственной вентиляции лёгких[ii]
withdrawal of support	The removal of all forms of life support such as a ventilator, a feeding tube, or other treatment used to keep a seriously ill patient alive.	Отключение от средств жизнеобеспечения

[i] Definition from www.eMedicinehealth.com.
[ii] Definition from http://www.mywhatever.com/cifwriter/content/66/4620.html.
[iii] Definition from http://www.pbs.org/secondopinion/episodes/endoflife/medicalglossary/story436.html.
[iv] Definition from http://www.dickinson.edu/endoflife/Glossary.html

Handout #5, EN
Bilingual Glossary of Palliative Care Terms
English-_____

Term	***English Definition***	***Equivalent***
advance directive[i]	Advance directives are legal documents that describe a patient's treatment preferences and designate a surrogate decision-maker in the event that the person should become unable to make medical decisions for him or herself. Advance directives generally fall into two categories: those that designate surrogate decision makers (power of attorney for health care, healthcare proxy), and those that designate care instructions (living will, POLST, pre-hospital DNR).	
advance care planning	Decisions made by a patients about their wishes regarding interventions and care if a physical condition made it impossible them to communicate their wishes in the moment.	
artificial nutrition and hydration	Means of life support providing calories, vitamins and minerals, either through feeding tubes or intravenously, to a patient who cannot eat or drink sufficiently by normal means.	
autopsy	An examination of the body in order to determine the cause of death, involving dissection of the remains.	
bereavement counseling	Counseling to help deal with on-going sadness regarding a loved one who has died or who is dying.	
brain death	A clinical condition in which the most basic functions of the brain are gone, including basic reflexes and control of breathing, so that life can only be maintained through artificial means.	
caregiver	A person who provides direct care for a patient. Caregivers can be professionals, such as Home Health Aides, or simply caring individuals such as family and friends.	

Term	*English Definition*	*Equivalent*
chaplain[ii]	An individual ordained or consecrated for religious ministry, specially trained to offer support, prayer, and spiritual guidance to patients and their families.	
coma	A state of profound unconsciousness caused by disease, injury or poison.v	
code status	A patient's "code status" tells providers whether a patient should be resuscitated or not should cardiac or respiratory arrest occur.	
comfort care	treatments that focus only on promoting comfort, not prolonging life artificially	
coping skills	The skills needed to emotionally handle difficult situations in life	
coroner	A public official who investigates by inquest any death not due to natural causes. Coroners are usually elected officials, who may or may not possess any special training in investigating the cause of death.	
CPR (cardiopulmonary resuscitation)[i]	The emergency substitution of heart and lung action to restore life to someone who has ceased to breathe and whose heart is not pumping. The two main components of cardiopulmonary resuscitation (CPR) are chest compressions to force blood from the heart to the body, and artificial breathing by forcing air into the lungs (through mouth-to-mouth breathing or through medical equipment).	
do-not-resuscitate order (DNR)[iii]	A doctor's written instructions not to attempt cardiopulmonary resuscitation (CPR) on a specific patient in the event of cardiac or respiratory arrest. The DNR order should be noted in a person's medical chart like any other medical order, and may be filed at hospitals, in private practice, with local emergency services, and with companies such as MedicAlert (which provides a bracelet to wear).	

Term	*English Definition*	*Equivalent*
durable power of attorney[i]	A legal document in which a patient designates a specific individual to take legal action on his/her behalf in the case of an incapacitating medical condition. The general durable power of attorney allows an individual to make bank transactions, sign Social Security checks, apply for disability, or simply write checks to pay the utility bill while an individual is medically incapacitated. Compare with "durable power of attorney for health care."	
durable power of attorney for health care	A legal document in which a patient designates a specific individual to make healthcare decisions on his or her behalf. A Durable Power of Attorney for Health Care does not allow the surrogate decision maker power over financial decisions. Note that when healthcare providers talk about a "durable power of attorney," they usually mean a durable power of attorney for health care.	
feeding tube	A tube placed into the stomach or small intestine to provide nutrition to a person who cannot eat or drink.	
funeral home	A commercial entity that prepares the deceased for burial or cremation and assists in preparing a funeral.	
goals of care	A patient or family's desired outcome(s) from his or her medical care. In some cases, a complete eradication of a disease is the goal of care, while in others, the goal is to control pain, or to recover a degree of mobility.	
health proxy[i]	A legal document in which an individual designates another person to make health care decisions if he or she cannot participate in medical decision-making, for any reason. This term also refers to the person who has been so designated. The health care proxy has, in essence, the same rights to request or refuse treatment that the individual would have if capable of making and communicating decisions.	
health status	The condition of an individual's health.	

Term	*English Definition*	*Equivalent*
heart/lung machine	A machine that artificially takes over the function of the lungs and heart.	
home health aide	A trained and certified healthcare worker who monitors a home-bound patient's condition and assists with personal hygiene and light housework.	
hospice care[iii]	A special way of caring for people with terminal illnesses by meeting the patient's physical, emotional, social, and spiritual needs, as well as the needs of the family. The goals of hospice are to keep the patient as comfortable as possible by relieving pain and other symptoms; to prepare for a death that follows the wishes and needs of the patient; and to reassure both the patient and family members by helping them to understand and manage what is happening. To be eligible for hospice care, a physician must indicate that the patient is likely to die within six months.	
immediate family	A patient's closest relatives, usually considered to be parents, siblings, spouse and children.	
intensive care unit (ICU)[iii]	A specialized part of the hospital designed for care of the critically ill whose conditions require constant monitoring.	
intubation[i]	Endotracheal intubation is a procedure by which a tube is inserted through the mouth down into the trachea in order to enable mechanical ventilation, in a patient who cannot safely breathe on his or her own. Also referred to as "inserting an airway."	
life support	Equipment, material or treatment used to keep a seriously ill patient alive: e.g. artificial nutrition such as a feeding tube, mechanical ventilation, dialysis.	

Term	*English Definition*	*Equivalent*
living will[i]	A written document that specifies what types of medical treatments are desired under specific circumstances. The most common statement in a living will is to the effect that: If I suffer an incurable, irreversible illness, disease, or condition and my attending physician determines that my condition is terminal, I direct that life-sustaining measures that would serve only to prolong my dying be withheld or discontinued. More specific living wills may include an individual's desire for such services such as analgesia (pain relief), antibiotics, hydration, feeding, and the use of ventilators or cardiopulmonary resuscitation.	
long-term care	A healthcare facility that provides nursing care to patients over an extended period of time.	
Medical Examiner	A qualified physician, often with advanced training in forensic pathology (the application of medical knowledge to questions of the law), who investigates deaths not due to natural causes. Medical examiners are usually appointed to the position.	
metastasis	The spread of a disease (usually cancer) from the initial site to another part of the body.	
morgue	In a hospital, an area where the body of the deceased is kept under refrigeration until the funeral home can arrange for transport to the mortuary.	
next of kin	A legal term referring to the person or persons most closely related by blood to an individual. While not related by blood, a spouse is usually included as “next of kin.”	
organ donation	The act of giving permission for a patient’s organs to be harvested after his death for transplantation into another individual	

Term	*English Definition*	*Equivalent*
persistent vegetative state (PVS)[iv]	A clinical condition of complete unawareness of the self and environment. Even though PVS patients may exhibit sleep wake cycles, they show no evidence of response to or understanding of environmental stimuli. Unlike with a coma, there is no reasonable hope for recovery for those in a PVS. Although life expectancy for patients in a PVS is between two and five years, there are a number of cases where PVS patients are sustained on life support for decades. It has been estimated that there are somewhere between 15,000 and 35,000 PVS patients being sustained in the U.S. at any given time.	
POLST	Physicians Orders for Life-Sustaining Treatment. A legal form, filled out by a patient with his or her physician, that instructs healthcare personnel as to what degree of interventional treatment the patient wants toward the end of his or her life.	
pre-hospital DNR	A legal document, signed by a patient and his or her physician, whose purpose is to instruct Emergency Medical Services personnel NOT to resuscitate a patient if the patient's heart stops. The types of resuscitation covered in a DNR include chest compressions (as in CPR), assisted ventilation, endotracheal intubation, defibrillation, and medications that support resuscitation. The form does NOT affect treatment for any other kind of emergency medical condition such as bleeding, trauma or difficulty breathing.	
prognosis	The likelihood of recovery from a disease or trauma, based on the normal course of the disease/condition or on the special circumstances of a particular case. When discussing terminal illnesses, some providers may use "prognosis" to mean "the estimated time remaining to live."	
quality of life	An expression of the actions, experiences, or feelings that make life worth living, for an individual patient.	
respite care	A program that either sends temporary caretakers to a patient's home, or allows a patient to be admitted to a healthcare facility temporarily, in order to give the principle caregiver a break.	

Term	*English Definition*	*Equivalent*
restlessness	The inability to stay still, often involuntary	
skilled nursing facility[ii]	A residential facility that provides professional nursing care around the clock, usually along with rehabilitation	
support	Actions and attitudes that help an individual or group. In palliative care, when providers talk about patient "support," they do not mean financial help but usually emotional and logistical help.	
surrogate decision-maker	A person who may make health-related decisions on behalf of a patient who is not able to make decisions for himself. A surrogate may be designated verbally, by the patient, or legally, through a written Advance Directive or by the court.	
ventilator[ii]	A machine that takes over breathing for the patient, controlling the intake and expiration of air	
withdrawal of support	The removal of all forms of life support such as a ventilator, a feeding tube, or other treatment used to keep a seriously ill patient alive.	

[i] Definition from www.eMedicinehealth.com.
[ii] Definition from http://www.mywhatever.com/cifwriter/content/66/4620.html.
[iii] Definition from http://www.pbs.org/secondopinion/episodes/endoflife/medicalglossary/story436.html.
[iv] Definition from http://www.dickinson.edu/endoflife/Glossary.html

Handout #6
Palliative Care Terminology
Conversion Exercise

Instructions
This exercise can be done orally in language concordant pairs or individually in writing.

If working in pairs:
1. Assign the odd-numbered sentences to Interpreter #1 and the even-numbered sentences to Interpreter #2.
2. Take a minute for both interpreters to read their sentences to themselves and to look up the terms they don't know in the glossary.
3. Then have Interpreter #2 read the first sentence aloud in English. Have Interpreter #2 interpret it into the non-English language. Remember that interpreting is not about simply substituting terms; sometimes the interpretation will be more accurate and sound more natural if the word order is changed or a paraphrase included.
4. Interpreter #2, provide feedback on the interpretation.
5. Then have Interpreter #1 read the second sentence out loud. Have interpreter #2 interpret it into the non-English language. Interpreter #1, provide feedback.
6. Continue taking turns.

If working alone:
1. Look up the italicized words in the glossary.
2. Translate each sentence into your non-English language on a separate piece of paper, just as you would interpret it. Remember that interpreting is not about simply substituting terms; sometimes the interpretation will be more accurate and sound more natural if the word order is changed or a paraphrase included.
3. If possible, have another speaker of your non-English language check your work.

Exercise
1. Do you have an *advance directive* that I could put in your chart?

2. It would be a good idea to have your grandfather fill out a *durable power of attorney for health care.*

3. Then if a situation arises in which he can't make decisions for himself, we can consult with his *surrogate decision-maker.*

4. Are you the patient's *next of kin?*

5. I'm afraid we only allow *immediate family* into the *ICU.*

6. Your grandfather has been *intubated* and he's on a *ventilator.* He won't be able to talk to you.

7. A *feeding tube* might be helpful in the short term.

8. What are your grandfather's *goals of care*?

9. I can put him on *life support*, but, honestly, the *prognosis* is not good.

10. The cancer has *metastasized.*

11. Despite anything we do, I believe he will end up eventually in a *coma.*

12. Have you considered a *hospice program?*

13. Whether you care for him at home or in a *long-term care facility,* his *quality of life* will be higher.

14. A *home health aide* will come by your home every day, and if necessary, our *respite care* program can give the primary *caregiver* a break.

15. A *DNR* is a standing order from the doctor that, if his heart should stop, we will let him go peacefully, without trying to revive him with *CPR.*

16. This is a delicate subject, I know, but has anyone discussed *organ donation* with you?

17. No, the *coroner* won't have to do an *autopsy.*

18. You can have the *funeral home* pick up your grandfather's remains from the *morgue* as soon as it is convenient.

19. Our chaplain offers *bereavement counseling,* which many people find to be a great *support.*

20. He also helps people develop *coping skills*.

21. It's going to take a long time for your brother to recuperate from this accident. Our *palliative care team* will be working with your brother's physician at the *skilled nursing facility* to make sure that he's as comfortable as possible.

Handout #7
Practice Interpreting Feedback form

Interpreter: _____

Language pair: _____

Evaluator: _____

Date: _____

Criteria	Examples
Aspects of the interpretation that the interpreter did well	
Omissions	
Additions	
Meaning changes	
Linguistic proficiency (e.g. false cognates, inserted English, work-arounds, etc)	
Delivery (e.g. stammering, pausing, backtracking, insecure facial expressions)	

	Consistently	Occasionally	Not at all
Used the first person			
Interpreted emotions/tone of voice of speaker			
Asked for clarification if did not understand			
Checked for patient understanding			
Managed the flow appropriately			
Maintained transparency when intervening			
Was aware when a cultural issue arose			
Explained cultural framework when necessary			
Avoided stereotyping when explaining			

Guidelines for Giving Feedback

1. Let the interpreter critique him- or herself first.
   e.g. “What do you think you did well?” “Is there anything you would change?”

2. Hearing feedback can be hard. Start with something positive.
   e.g. “I thought you managed the flow really well. You stopped the provider three times when he was going on too long.”

3. Begin each comment with “I”.
   e.g. “I noticed that you . . . “

4. Ask why.
   e.g. “I wondered why you chose to skip this part of the interpretation.”

5. Provide specific examples.
   e.g. Instead of “You left out a lot of things” try saying, “I didn’t hear you interpret that part about . . . .”

6. There are many regional variations within languages. Before assuming that a word usage is incorrect, ask whether it might be a regional dialect.
   e.g. “I’ve never heard _____ used to say _____. Is it used that way in the home country of anyone here?”

7. Share your thoughts and observations. NOBODY learns anything if we all stay quiet!

Guidelines for Getting Feedback

1. DTIP (Don’t Take It Personally)
   It’s easy to feel threatened by feedback. It will help if you can view feedback as an opportunity to improve, not as a criticism. Think of corrections to the way you interpreted something, even if your word choice was correct, as a chance to expand your vocabulary. And if you find yourself feeling defensive, just stop and take a deep breath.

2. Listen actively and ask questions.
   Paraphrase back to the evaluator what you heard him or her say. This will help clarify what’s being said, and it will help you remember it.

3. Don’t argue.
   Just because someone says it, doesn’t mean you have to agree with it. But at least consider the possibility that the evaluator may be right.

4. Giving feedback can be hard. Say thank-you. And mean it.

Handout #8 SP
Practice Interpreting Dialogues: English-Spanish

Instructions

These exercises are designed to be used in a small group of four people. Choose one person to play the role of the clinician, one to play the role of the patient, one to interpret and one to observe.

The interpreter may NOT look at the script.

Doctor, start by reading your part. At the end of each paragraph, pause to let the interpreter interpret. Then the patient reads. Then the interpreter interprets. If the interpreter uses a hand signal to ask you to pause, do so. If the interpreter intervenes, respond as you think the doctor or the patient would. Mark on your scripts any places where the interpreter adds, omits or changes meaning.

Interpreter, remember that you are interpreting for meaning, not words. If the speakers go on too long, use your interpreting techniques to get them to pause. Ask the meaning of words you don't know.

Observer, throughout the exercise, use the Feedback Form to keep track of interpreting strengths and errors. Were there places where meaning was added, omitted or changed? Were there places where alternative vocabulary might have been used, or where the interpretation did not sound native? When the first dialogue is finished, provide this feedback to the interpreter.

When you are done giving feedback, switch roles and go on to Scene 2. Continue this pattern till everyone has had a chance to interpret.

Dialogue #1

Dr. Halferty	Mrs. Loreto, you may remember that we did a CT scan of your abdomen last week. Well, we got the results back, would you like me to tell you the full details? Or, if not, is there somebody else you'd like me to talk to?
Mrs. Loreto	A mí, por favor; hábleme a mí.
Dr. Halferty	Well, I'm afraid that the news in not good. The test showed that the cancer has metastasized to your liver. That means it has spread, in this case, to the liver.
Mrs. Loreto	Yo ya sabía que algo no andaba bien. Lo presentía.

Ay, no. Entonces ahora ¿qué? No más quimioterapia, por favor. Otra vez no.

Dr. Halferty No, I know that was hard for you last time, and I'm afraid we've exhausted whatever benefit we could get from chemotherapy anyway. Actually . . . I think it's time we talked about a different kind of treatment regimen called palliative care.

Mrs. Loreto ¡Con tal de que no sea quimioterapia! Así que, ¿en qué consiste este tratamiento?

Dr. Halferty Instead of trying to cure the cancer, we'll be focusing on controlling the symptoms being caused by the cancer -- like the pain and the nausea from the bowel obstruction.

We can do everything possible to make you comfortable so that you can enjoy the best quality of life possible in the time you have left.

Mrs. Loreto ¡Me parece muy bien! No puedo ni pensar en recibir más quimioterapia.

Y ¿cuánto me va a durar este nuevo tratamiento?

Dr. Halferty Well, as long as you need it.

Mrs. Loreto *(confused and unsure)* Aja . . .

(LONG PAUSE. WAIT TO SEE IF THE INTERPRETER WILL INTERVENE.)

Dr. Halferty Let me try again. Mrs. Loreto, I think I wasn't very clear. Your cancer has spread to the point that there's nothing we can do to cure it or even to stop it from growing. But we can help you feel as comfortable as possible until you pass.

Dialogue #2

Mrs. Loreto: Me está diciendo que me voy a morir.

Dr. Halferty Yes. I'm very sorry . . . I wish the news were different.

Mrs. Loreto No lo esperaba . . . tan pronto . . .

Dr. Halferty I can see you're upset. Tell me more about how you are feeling. You look worried. What worries you the most?

Mrs. Loreto Pues, para mis hijos esto va a ser un golpe fuerte . . . .

Dr. Halferty You know, patients who want the best treatment of their symptoms, and who would no longer benefit from chemotherapy, are eligible for a type of care called hospice care. Have you ever heard of that?

Mrs. Loreto No.

Dr. Halferty Well, hospice care is a special type of care for people who are near the end of their lives. You could either be at home or in a long-term care facility, and a team of doctors, nurses, social workers and chaplains would help control your symptoms like the pain that you're afraid of.

They'd also help you do what's most important to you with the time that you have. And they'd be there to provide support for your family.

Mrs. Loreto No sé, doctor. Puede que sea lo mejor . . . no sé. . .

Ya soy muy vieja para estar tomando estas decisiones. ¿Por qué no habla con mis hijos?

Dr. Halferty I could do that.

Mrs. Loreto ¿Sabía Ud. que tengo cinco hijos? Ramón, Ernesto, Julieta, Elena y Javier. Ernesto y Julieta viven en Tejas, y Ramón sigue en Zacatecas – el único que sigue en nuestra tierra. Ojalá lo pudiera ver antes de que Dios me lleve.

Dr. Halferty I wish that for you, too. You know, it's OK to want your next-of-kin or some other specific person to make those decisions. You could fill out a healthcare proxy or Power of Attorney for Health Care. That gives someone you trust the right to make these decisions for you.

Mrs. Loreto Hable con Ramón. Él sabrá qué hacer.

Dialogue #3

(In this dialogue, the observer will read the part of the son or daughter.)

Dr. Halferty Thanks for meeting with me today about your mom.

Javier No, más bien, le agradecemos a Ud. ¿Cómo está mi madre? No entendemos por qué sigue en el hospital.

Dr. Halferty I wish I had better news for you. The most recent CT showed that the cancer has spread to your mother's liver. That is very serious. There

	are no more treatments that would be effective against the cancer. We think it's time to transition her to hospice care.
Javier	Y ¿qué es eso? ¿Un tratamiento nuevo?
Dr. Halferty	Hospice care is a medical program provided by a team of healthcare professionals including doctors, nurses, social workers, and chaplains. They would treat her symptoms, like the pain, in order to make her more comfortable, and offer support to both your mother and your family. But there's nothing more we can do to cure the cancer.
Javier	Entonces, está bien, ¿verdad? Si está cómoda, no hay problema.
Dr. Halferty	Well, the cancer will keep growing. And eventually, that will be incompatible with life.
Javier	No entiendo. ¿Me está diciendo que se va a morir? *(getting angry)* ¿Que la van a dejar morir?
Dr. Halferty	I can understand your anger, Mr. Dominguez. Sometimes it makes me angry too. I wish we had something else we could do for your mother, to cure the cancer, but once this type of cancer metastasizes to the liver, we're really out of options.
Elena	*(devastated, teary)* Si no la pueden curar, entonces ¿qué?
Dr. Halferty	There are lots of things the hospice team can do to help your mother be more comfortable as the end approaches. Like using medications to control her pain and nausea. The hospice team would focus on helping her have energy to enjoy life as much as possible at home with you. I want you to know that I've talked with your mother about this, and she understands that there is nothing left we can do to cure the cancer.
Javier	*(angrily—do NOT pause to let the interpreter interpret)* Pues, ¡Yo no estoy de acuerdo! ¡Tienen que hacer algo! No pueden simplemente dejarla morir –
Elena	(*Do NOT pause to let the interpreter interpret)* Javier, por favor, el doctor está intentando ayudar. Y si mamá está de acuerdo –

Javier ¿Cómo va a ser posible? ¿Tú vas a estar de acuerdo con que la dejen morir? Pues, por mi parte, yo no la voy abandonar.

Elena *(crying)* Javier, ¿cómo me puedes decir eso? ¡No es justo! Tú sabes que yo haría lo que sea para mamá. Pero el doctor dice que no hay nada más que puedan hacer. . . . Debemos traer a Ramón, a Julieta y Ernesto. Debemos decidir juntos, cuándo lleguen todos.

Javier *(disgusted noise)* Já, Ramón.

Elena ¡Por ella lo digo! Ella lo va querer ver. Y tú lo sabes.

Dialogue #4

Dr. Halferty I can hear how upset you both are about this news, and I don't blame you. This is very hard to hear.

But I want to assure you that if there were anything at all we could do that would give us hope for a cure, we would do it.

There just isn't anything.

I explained this to your mother and she *seemed* to understand.

And then I spoke to her about transitioning to hospice care, but she really didn't want to talk about that.

She HAS agreed to name a surrogate decision maker, who would be available to help us make these decisions.

She wanted to name her son Ramón, but I understand that he lives in Mexico. Is that right?

Elena Si, vive en Zacatecas.

Dr. Halferty I think it would be wiser to name one of the two of you who live here. After all, you could talk with her about her wishes and you would be nearby if we needed to ask questions.

Elena Debemos esperar que llegue Ramón, Julieta y Ernesto. Pero *(pause, realizing)* Ramón no tiene visa para venir.

Dr. Halferty My point exactly. Elena, you are your mother's principle caregiver. Maybe she would agree to name you as her decision-maker.

Elena No, no, debemos esperar que lleguen los otros.

Dr. Halferty	*(at a loss)* But it sounds like that could be quite a while . . . And we really need someone named to make decisions for your mom. We don't know how quickly this cancer may advance . . .
Javier	Elena tiene razón. Cuando todos lleguen, podemos decidir.
Dr. Halferty	Hm. *(To family)* Mr. and Ms. Dominguez, is this a decision you can make between the two of you? Or is it absolutely essential to consult with your brothers and your sister first?
Elena	*(surprised)* Pues, claro, ¡no podemos tomar una decisión como ésta solos!
Javier	Así es. Tenemos que hablar con mis hermanos.
Elena	Pero, ¿cómo vamos a traer a Ramón?
Dr. Halferty	OK. I'll see if we can get a Social Worker to work on getting an emergency medical visa for Ramón so that he can come to be with your mother. If that doesn't work out, well set up a conference call so you can all talk and make some decisions.
Elena	Gracias, doctor. Que Dios lo bendiga.

Handout #8 MN
Practice Interpreting Dialogues: English-Simplified Chinese

Instructions

These exercises are designed to be used in a small group of four people. Choose one person to play the role of the clinician, one to play the role of the patient, one to interpret and one to observe.

The interpreter may NOT look at the script.

Doctor, start by reading your part. At the end of each paragraph, pause to let the interpreter interpret. Then the patient reads. Then the interpreter interprets. If the interpreter uses a hand signal to ask you to pause, do so. If the interpreter intervenes, respond as you think the doctor or the patient would Mark on your scripts any places where the interpreter adds, omits or changes meaning.

Interpreter, remember that you are interpreting for meaning, not words. If the speakers go on too long, use your interpreting techniques to get them to pause. Ask the meaning of words you don't know.

Observer, throughout the exercise, use the Feedback Form to keep track of interpreting strengths and errors. Were there places where meaning was added, omitted or change? Were there places where alternative vocabulary might have been used, or where the interpretation did not sound native?When the first dialogue is finished, provide this feedback to the interpreter.

When you are done giving feedback, switch roles and go on to Scene 2. Continue this pattern till everyone has had a chance to interpret.

Dialogue #1: Patient-provider encounter

Dr. Halferty: Mrs. Ye, may remember that we did a CT scan of your abdomen last week.

Well, we got the results back, would you like me to tell you the full details? Or, if not, is there somebody else you'd like me to talk to?

Patient: 不，请您和我说说吧。

Dr. Halferty: Well, I'm afraid that the news in not good. The test showed that the cancer has metastasized to your liver.

Patient: 我知道有些不对劲。我能感觉到。

哦。那么，现在怎么办？请别再进行化疗了。我不想再做了。

Dr. Halferty: No, I know that was hard for you last time, and I'm afraid we've exhausted whatever benefit we could get from chemotherapy anyway.

Actually . . . I think it's time we talked about a different kind of treatment regimen called palliative care.

Patient: 只要不再进行化疗就好！那么，这次治疗将是怎么样的治疗？

Dr. Halferty: Instead of trying to cure the cancer, we'll be focusing on controlling the symptoms being caused by the cancer -- like the pain and the nausea from the bowel obstruction.

We can do everything possible to make you comfortable so that you can enjoy the best quality of life possible in the time you have left.

Patient: 那好！我只是无法再接受更多的化疗了。那么，这种新治疗要持续多久？

Dr. Halferty: Well, as long as you need it.

Patient: *(confused and unsure)* 我明白了。...

(LONG PAUSE. WAIT TO SEE IF THE INTERPRETER WILL INTERVENE.)

Dr. Halferty: I think I wasn't very clear. Your cancer has spread to the point that there's nothing we can do to cure it or even to stop it from growing.

But we can help you feel as comfortable as possible until you pass.

Dialogue #2

Patient: 您是说我快要死了。.

Dr. Halferty: Yes. I'm very sorry . . . I wish the news were different.

Patient: 我没想到这点。..太快了。..

Dr. Halferty: I can see you're upset. Tell me more about how you are feeling. You look worried. What worries you the most?

Patient: 只是我的家人还需要我。而且这家医院太贵了。我希望能回家，但是谁

来照顾我呢？此外，疼痛也是个问题。

Dr. Halferty: You know, patients who want the best treatment of their symptoms, and who would no longer benefit from chemotherapy, are eligible for a type of care called hospice care. Have you ever heard of that?

Patient: 没有。

Dr. Halferty: Well, hospice care is a special type of care for people who are near the end of their lives.

You could either be at home or in a long-term care facility, and a team of doctors, nurses, social workers and chaplains would help control your symptoms like the pain that you're afraid of.

They'd also help you do what's most important to you with the time that you have. And they'd be there to provide support for your family.

Patient: 我不知道，医生。也许这样最好。我不知道。

我太老了，不适合做这些决定。您可以和我的孩子们谈谈。

Dr. Halferty: I could do that.

Patient: *(wistfully)*您知道我有五个孩子吗？叶永刚, 叶永强，叶永丽, 叶永明和叶永婧。叶永强和叶永丽住在德克萨斯州，叶永刚仍住在中国。
我希望在临终前能见到仍住在中国的叶永刚。

Dr. Halferty: I wish that for you, too. You know, it's OK to want your next-of-kin or some other specific person to make those decisions.

You could fill out a healthcare proxy or Power of Attorney for Health Care. That gives someone you trust the right to make these decisions for you.

Patient: 和叶永刚说说。叶永刚会知道该做什么。

Dialogue #3: Family meeting

Dr. Halferty Thanks for meeting with me today about your mom.

叶永明 不，恰恰相反，谢谢您和我们见面。

那么，我母亲的病情如何？我们不明白为什么她还住在医院。

Dr. Halferty I wish I had better news for you. The most recent CT showed that the cancer has spread to your mother's liver. That is very serious.

There are no more treatments that would be effective against the cancer. We think it's time to transition her to hospice care.

叶永明 那是什么？是一种新的治疗方法吗？

Dr. Halferty Hospice care is a medical program provided by a team of healthcare professionals including doctors, nurses, social workers, and chaplains.

They would treat her symptoms, like the pain, in order to make her more comfortable, and offer support to both your mother and your family. But there's nothing more we can do to cure the cancer.

叶永明 这么说，情况还不错，对吧？如果她感觉舒适，那就没有问题了。

Dr. Halferty Well, the cancer will keep growing. And eventually, that will be incompatible with life.

叶永明 我不明白。您是不是说我母亲要死了？您打算放手让她死去？

Dr. Halferty I can understand your anger, Mr. Ye. Sometimes it makes me angry too.

I wish we had something else we could do for your mother, to cure the cancer, but once this type of cancer metastasizes to the liver, we're really out of options.

叶永婧 如果您不能治好她，那下一步该怎么办？

Dr. Halferty There are lots of things the hospice team can do to help your mother be more comfortable as the end approaches. Like using medications to control her pain and nausea.

The hospice team would focus on helping her have energy to enjoy life as much as possible at home with you.

I want you to know that I've talked with your mother about this, and she understands that there is nothing left we can do to cure the cancer.

叶永明 *(angrily—do NOT pause to let the interpreter interpret)*嗯，我不同意！您得做点什么！您不能就这样让她死去。

叶永婧 （*Do NOT pause to let the interpreter interpret)*叶永明，别激动，医生正在尽最大的努力。而且如果妈同意 –

叶永明 我无法相信！你觉得任由妈死去没什么问题吗？好吧，反正我是绝不会放弃妈的！

叶永婧 *(crying)*你怎么能这样对我说呢？这不公平！你知道我愿意为妈做任何事情。但是医生说能做的他们都做了。我们应该把叶永刚, 叶永强, 和叶永丽都叫来。我们应该等所有人到齐后再做决定。

叶永明 *(disgusted noise)*哼，叶永刚

Dialogue #4

Dr. Halferty I can hear how upset you both are about this news, and I don't blame you. This is very hard to hear.

But I want to assure you that if there were anything at all we could do that would give us hope for a cure, we would do it.

There just isn't anything.

I explained this to your mother and she *seemed* to understand.

And then I spoke to her about transitioning to hospice care, but she really didn't want to talk about that.

She HAS agreed to name a surrogate decision maker, who would be available to help us make these decisions.

She wanted to name her son Ye Yong Gang, but I understand that he lives in China. Is that right?

叶永婧 是的，他住在中国，上海。

Dr. Halferty I thinkitwould be wisertonameone of thetwo of youwholivehere. After all, you could talk with her about her wishes and you would be nearby if we needed to ask questions.

叶永婧 我们应该等到叶永刚、叶永强, 和叶永丽,过来才做决定。(pause) 叶永刚要得到签证才可以过来。

Dr. Halferty My point exactly. Ms. Ye, you are your mother's principle caregiver. Maybe she would agree to name you as her decision-maker.

叶永婧 不，不，我们应该等到其他人都来了再说。

Dr. Halferty *(at a loss)* But it sounds like that could be quite a while . . . And we really need someone named to make decisions for your mom. We don't know how quickly this cancer may advance . . .

叶永明 Elena 说得对。所有人来这儿后我们才能决定。

Dr. Halferty Mr. and Ms. Ye, is this a decision you can make between the two of you? Or is it absolutely essential to consult with your brothers and your sister first?

叶永婧 当然。我们不能独自做这样的决定！

叶永明 对。我们首先得同兄弟姐妹们商量一下。

叶永婧 但是，我们如何才能让叶永刚来到这儿呢？

Dr. Halferty OK. I'll see if we can get a Social Worker to work on getting an emergency medical visa for your brother so that he can come to be with your mother. If that doesn't work out, we'll set up a conference call so you can all talk and make some decisions.

叶永婧 谢谢您，医生。愿老天保佑您。

Handout #8 CA
Practice Interpreting Dialogues: English-Traditional Chinese

Instructions

These exercises are designed to be used in a small group of four people. Choose one person to play the role of the clinician, one to play the role of the patient, one to interpret and one to observe.

The interpreter may NOT look at the script.

Doctor, start by reading your part. At the end of each paragraph, pause to let the interpreter interpret. Then the patient reads. Then the interpreter interprets. If the interpreter uses a hand signal to ask you to pause, do so. If the interpreter intervenes, respond as you think the doctor or the patient would Mark on your scripts any places where the interpreter adds, omits or changes meaning.

Interpreter, remember that you are interpreting for meaning, not words. If the speakers go on too long, use your interpreting techniques to get them to pause. Ask the meaning of words you don't know.

Observer, throughout the exercise, use the Feedback Form to keep track of interpreting strengths and errors. Were there places where meaning was added, omitted or change? Were there places where alternative vocabulary might have been used, or where the interpretation did not sound native?When the first dialogue is finished, provide this feedback to the interpreter.

When you are done giving feedback, switch roles and go on to Scene 2. Continue this pattern till everyone has had a chance to interpret.

Dialogue #1: Patient-provider encounter

Dr. Halferty: Mrs. Ye, you may remember that we did a CT scan of your abdomen last week.

Well, we got the results back, would you like me to tell you the full details? Or, if not, is there somebody else you'd like me to talk to?

Patient: 不，請您和我說說吧。

Dr. Halferty: Well, I'm afraid that the news in not good. The test showed that the cancer has metastasized to your liver.

Patient: 我知道有些不對勁。我能感覺到。

哦。那麼，現在怎麼辦？請別再進行化療了。我不想再做了。

Dr. Halferty: No, I know that was hard for you last time, and I'm afraid we've exhausted whatever benefit we could get from chemotherapy anyway.

Actually . . . I think it's time we talked about a different kind of treatment regimen called palliative care.

Patient: 只要不再進行化療就好！那麼，這次治療將是怎麼樣的治療？

Dr. Halferty: Instead of trying to cure the cancer, we'll be focusing on controlling the symptoms being caused by the cancer -- like the pain and the nausea from the bowel obstruction.

We can do everything possible to make you comfortable so that you can enjoy the best quality of life possible in the time you have left.

Patient: 那好！我只是無法再接受更多的化療了。那麼，這種新治療要持續多久？

Dr. Halferty: Well, as long as you need it.

Patient: *(confused and unsure)* 我明白了。

(LONG PAUSE. WAIT TO SEE IF THE INTERPRETER WILL INTERVENE.)

Dr. Halferty: I think I wasn't very clear. Your cancer has spread to the point that there's nothing we can do to cure it or even to stop it from growing.

But we can help you feel as comfortable as possible until you pass.

Dialogue #2

Patient: 您是說我快要死了。

Dr. Halferty: Yes. I'm very sorry . . . I wish the news were different.

Patient: 我沒想到這點。..太快了。

Dr. Halferty: I can see you're upset. Tell me more about how you are feeling. You look worried. What worries you the most?

Patient: 只是我的家人還需要我。而且這家醫院太貴了。我希望能回家，但是誰來照顧我呢？此外，疼痛也是個問題。

Dr. Halferty: You know, patients who want the best treatment of their symptoms, and who would no longer benefit from chemotherapy, are eligible for a

type of care called hospice care. Have you ever heard of that?

Patient: 沒有。

Dr. Halferty: Well, hospicecareis a specialtype of careforpeoplewho are neartheend of theirlives.

You could either be at home or in a long-term care facility, and a team of doctors, nurses, social workers and chaplains would help control your symptoms like the pain that you're afraid of.

They'd also help you do what's most important to you with the time that you have. And they'd be there to provide support for your family.

Patient: 我不知道，醫生。也許這樣最好。..我不知道。..
我太老了，不適合做這些決定。您可以和我的孩子們談談。

Dr. Halferty: I could do that.

Patient: *(wistfully)*您知道我有五個孩子嗎？葉永剛, 葉永強，葉永麗, 葉永明和葉永婧。葉永強和葉永麗住在德克薩斯州，葉永剛仍住在中國。
我希望在臨終前能見到仍住在中國的葉永剛。

Dr. Halferty: I wish that for you, too. You know, it's OK to want your next-of-kin or some other specific person to make those decisions.

You could fill out a healthcare proxy or Power of Attorney for Health Care. That gives someone you trust the right to make these decisions for you.

Patient: 和葉永剛說說。葉永剛會知道該做什麼。

Dialogue #3: Family meeting

Dr. Halferty Thanks for meeting with me today about your mom.

葉永明 不，恰恰相反，謝謝您和我們見面。
那麼，我母親的病情如何？我們不明白為什麼她還住在醫院。

Dr. Halferty I wish I had better news for you. The most recent CT showed that the cancer has spread to your mother's liver. That is very serious.

There are no more treatments that would be effective against the cancer. We think it's time to transition her to hospice care.

葉永明 那是什麼？是一種新的治療方法嗎？

Dr. Halferty Hospice care is a medical program provided by a team of healthcare professionals including doctors, nurses, social workers, and chaplains.

They would treat her symptoms, like the pain, in order to make her more comfortable, and offer support to both your mother and your family. But there's nothing more we can do to cure the cancer.

葉永明 這麼說，情況還不錯，對吧？如果她感覺舒適，那就沒有問題了。

Dr. Halferty Well, the cancer will keep growing. And eventually, that will be incompatible with life.

葉永明 我不明白。您是不是說我母親要死了？您打算放手讓她死去？

Dr. Halferty I can understand your anger, Mr. Ye.Sometimes it makes me angry too.

I wish we had something else we could do for your mother, to cure the cancer, but once this type of cancer metastasizes to the liver, we're really out of options.

葉永婧 如果您不能治好她，那下一步該怎麼辦？

Dr. Halferty There are lots of things the hospice team can do to help your mother be more comfortable as the end approaches. Like using medications to control her pain and nausea.

The hospice team would focus on helping her have energy to enjoy life as much as possible at home with you.

I want you to know that I've talked with your mother about this, and she understands that there is nothing left we can do to cure the cancer.

葉永明 *(angrily—do NOT pause to let the interpreter interpret)*嗯，我不同意！您得做點什麼！您不能就這樣讓她死去。

葉永婧 (*Do NOT pause to let the interpreter interpret)*葉永明，別激動，醫生正在盡最大的努力。而且如果媽同意…

葉永明 我無法相信！你覺得任由媽死去沒什麼問題嗎？好吧，反正我是絕不會放棄媽的！

葉永婧 *(crying)* 你怎麼能這樣對我說呢？這不公平！你知道我願意為媽做任何事情。但是醫生說能做的他們都做了。我們應該把葉永剛, 葉永強, 和葉永麗都叫來。我們應該等所有人到齊後再做決定。

葉永明 *(disgusted noise)*哼，葉永剛

Dialogue #4

Dr. Halferty I can hear how upset you both are about this news, and I don't blame you. This is very hard to hear.

But I want to assure you that if there were anything at all we could do that would give us hope for a cure, we would do it.

There just isn't anything.

I explained this to your mother and she *seemed* to understand.

And then I spoke to her about transitioning to hospice care, but she really didn't want to talk about that.

She HAS agreed to name a surrogate decision maker, who would be available to help us make these decisions.

She wanted to name her son Ye Yong Gang, but I understand that he lives in China. Is that right?

葉永婧 是的，他住在中國，上海。

Dr. Halferty I thinkitwould be wisertonameone of thetwo of youwholivehere. After all, you could talk with her about her wishes and you would be nearby if we needed to ask questions.

葉永婧 我們應該等到葉永剛、葉永強,葉永明和葉永麗過來才做決定。(pause) 葉永剛要得到簽證才可以過來。

Dr. Halferty My point exactly. Ms. Ye, you are your mother's principle caregiver. Maybe she would agree to name you as her decision-maker.

葉永婧 不，不，我們應該等到其他人都來了再說。

Dr. Halferty *(at a loss)* But it sounds like that could be quite a while . . . And we really need someone named to make decisions for your mom. We don't know how quickly this cancer may advance . . .

葉永明 說得對。所有人來這兒後我們才能決定。

Dr. Halferty Mr. and Ms. Ye, is this a decision you can make between the two of you? Or is it absolutely essential to consult with your brothers and your sister first?

葉永婧 當然。我們不能獨自做這樣的決定！

葉永明　對。我們首先得同兄弟姐妹們商量一下。

葉永婧　但是，我們如何才能讓葉永剛來到這兒呢？

Dr. Halferty　OK. I'll see if we can get a Social Worker to work on getting an emergency medical visa for your brother so that he can come to be with your mother. If that doesn't work out, we'll set up a conference call so you can all talk and make some decisions.

葉永婧　謝謝您，醫生。願老天保佑您。

Handout #8 VT
Practice Interpreting Dialogues: English-Vietnamese

Instructions

These exercises are designed to be used in a small group of four people. Choose one person to play the role of the clinician, one to play the role of the patient, one to interpret and one to observe.

The interpreter may NOT look at the script.

Doctor, start by reading your part. At the end of each paragraph, pause to let the interpreter interpret. Then the patient reads. Then the interpreter interprets. If the interpreter uses a hand signal to ask you to pause, do so. If the interpreter intervenes, respond as you think the doctor or the patient would Mark on your scripts any places where the interpreter adds, omits or changes meaning.

Interpreter, remember that you are interpreting for meaning, not words. If the speakers go on too long, use your interpreting techniques to get them to pause. Ask the meaning of words you don't know.

Observer, throughout the exercise, use the Feedback Form to keep track of interpreting strengths and errors. Were there places where meaning was added, omitted or change? Were there places where alternative vocabulary might have been used, or where the interpretation did not sound native? When the first dialogue is finished, provide this feedback to the interpreter.

When you are done giving feedback, switch roles and go on to Scene 2. Continue this pattern till everyone has had a chance to interpret.

Dialogue #1: Patient-provider encounter

Dr. Halferty: Lan, you may remember that we did a CT scan of your abdomen last week.

Well, we got the results back, would you like me to tell you the full details? Or, if not, is there somebody else you'd like me to talk to?

Patient: Không, hãy nói với tôi.

Dr. Halferty: Well, I'm afraid that the news in not good. The test showed that the cancer has metastasized to your liver.

Patient: Tôi biết có chuyện không hay. Tôi linh cảm được mà.

Ôi trời. Vậy, bây giờ sao rồi? Xin bác sĩ đừng làm hóa trị nữa. Không làm nữa.

Dr. Halferty: No, I know that was hard for you last time, and I'm afraid we've exhausted whatever benefit we could get from chemotherapy anyway.

Actually . . . I think it's time we talked about a different kind of treatment regimen called palliative care.

Patient: Miễn là không hóa trị nữa! Vậy, biện pháp điều trị này như thế nào?

Dr. Halferty: Instead of trying to cure the cancer, we'll be focusing on controlling the symptoms being caused by the cancer -- like the pain and the nausea from the bowel obstruction.

We can do everything possible to make you comfortable so that you can enjoy the best quality of life possible in the time you have left.

Patient: Tốt rồi! Tôi không thể chịu được cảnh phải hóa trị thêm. Vậy, biện pháp điều trị mới này sẽ kéo dài bao lâu?

Dr. Halferty: Well, as long as you need it.

Patient: *(confused and unsure)* Tôi hiểu rồi. . . .

(LONG PAUSE. WAIT TO SEE IF THE INTERPRETER WILL INTERVENE.)

Dr. Halferty: Lan, I think I wasn't very clear. Your cancer has spread to the point that there's nothing we can do to cure it or even to stop it from growing.

But we can help you feel as comfortable as possible until you pass.

Dialogue #2

Patient: Ý bác sĩ là tôi sắp chết. .

Dr. Halferty: Yes. I'm very sorry . . . I wish the news were different.

Patient: Tôi không ngờ chuyện này. . . quá sớm như thế. . .

Dr. Halferty: I can see you're upset. Tell me more about how you are feeling. You look worried. What worries you the most?

Patient: Chỉ vì gia đình vẫn cần có tôi. Và chi phí bệnh viện này quá đắt. Tôi ước chi có thể về nhà, nhưng ai sẽ chăm sóc tôi đây? Và rồi lại đau

đớn. . .

Dr. Halferty: You know, patients who want the best treatment of their symptoms, and who would no longer benefit from chemotherapy, are eligible for a type of care called hospice care. Have you ever heard of that?

Patient: Không.

Dr. Halferty: Well, hospice care is a special type of care for people who are near the end of their lives.
You could either be at home or in a long-term care facility, and a team of doctors, nurses, social workers and chaplains would help control your symptoms like the pain that you're afraid of.

They'd also help you do what's most important to you with the time that you have. And they'd be there to provide support for your family.

Patient: Tôi không biết thưa bác sĩ. . Có thể đó sẽ là lựa chọn tốt nhất. . . Tôi không biết nữa. . .

Tôi quá già không thể đưa ra những quyết định này. Tại sao bác sĩ không nói chuyện với các con tôi?

Dr. Halferty: I could do that.

Patient: *(wistfully)* Bác sĩ có biết tôi có năm người con không? Nam, Sơn, Cúc, Việt và Trúc. Sơn và Cúc sống ở Texas, và Nam vẫn sống ở Việt Nam.

Đứa con duy nhất còn ở quê nhà. Tôi ước chi có thể gặp nó trước khi ra đi.

Dr. Halferty: I wish that for you, too. You know, it's OK to want your next-of-kin or some other specific person to make those decisions.

You could fill out a healthcare proxy or Power of Attorney for Health Care. That gives someone you trust the right to make these decisions for you.

Patient: Hãy nói chuyện với Nam. Nam sẽ biết phải làm gì.

Dialogue #3: Family meeting

Dr. Halferty Thanks for meeting with me today about your mom.

Việt Không, trái lại – chúng tôi xin cám ơn BÁC SĨ đã gặp chúng tôi.

Vậy, mẹ tôi sao rồi? Chúng tôi không hiểu tại sao bà vẫn nằm viện.

Dr. Halferty I wish I had better news for you. The most recent CT showed that the cancer has spread to your mother's liver. That is very serious.

There are no more treatments that would be effective against the cancer. We think it's time to transition her to hospice care.

Việt Như thế là gì? Một biện pháp điều trị mới à?

Dr. Halferty Hospice care is a medical program provided by a team of healthcare professionals including doctors, nurses, social workers, and chaplains.

They would treat her symptoms, like the pain, in order to make her more comfortable, and offer support to both your mother and your family. But there's nothing more we can do to cure the cancer.

Việt Vậy, như thế là ổn phải không? Nếu bà ấy được thoải mái, thì không có vấn đề gì.

Dr. Halferty Well, the cancer will keep growing. And eventually, that will be incompatible with life.

Việt Tôi không hiểu. Có phải bác sĩ nói rằng mẹ tôi sắp qua đời? Và bác sĩ sẽ để bà chết?

Dr. Halferty I can understand your anger, Mr. Nguyen. Sometimes it makes me angry too.

I wish we had something else we could do for your mother, to cure the cancer, but once this type of cancer metastasizes to the liver, we're really out of options.

Trúc Nếu bác sĩ không thể chữa bệnh cho bà, vậy thì sao?

Dr. Halferty There are lots of things the hospice team can do to help your mother be more comfortable as the end approaches. Like using medications to control her pain and nausea.

The hospice team would focus on helping her have energy to enjoy life as much as possible at home with you.

I want you to know that I've talked with your mother about this, and she understands that there is nothing left we can do to cure the cancer.

Việt *(angrily—do NOT pause to let the interpreter interpret)* Này, tôi không đồng ý! Bác sĩ phải làm gì đi chứ! Không thể để bà ấy chết.

Trúc (*Do NOT pause to let the interpreter interpret)* Anh Việt ạ, anh bình tĩnh nhé, bác sĩ đang cố gắng giúp mà. Và nếu mẹ đồng ý —

Việt Không tin nổi! Bác sĩ để mẹ chết mà em thấy được à? Anh thì anh sẽ không bỏ rơi mẹ đâu!

Trúc *(crying)* Làm sao anh có thể nói thế với em? Thật không công bằng! Anh biết em sẽ chẳng nề hà việc gì vì mẹ mà. Nhưng bác sĩ nói họ KHÔNG thể làm gì nữa. Hay là mình bảo Nam sang, cùng với Sơn và Cúc . . . Tốt nhất là mình cùng quyết định với nhau, khi mọi người có mặt ở đây.

Việt *(disgusted noise)* Hừ, Nam

Dialogue #4

Dr. Halferty I can hear how upset you both are about this news, and I don't blame you. This is very hard to hear.

But I want to assure you that if there were anything at all we could do that would give us hope for a cure, we would do it.

There just isn't anything.

I explained this to your mother and she *seemed* to understand.

And then I spoke to her about transitioning to hospice care, but she really didn't want to talk about that.

She HAS agreed to name a surrogate decision maker, who would be available to help us make these decisions.

She wanted to name her son, Nam, but I understand that he lives in Vietnam. Is that right?

Trúc Vâng ạ, anh ấy ở Cần Thơ.

Dr. Halferty I think it would be wiser to name one of the two of you who live here. After all, you could talk with her about her wishes and you would be nearby if we needed to ask questions.

Trúc Tốt nhất là chờ đến khi Nam, Sơn, và Cúc đến đây. Nhưng (pause) Nam không có thị thực để có thể sang đây được.

Dr. Halferty My point exactly. Ms. Nguyen, you are your mother's principle caregiver. Maybe she would agree to name you as her decision-maker.

Trúc Không, không, chúng tôi sẽ chờ cho đến khi những người kia có mặt ở đây.

Dr. Halferty *(at a loss)* But it sounds like that could be quite a while . . . And we really need someone named to make decisions for your mom. We don't know how quickly this cancer may advance . . .

Việt Trúc nói đúng. Khi mọi người đến đây được, lúc đó chúng tôi mới quyết định được.

Dr. Halferty Mr. and Ms. Nguyen, is this a decision you can make between the two of you? Or is it absolutely essential to consult with your brothers and your sister first?

Trúc Dĩ nhiên -- chúng tôi không thể quyết định một mình!

Việt Đúng thế. Trước tiên chúng tôi phải trao đổi với các anh chị của mình.

Trúc Nhưng chúng tôi sẽ đưa Nam đến đây bằng cách nào?

Dr. Halferty OK. I'll see if we can get a Social Worker to work on getting an emergency medical visa for Nam so that he can come to be with your mother. If that doesn't work out, well set up a conference call so you can all talk and make some decisions.

Trúc Xin cám ơn bác sĩ. Chúa phù hộ cho [ông/bà].

Handout #8 KR
Practice Interpreting Dialogues: English-Korean

Instructions

These exercises are designed to be used in a small group of four people. Choose one person to play the role of the clinician, one to play the role of the patient, one to interpret and one to observe.

The interpreter may NOT look at the script.

Doctor, start by reading your part. At the end of each paragraph, pause to let the interpreter interpret. Then the patient reads. Then the interpreter interprets. If the interpreter uses a hand signal to ask you to pause, do so. If the interpreter intervenes, respond as you think the doctor or the patient would Mark on your scripts any places where the interpreter adds, omits or changes meaning.

Interpreter, remember that you are interpreting for meaning, not words. If the speakers go on too long, use your interpreting techniques to get them to pause. Ask the meaning of words you don't know.

Observer, throughout the exercise, use the Feedback Form to keep track of interpreting strengths and errors. Were there places where meaning was added, omitted or change? Were there places where alternative vocabulary might have been used, or where the interpretation did not sound native? When the first dialogue is finished, provide this feedback to the interpreter.

When you are done giving feedback, switch roles and go on to Scene 2. Continue this pattern till everyone has had a chance to interpret.

Dialogue #1: Patient-provider encounter

Dr. Halferty: Mrs. Lee, you may remember that we did a CT scan of your abdomen last week.

Well, we got the results back, would you like me to tell you the full details? Or, if not, is there somebody else you'd like me to talk to?

Patient: 아니예요, 저에게 말해 주세요.

Dr. Halferty: Well, I'm afraid that the news in not good. The test showed that the cancer has metastasized to your liver.

Patient: 뭔가 이상이 있다는 걸 알고 있었어요. 어쩐지 그런 느낌이 들었어요.

아… 이제 그럼 어떻게 되는거죠? 화학요법은 그만 두겠어요. 다시는 받지 않겠어요.

Dr. Halferty: No, I know that was hard for you last time, and I'm afraid we've exhausted whatever benefit we could get from chemotherapy anyway.

Actually… I think it's time we talked about a different kind of treatment regimen: palliative care.

Patient: 더 이상 화약요법을 받지 않아도 된다면요! 이 치료법은 어떤건가요?

Dr. Halferty: Instead of trying to cure the cancer, we'll be focusing on controlling the symptoms being caused by the cancer -- like the pain and the nausea from the bowel obstruction.

We can do everything possible to make you comfortable so that you can enjoy the best quality of life possible in the time you have left.

Patient: 괜찮네요! 정말, 화학요법은 더 이상 견디지 못하겠어요. 이 새 치료법은 얼마나 지속되는데요?

Dr. Halferty: Well, as long as you need it.

Patient: *(confused and unsure)* 네…

(LONG PAUSE. WAIT TO SEE IF THE INTERPRETER WILL INTERVENE.)

Dr. Halferty: Mrs. Lee, I think I wasn't very clear. Your cancer has spread to the point that there's nothing we can do to cure it or even to stop it from growing.

But we can help you feel as comfortable as possible until you pass.

Dialogue #2

Patient: 제가 … 죽을 거란 말씀이시군요…

Dr. Halferty: Yes. I'm very sorry … I wish the news were different.

Patient: 미처 생각 못했어요… 너무 일러…

Dr. Halferty: I can see you're upset. Tell me more about how you are feeling. You look worried. What worries you the most?

Patient: 그냥… 가족들이 아직도 저를 필요로 하고요…, 그리고 이 병원은 너무 비싸요. 집에 갈 수 있었으면 좋겠지만, 그럼 누가 나를 돌봐줄 수 있을까요? 그리고 또, 통증도 있고…

Dr. Halferty: You know, patients who want the best treatment of their symptoms, and who would no longer benefit from chemotherapy, are eligible for a type of care called hospice care. Have you ever heard of that?

Patient: 아니요.

Dr. Halferty: Well, hospice care is a special type of care for people who are near the end of their lives.

You could either be at home or in a long-term care facility, and a team of doctors, nurses, social workers and chaplains would help control your symptoms like the pain that you're afraid of.

They'd also help you do what's most important to you with the time that you have. And they'd be there to provide support for your family.

Patient: 선생님, 잘 모르겠어요… 어쩜 이게 최선일지도… 모르겠어요…

이런 결정을 내리기에는 저는 너무 늙었어요. 제 아이들에게 말씀하시는 건 어떨까요?

Dr. Halferty: I could do that.

Patient: *(wistfully)* 저에게 다섯 명의 자식이 있는 거 아세요? 철수, 민국, 영희, 호기 그리고 미희. 민국 과 영희 는 텍사스에 살고 철수 는 아직 한국 에 있어요.

아직도 우리 나라에 살고 있는 유일한 자식이죠. 죽기 전에 그를 볼 수 있었으면 좋겠어요.

Dr. Halferty: I wish that for you, too. You know, it's OK to want your next-of-kin or some other specific person to make those decisions.

You could fill out a healthcare proxy or Power of Attorney for Health Care. That gives someone you trust the right to make these decisions for you.

Patient: 철수에게 말씀해 보시죠. 철수는 어떻게 해야 할 지 알거예요.

Dialogue #3: Family meeting

Dr. Halferty Thanks for meeting with me today about your mom.

호기 아니예요, 우리를 만나주셔서 오히려 저희가 감사해요.

그런데, 저희 어머니는 좀 어떠세요? 왜 아직 병원에 계시는 건지 이해가 잘 되지 않습니다.

Dr. Halferty I wish I had better news for you. The most recent CT showed that the cancer has spread to your mother's liver. That is very serious.

There are no more treatments that would be effective against the cancer. We think it's time to transition her to hospice care.

호기 그게 뭔데요? 새로운 치료법인가요?

Dr. Halferty Hospice care is a medical program provided by a team of healthcare professionals including doctors, nurses, social workers, and chaplains.

They would treat her symptoms, like the pain, in order to make her more comfortable, and offer support to both your mother and your family. But there's nothing more we can do to cure the cancer.

호기 그럼, 괜찮은거네요, 그렇죠? 어머니만 편안해 하신다면 문제 없잖아요.

Dr. Halferty Well, the cancer will keep growing. And eventually, that will be incompatible with life.

호기 이해하지 못하겠어요. 저희 어머니가 돌아가실 거란 말씀이신가요? 어머니를 돌아가시게 그냥 내버려두신단 말씀이세요?

Dr. Halferty I can understand your anger, Mr. Lee. Sometimes it makes me angry too.

I wish we had something else we could do for your mother, to cure the cancer, but once this type of cancer metastasizes to the liver, we're really out of options.

미희 선생님이 어머니를 낫게 하실 수 없다면, 그럼 어떻게 되는거예요?

Dr. Halferty There are lots of things the hospice team can do to help your mother be more comfortable as the end approaches. Like using medications to control her pain and nausea.

The hospice team would focus on helping her have energy to enjoy life as much as possible at home with you.

I want you to know that I've talked with your mother about this, and she understands that there is nothing left we can do to cure the cancer.

호기 *(angrily—do NOT pause to let the interpreter interpret)* 어쨌건, 저는 동의 못해요! 무엇이든지 하셔야 해요! 어머니를 이렇게 돌아가시게 할 수는 없어요.

미희 (*Do NOT pause to let the interpreter interpret)* 호기오빠, 그만해요, 의사 선생님은 도와주려고 애쓰시고 있잖아. 그리고 만약 어머니가 동의하신다면 –

호기 정말 믿을 수가 없어! 너는 어머니를 그냥 돌아가시게 해도 괜찮단 말이야? 적어도, 나는 어머니를 버리지 않을 거야!

미희 *(crying)* 어떻게 나에게 그런 말을 할 수 있어? 정말 억울해! 오빠는 내가 어머니를 위해서라면 뭐든 할거라는 걸 알잖아. 그러나 의사 선생님이 할 수 있는 게 더 이상 없다고 말씀하시잖아… 철수오빠, 민국오빠 그리고 영희언니를 데려와야 해… 모두 여기 모였을 때 같이 모든 걸 결정해야 해.

호기 *(disgusted noise)* 허어, 철수형.

Dialogue #4

Dr. Halferty I can hear how upset you both are about this news, and I don't blame you. This is very hard to hear.

But I want to assure you that if there were anything at all we could do that would give us hope for a cure, we would do it.

There just isn't anything.

I explained this to your mother and she *seemed* to understand.

And then I spoke to her about transitioning to hospice care, but she really didn't want to talk about that.

She HAS agreed to name a surrogate decision maker, who would be available to help us make these decisions.

She wanted to name her son, Chul-Soo, but I understand that he lives in Korea. Is that right?

미희 네, 한국에 살아요.

Dr. Halferty I think it would be wiser to name one of the two of you who live here. After all, you could talk with her about her wishes and you would be nearby if we needed to ask questions.

미희 우린 철수오빠, 민국오빠 그리고 영희언니가 여기 올 때까지 기다려야 해요. 하지만 (pause) 철수오빠는 비자가 없어서 올 수 없어요.

Dr. Halferty My point exactly, Ms. Lee, you are your mother's principal caregiver. Maybe she would agree to name you as her decision-maker.

미희 아니, 아니예요. 모두 여기 올 때까지 기다려야 해요.

Dr. Halferty *(at a loss)* But it sounds like that could be quite a while… And we really need someone named to make decisions for your mom. We don't know how quickly this cancer may advance…

호기 미희말이 옳아요. 모두 여기 모이면, 그 때 결정해야해요.

Dr. Halferty Mr. and Ms. Lee, is this a decision you can make between the two of you? Or is it absolutely essential to consult with your brothers and your sister first?

미희 물론이예요 -- 그런 결정을 우리끼리 할 수는 없어요!

호기 맞아요. 먼저 형제들과 의논해야 해요.

미희 하지만 철수오빠를 어떻게 여기에 오게 하지요?

Dr. Halferty OK. I'll see if we can get a Social Worker to work on getting an emergency medical visa for Chul-Soo so that he can come to be with your mother. If that doesn't work out, we'll set up a conference call so you can all talk and make some decisions.

미희 감사합니다, 선생님. 대단히 감사합니다.

Handout #8 TG
Practice Interpreting Dialogues: English-Tagalog

Instructions

These exercises are designed to be used in a small group of four people. Choose one person to play the role of the clinician, one to play the role of the patient, one to interpret and one to observe.

The interpreter may NOT look at the script.

Doctor, start by reading your part. At the end of each paragraph, pause to let the interpreter interpret. Then the patient reads. Then the interpreter interprets. If the interpreter uses a hand signal to ask you to pause, do so. If the interpreter intervenes, respond as you think the doctor or the patient would Mark on your scripts any places where the interpreter adds, omits or changes meaning.

Interpreter, remember that you are interpreting for meaning, not words. If the speakers go on too long, use your interpreting techniques to get them to pause. Ask the meaning of words you don't know.

Observer, throughout the exercise, use the Feedback Form to keep track of interpreting strengths and errors. Were there places where meaning was added, omitted or change? Were there places where alternative vocabulary might have been used, or where the interpretation did not sound native? When the first dialogue is finished, provide this feedback to the interpreter.

When you are done giving feedback, switch roles and go on to Scene 2. Continue this pattern till everyone has had a chance to interpret.

Dialogue #1: Patient-provider encounter

Dr. Halferty: Caridad, you may remember that we did a CT scan of your abdomen last week.

Well, we got the results back, would you like me to tell you the full details? Or, if not, is there somebody else you'd like me to talk to?

Patient: Hindi po, kausapin n'yo ako, pakiusap.

Dr. Halferty: Well, I'm afraid that the news in not good. The test showed that the cancer has metastasized to your liver.

Patient: Alam kong may mali. Talagang naramdaman ko ito.

Diyos ko. Paano na ngayon? Wala na po sanang chemotherapy. Ayoko nang maulit ito.

Dr. Halferty: No, I know that was hard for you last time, and I'm afraid we've exhausted whatever benefit we could get from chemotherapy anyway.

Actually . . . I think its time we talked about a different kind of treatment regimen called palliative care.

Patient: Basta wala nang chemotherapy! Ano bang klase ng paggamot ito?

Dr. Halferty: Instead of trying to cure the cancer, well be focusing on controlling the symptoms being caused by the cancer -- like the pain and the nausea from the bowel obstruction.

We can do everything possible to make you comfortable so that you can enjoy the best quality of life possible in the time you have left.

Patient: Maganda po 'yan! Hindi ko lang talaga kaya ng higit pang chemotherapy. Gaano katagal ang bagong paggamot na ito?

Dr. Halferty: Well, as long as you need it.

Patient: *(confused and unsure)* Hanggang kailangan ko . . . .

(LONG PAUSE. WAIT TO SEE IF THE INTERPRETER WILL INTERVENE.)

Dr. Halferty: Caridad, I think I wasn't very clear. Your cancer has spread to the point that there's nothing we can do to cure it or even to stop it from growing.

But we can help you feel as comfortable as possible until you pass.

Dialogue #2

Patient: Sinasabi n'yo sa akin na mamamatay na ako . .

Dr. Halferty: Yes. I'm very sorry . . . I wish the news were different.

Patient: Hindi ko ito inaasahan . . . masyadong maaga . . .

Dr. Halferty: I can see you're upset. Tell me more about how you are feeling. You look worried. What worries you the most?

Patient: Kailangan pa ako ng aking pamilya. At ang ospital na ito ay masyadong mahal. Gusto ko nang umuwi, pero sino ang mangangalaga sa akin? At saka, may nararamdan akong sakit. . .

Dr. Halferty: You know, patients who want the best treatment of their symptoms, and who would no longer benefit from chemotherapy, are eligible for a type of care called hospice care. Have you ever heard of that?

Patient: Hindi pa.

Dr. Halferty: Well, hospice care is a special type of care for people who are near the end of their lives.

You could either be at home or in a long-term care facility, and a team of doctors, nurses, social workers and chaplains would help control your symptoms like the pain that you're afraid of.

They'd also help you do what's most important to you with the time that you have. And they'd be there to provide support for your family.

Patient: Ewan ko po, doktor. . Maaaring ito ang pinakamabuti. . . Ewan ko . . .

Masyadong matanda na ako para gawin ang mga desisyong ito. Bakit hindi po ninyo kausapin ang aking mga anak?

Dr. Halferty: I could do that.

Patient: *(wistfully)* Alam po ba ninyo na ako ay may limang anak? Sina Roberto, Fernando, Celia, Ronilo at Ligaya. Sina Fernando at Celia ay nakatira sa Texas, at Roberto ay nasa Pilipinas pa.

Ang tanging naroon pa rin aming sariling bansa. Sana ay makita ko siya bago ako mamatay.

Dr. Halferty: I wish that for you, too. You know, its OK to want your next-of-kin or some other specific person to make those decisions.

You could fill out a healthcare proxy or Power of Attorney for Health Care. That gives someone you trust the right to make these decisions for you.

Patient: Kausapin po ninyo si Roberto. Alam ni Roberto ang gagawin.

Dialogue #3: Family meeting

Dr. Halferty Thanks for meeting with me today about your mom.

Ronilo Hindi po – ako po ang dapat magpasalamat sa INYO sa pakikipagkita sa amin.

Kamusta po ang aking ina? Hindi po naming maintindihan kung bakit nasa ospital pa rin siya.

Dr. Halferty I wish I had better news for you. The most recent CT showed that the cancer has spread to your mother's liver. That is very serious.

There are no more treatments that would be effective against the cancer. We think its time to transition her to hospice care.

Ronilo At ano po iyon? Isang bagong uri ng paggamot?

Dr. Halferty Hospice care is a medical program provided by a team of healthcare professionals including doctors, nurses, social workers, and chaplins.

They would treat her symptoms, like the pain, in order to make her more comfortable, and offer support to both your mother and your family. But there's nothing more we can do to cure the cancer.

Ronilo Okey naman iyon, di po ba? Kung komportable siya, walang problema.

Dr. Halferty Well, the cancer will keep growing. And eventually, that will be incompatible with life.

Ronilo Hindi ko naiintindihan. Sinasabi po ba ninyo na ang aking ina ay mamamatay na? Na hahayaan ninyo siyang mamatay?

Dr. Halferty I can understand your anger, Mr. Aquino. Sometimes it makes me angry too.

I wish we had something else we could do for your mother, to cure the cancer, but once this type of cancer metastasizes to the liver, we're really out of options.

Ligaya Kung hindi ninyo siya magagamot, ano ang dapat gawin?

Dr. Halferty There are lots of things the hospice team can do to help your mother be more comfortable as the end approaches. Like using medications to control her pain and nausea.

The hospice team would focus on helping her have energy to enjoy life as much as possible at home with you.

I want you to know that I've talked with your mother about this, and she understands that there is nothing left we can do to cure the cancer.

Ronilo *(angrily—do NOT pause to let the interpreter interpret)* Hindi po ako sumasang-ayon! Dapat na mayroon kayong gawin! Hindi ninyo siya dapat hayaang mamatay.

Ligaya *(Do NOT pause to let the interpreter interpret)* Ronilo, intindihin mo sana, gusto lamang tumulong ng doktor. At kung pumapayag si Mom –

Ronilo Hindi ako makapaniwala! Payag kayong hayaan siyang mamatay? Pero, hindi ako pumapayag, hindi ko siya iiwan!

Ligaya *(crying)* Paano mo nagawang sabihin iyan sa akin? Hindi iyan makatarungan! Alam mong gagawin ko ang lahat para kay Mom. Pero sinabi ng doktor na WALA nang magagawa pa. . . Dapat nating papuntahin sina Roberto, Fernando at Celia . . . Dapat tayong magpasiyang magkakasama, kapag narito ang lahat.

Ronilo *(disgusted noise)* Ha, si Roberto.

Dialogue #4

Dr. Halferty I can hear how upset you both are about this news, and I don't blame you. This is very hard to hear.

But I want to assure you that if there were anything at all we could do that would give us hope for a cure, we would do it.

There just isn't anything.
I explained this to your mother and she *seemed* to understand.

And then I spoke to her about transitioning to hospice care, but she really didn't want to talk about that.

She HAS agreed to name a surrogate decision maker, who would be available to help us make these decisions.

She wanted to name her son Roberto, but I understand that he lives in the Philippines. Is that right?

Ligaya Opo, nakatira siya Cavite.

Dr. Halferty I think it would be wiser to name one of the two of you who live here. After all, you could talk with her about her wishes and you would be nearby if we needed to ask questions.

Ligaya Dapat tayong maghintay hanggang dumating sina Roberto, Fernando, at Celia. Pero si *(pause)* Roberto ay walang visa na magpapahintulot sa kanya na pumunta rito.

Dr. Halferty My point exactly. Ms. Aquino, you are your mother's principle caregiver. Maybe she would agree to name you as her decision-maker.

Ligaya	Hindi po, hindi, kailangan naming maghintay hanggang dumating ang iba.
Dr. Halferty	*(at a loss)* But it sounds like that could be quite a while . . . And we really need someone named to make decisions for your mom. We don't know how quickly this cancer may advance . . .
Ronilo	Tama si Ligaya. Kapag narito na ang lahat, saka kami magpapasiya.
Dr. Halferty	Mr. and Ms. Aquino, is this a decision you can make between the two of you? Or is it absolutely essential to consult with your brothers and your sister first?
Ligaya	Talaga – hindi kami makagagawa ng ganyang desisyon nang wala ang iba!
Ronilo	Tama ‘yan. Kailangan muna naming makausap ang aming mga kapatid.
Ligaya	Pero paano naming mapapapunta rito si Roberto?
Dr. Halferty	OK. I'll see if we can get a Social Worker to work on getting an emergency medical visa for Roberto so that he can come to be with your mother. If that doesn't work out, well set up a conference call so you can all talk and make some decisions.
Ligaya	Salamat po, doktor. Pagpalain po kayo ng Diyos.

Handout #8 RS
Practice Interpreting Dialogues: English-Russian

Instructions

These exercises are designed to be used in a small group of four people. Choose one person to play the role of the clinician, one to play the role of the patient, one to interpret and one to observe.

The interpreter may NOT look at the script.

Doctor, start by reading your part. At the end of each paragraph, pause to let the interpreter interpret. Then the patient reads. Then the interpreter interprets. If the interpreter uses a hand signal to ask you to pause, do so. If the interpreter intervenes, respond as you think the doctor or the patient would Mark on your scripts any places where the interpreter adds, omits or changes meaning.

Interpreter, remember that you are interpreting for meaning, not words. If the speakers go on too long, use your interpreting techniques to get them to pause. Ask the meaning of words you don't know.

Observer, throughout the exercise, use the Feedback Form to keep track of interpreting strengths and errors. Were there places where meaning was added, omitted or change? Were there places where alternative vocabulary might have been used, or where the interpretation did not sound native? When the first dialogue is finished, provide this feedback to the interpreter.

When you are done giving feedback, switch roles and go on to Scene 2. Continue this pattern till everyone has had a chance to interpret.

Dialogue #1: Patient-provider encounter

Dr. Halferty: Mrs. Ivanova, you may remember that we did a CT scan of your abdomen last week.

Well, we got the results back, would you like me to tell you the full details? Or, if not, is there somebody else you'd like me to talk to?

Patient: Нет, говорите со мной, пожалуйста.

Dr. Halferty: Well, I'm afraid that the news in not good. The test showed that the cancer has metastasized to your liver.

Patient: Я знала, что что-то там не в порядке. Я просто чувствовала.

О, Боже .И что теперь? Только не химиотерапию снова, пожалуйста. Только не это.

Dr. Halferty: No, I know that was hard for you last time, and I'm afraid we've exhausted whatever benefit we could get from chemotherapy anyway.

Actually . . . I think it's time we talked about a different kind of treatment regimen called palliative care.

Patient: Только без химиотерапии! Итак, как будет выглядеть это лечение?

Dr. Halferty: Instead of trying to cure the cancer, we'll be focusing on controlling the symptoms being caused by the cancer -- like the pain and the nausea from the bowel obstruction.

We can do everything possible to make you comfortable so that you can enjoy the best quality of life possible in the time you have left.

Patient: Отлично! Я просто не переживу еще один курс химиотерапии. И как долго продлится этот новый курс лечения?

Dr. Halferty: Well, as long as you need it.

Patient: *(confused and unsure)* Понятно. . . .

(LONG PAUSE. WAIT TO SEE IF THE INTERPRETER WILL INTERVENE.)

Dr. Halferty: Mrs. Ivanova, I think I wasn't very clear. Your cancer has spread to the point that there's nothing we can do to cure it or even to stop it from growing.

But we can help you feel as comfortable as possible until you pass.

Dialogue #2

Patient: Выговорите, что я умираю. .

Dr. Halferty: Yes. I'm very sorry . . . I wish the news were different.

Patient: Я не ожидала такого. . . так скоро. . .

Dr. Halferty: I can see you're upset. Tell me more about how you are feeling. You look worried. What worries you the most?

Patient: Просто моя семья еще нуждается во мне. А эта больница такая дорогая. Я бы хотела, чтоб меня отпустили домой, но кто будет за мной ухаживать? Да и боли. . .

Dr. Halferty: You know, patients who want the best treatment of their symptoms, and who would no longer benefit from chemotherapy, are eligible for a type of care called hospice care. Have you ever heard of that?

Patient: Нет.

Dr. Halferty: Well, hospice care is a special type of care for people who are near the end of their lives.

You could either be at home or in a long-term care facility, and a team of doctors, nurses, social workers and chaplains would help control your symptoms like the pain that you're afraid of.

They'd also help you do what's most important to you with the time that you have. And they'd be there to provide support for your family.

Patient: Не знаю, доктор. . Возможно, это будет лучшим решением. . .Не знаю. . .

Я слишком стара,чтобы принимать такие решения. Почему бы Вам не поговорить с моими детьми?

Dr. Halferty: I could do that.

Patient: *(wistfully)* Вы знаети что у меня пятеро детей? Алексей, Анна ,Петр , Марина и Елена. Анна и Петр живут в Техасе, а Алексей в России.

Он один остался на нашей родине. Я бы хотела повидать его, прежде чем придет мой час.

Dr. Halferty: I wish that for you, too. You know, it's OK to want your next-of-kin or some other specific person to make those decisions.

You could fill out a healthcare proxy or Power of Attorney for Health Care. That gives someone you trust the right to make these decisions for you.

Patient: Поговорите с Алексеем. Он знает что делать.

Dialogue #3: Family meeting

Dr. Halferty Thanks for meeting with me today about your mom.

Марина Нет, напротив, спасибо ВАМ, что встретились с нами.

Как себя чувствует моя мама? Мы не понимаем, почему она все еще в больнице.

Dr. Halferty I wish I had better news for you. The most recent CT showed that the cancer has spread to your mother's liver. That is very serious.

There are no more treatments that would be effective against the cancer. We think it's time to transition her to hospice care.

Марина А что это такое? Новый вид лечения?

Dr. Halferty Hospice care is a medical program provided by a team of healthcare professionals including doctors, nurses, social workers, and chaplains.

They would treat her symptoms, like the pain, in order to make her more comfortable, and offer support to both your mother and your family. But there's nothing more we can do to cure the cancer.

Марина То есть, так лучше, да? Если ей так удобно, то без проблем.

Dr. Halferty Well, the cancer will keep growing. And eventually, that will be incompatible with life.

Марина Я не понимаю.Вы уверены, что моя мама умирает? Вы что намерены дать ей умереть?

Dr. Halferty I can understand your anger, Mr. Ivanova . Sometimes it makes me angry too.

I wish we had something else we could do for your mother, to cure the cancer, but once this type of cancer metastasizes to the liver, we're really out of options.

Елена Если Вы не может ее вылечить, что тогда делать?

Dr. Halferty There are lots of things the hospice team can do to help your mother be more comfortable as the end approaches. Like using medications to control her pain and nausea.

The hospice team would focus on helping her have energy to enjoy life as much as possible at home with you.

I want you to know that I've talked with your mother about this, and she understands that there is nothing left we can do to cure the cancer.

Марина *(angrily—do NOT pause to let the interpreter interpret)* Хм, я не согласна! Вы должны что-то сделать! Вы неможете просто оставить ее умирать.

Елена (*Do NOT pause to let the interpreter interpret)* Марина, пожалуйста! Доктор пытается помочь. И если мама согласна –

Марина Я не могу поверить в это! То есть вас всех устраивает просто дать ей умереть? Ну, лично я ее не оставлю!

Елена *(crying)* Как ты можешь мне такое говорить? Это несправедливо! Ты же знаешь, я все сделаю для мамы. Но доктор говорит, что они больше НИЧЕГО не могут сделать. Нужно, чтобы приехали Алексей, Анна и Петр. . . Мы должны принять решение все вместе)

Марина *(disgusted noise)* Ох, Алексей

Dialogue #4

Dr. Halferty I can hear how upset you both are about this news, and I don't blame you. This is very hard to hear.

But I want to assure you that if there were anything at all we could do that would give us hope for a cure, we would do it.

There just isn't anything.

I explained this to your mother and she *seemed* to understand.

And then I spoke to her about transitioning to hospice care, but she really didn't want to talk about that.

She HAS agreed to name a surrogate decision maker, who would be available to help us make these decisions.

She wanted to name her son Alexey, but I understand that he lives in Russia Is that right?

Елена Да. Он живет в Росси. В Новгороде.

Dr. Halferty I think it would be wiser to name one of the two of you who live here. After all, you could talk with her about her wishes and you would be nearby if we needed to ask questions.

Елена	Мы должны дождаться приезда Алексея, Анны и Петра. Но*(pause)*у Алексея нет визы .
Dr. Halferty	My point exactly. Ms. Ginsburg, you are your mother's principle caregiver. Maybe she would agree to name you as her decision-maker.
Елена	Нет-нет, мы должны дождаться, пока не приедут остальные.
Dr. Halferty	*(at a loss)* But it sounds like that could be quite a while . . . And we really need someone named to make decisions for your mom. We don't know how quickly this cancer may advance . . .
Марина	Елена права. Когда все приедут, тогда мы сможем принять решение.
Dr. Halferty	Mr. Ivanova and Ms. Ginsburg, is this a decision you can make between the two of you? Or is it absolutely essential to consult with your brothers and your sister first?
Елена	Конечно, мы не можем принять такое решение одни!
Марина	Правильно. Мы должны сначала поговорить с нашими братьями и сестрой.
Елена	Но как нам сделать так, чтобы Алексей приехал сюда?
Dr. Halferty	OK. I'll see if we can get a Social Worker to work on getting an emergency medical visa for Alexey so that he can come to be with your mother. If that doesn't work out, well set up a conference call so you can all talk and make some decisions.
Елена	Спасибо Вам, доктор.Благослови Вас Бог.

Handout #8 EN
Practice Interpreting Dialogues: English-English

Instructions

These exercises are designed to be used in a small group of four people. Choose one person to play the role of the clinician, one to play the role of the patient, one to interpret and one to observe.

The interpreter may NOT look at the script.

Doctor, start by reading your part. At the end of each paragraph, pause to let the interpreter interpret. Then the patient reads. **Since the script in written in English, you will have to do a sight translation to read the patient's voice in your non-English language.** Then the interpreter interprets. If the interpreter uses a hand signal to ask you to pause, do so. If the interpreter intervenes, respond as you think the doctor or the patient would Mark on your scripts any places where the interpreter adds, omits or changes meaning.

Interpreter, remember that you are interpreting for meaning, not words. If the speakers go on too long, use your interpreting techniques to get them to pause. Ask the meaning of words you don't know.

Observer, throughout the exercise, use the Feedback Form to keep track of interpreting strengths and errors. Were there places where meaning was added, omitted or change? Were there places where alternative vocabulary might have been used, or where the interpretation did not sound native? When the first dialogue is finished, provide this feedback to the interpreter.

When you are done giving feedback, switch roles and go on to Scene 2. Continue this pattern till everyone has had a chance to interpret.

Dialogue #1

Dr. Halferty: You may remember that we did a CT scan of your abdomen last week.

Well, we got the results back, would you like me to tell you the full details? Or, if not, is there somebody else you'd like me to talk to?

Patient: No, talk to me, please.

Dr. Halferty: Well, I'm afraid that the news in not good. The test showed that the cancer has metastasized to your liver.

Patient: I knew something wasn't right. I just felt it.

Oh dear. So, what now? No more chemotherapy, please. Not again.

Dr. Halferty: No, I know that was hard for you last time, and I'm afraid we've exhausted whatever benefit we could get from chemotherapy anyway.

Actually . . . I think it's time we talked about a different kind of treatment regimen called palliative care.

Patient: Just as long as there's no more chemotherapy! So, what would this treatment look like?

Dr. Halferty: Instead of trying to cure the cancer, we'll be focusing on controlling the symptoms being caused by the cancer -- like the pain and the nausea from the bowel obstruction.

We can do everything possible to make you comfortable so that you can enjoy the best quality of life possible in the time you have left.

Patient: That's good! I just can't face getting more chemotherapy. So, how long will this new treatment last?

Dr. Halferty: Well, as long as you need it.

Patient: *(confused and unsure)* I see . . . .

(LONG PAUSE. WAIT TO SEE IF THE INTERPRETER WILL INTERVENE.)

Dr. Halferty: You know, I think I wasn't very clear. Your cancer has spread to the point that there's nothing we can do to cure it or even to stop it from growing.

But we can help you feel as comfortable as possible until you pass.

Dialogue #2

Patient: You're telling me I'm going to die . . .

Dr. Halferty: Yes. I'm very sorry . . . I wish the news were different.

Patient: I didn't expect it . . . so soon . . .

Dr. Halferty: I can see you're upset. Tell me more about how you are feeling. You look worried. What worries you the most?

Patient: It's just that my family still needs me. And this hospital is so expensive.

I wish could go home, but who would take care of me? And then, there's the pain. . .

Dr. Halferty: You know, patients who want the best treatment of their symptoms, and who would no longer benefit from chemotherapy, are eligible for a type of care called hospice care. Have you ever heard of that?

Patient: No.

Dr. Halferty: Well, hospice care is a special type of care for people who are near the end of their lives.

You could either be at home or in a long-term care facility, and a team of doctors, nurses, social workers and chaplains would help control your symptoms – like the pain that you're afraid of.

They'd also help you do what's most important to you with the time that you have. And they'd be there to provide support for your family.

Patient: I don't know, doctor. . Maybe this would be best. . . I don't know . . .

I'm too old to be making these decisions. Why don't you talk to my children?

Dr. Halferty: I could do that.

Patient: Did you know I have five children? My second son and my oldest daughter live in Texas, and my oldest son is still in our country.

The only one still in our homeland. I wish I could see him before it's my time.

Dr. Halferty: I wish that for you, too. You know, it's OK to want your next-of-kin or some other specific person to make those decisions.

You could fill out a healthcare proxy or Power of Attorney for Health Care. That gives someone you trust the right to make these decisions for you.

Patient: Talk to my son; he'll know what to do.

Dialogue #3

(In this dialogue, the observer will read the part of the son or daughter.)

Dr. Halferty Thanks for meeting with me today about your mom.

Son No, on the contrary -- thank YOU for meeting with us.

So, how is my mother? We don't understand why she's still in the hospital.

Dr. Halferty I wish I had better news for you. The most recent CT showed that the cancer has spread to your mother's liver. That is very serious.

There are no more treatments that would be effective against the cancer. We think it's time to transition her to hospice care.

Son And what is that? A new kind of treatment?

Dr. Halferty Hospice care is a medical program provided by a team of healthcare professionals including doctors, nurses, social workers, and chaplains.

They would treat her symptoms, like the pain, in order to make her more comfortable, and offer support to both your mother and your family. But there's nothing more we can do to cure the cancer.

Son So, that's OK, right? If she's comfortable, then there's no problem.

Dr. Halferty Well, the cancer will keep growing. And eventually, that will be incompatible with life.

Son I don't understand. Are you saying that my mother's going to die? That you're going to let her die?

Dr. Halferty I can understand your anger. Sometimes it makes me angry too.

I wish we had something else we could do for your mother, to cure the cancer, but once this type of cancer metastasizes to the liver, we're really out of options.

Daughter If you can't cure her, then what?

Dr. Halferty There are lots of things the hospice team can do to help your mother be more comfortable as the end approaches. Like using medications to control her pain and nausea.

The hospice team would focus on helping her have energy to enjoy life as much as possible at home with you.

I want you to know that I've talked with your mother about this, and she understands that there is nothing left we can do to cure the cancer.

Son *(angrily—do NOT pause to let the interpreter interpret)* Well, I don't agree! You have to do something! You can't just let her die.

Daughter (*Do NOT pause to let the interpreter interpret)* Please, the doctor is trying to help. And if mother is agreeing –

Son I can't believe this! You're OK with just letting her die? Well, as far as I'm concerned, I'm not going to abandon her!

Daughter *(crying)* How can you say that to me? That's not fair! You know I'd do anything for mother. But the doctor says there ISNT anything more that they can do. . . We should bring our brothers and sister . . . We should decide all together, when everyone's here.

Son *(disgusted noise)* Yeah, right.

Dialogue #4

Dr. Halferty I can hear how upset you both are about this news, and I don't blame you. This is very hard to hear.

But I want to assure you that if there were anything at all we could do that would give us hope for a cure, we would do it.

There just isn't anything.

I explained this to your mother and she *seemed* to understand.

And then I spoke to her about transitioning to hospice care, but she really didn't want to talk about that.

She HAS agreed to name a surrogate decision maker, who would be available to help us make these decisions.

She wanted to name her oldest son, but I understand that he lives back where you came from. Is that right?

Daughter Yes, he lives back home, in our country.

Dr. Halferty I think it would be wiser to name one of the two of you who live here. After all, you could talk with her about her wishes and you would be nearby if we needed to ask questions.

Daughter We should wait until our brothers and sister get here. But *(pause)* But our brother doesn't have a visa that would allow him to come.

Dr. Halferty My point exactly. Listen, you are your mother's principle caregiver. Maybe she would agree to name you as her decision-maker.

Daughter No, no, we should wait until the others get here.

Dr. Halferty *(at a loss)* But it sounds like that could be quite a while . . . And we really need someone named to make decisions for your mom. We don't know how quickly this cancer may advance . . .

Son No, my sister is right. When everyone gets here, then we can decide.

Dr. Halferty Tell me, is this a decision you can make between the two of you? Or is it absolutely essential to consult with your brothers and your sister first?

Daughter Of course -- we can't make a decision like that alone!

Son That's right. We have to talk to our brothers and sister first.

Daughter But how are we going to get our brother here?

Dr. Halferty OK. I'll see if we can get a Social Worker to work on getting an emergency medical visa for your brother so that he can come to be with your mother. If that doesn't work out, well set up a conference call so you can all talk and make some decisions.

Daughter Thank you, doctor. God bless you.

Handout #9 SP
Practice Interpreting, Chuchotage, English-Spanish

Practice #1
Physician consult with patient and her husband

Doctor: So, how have you been feeling over the past several days? How's the pain been?

Patient Pues, sí, me molesta un poco . .

Doctor: OK. On scale from one to ten, how bad would you say it was?

Patient No sé . . . quizá un cuatro . . . .

(From here on, do NOT pause for the interpreter to interpret)

Husband ¡¿Un cuatro?! Querida, tú sabes que anoche no aguantabas el dolor. Díselo al doctor.

Patient Ay, no fue para tanto. Además, ¿qué pueden hacer? Tengo quemaduras en todo el cuerpo – claro que me va a doler.

Husband No, precisamente de eso se trata. Te pueden controlar el dolor, pero tú tienes que decirles cuándo se te apeora.

Patient Me van a creer una quejona.

Husband No, mi'ja, no seas así. Para eso están ellos. ¿Te acuerdas? El doctor te dijo que tienes que decirles la verdad en respecto al dolor. Por favor. Me mata verte así.

Patient Bueno, pues, la verdad es que fue un 10. O mejor, un 15. Pero ¿de verdad crees que pueden hacer algo?

Practice #2
Social Worker consult with patient and her daughter

Social Worker I understand you've decided that a home hospice program would work for you. I'd be happy to help you find one.

Patient Gracias. Lo que más quiero es regresar a mi casa. O sea, a casa de mi hija. Solo espero no resultarle un a carga.

(From here on, do NOT pause for the interpreter to interpret)

Daughter *(to patient)* ¡No seas absurda, mama! Para mí, nunca me vas a ser un a carga. *(to social worker)* Actually, I do have some questions, though.

Social Worker Ask away! That's why I stopped by.

Daughter Well, I mean . . . will I have to . . . um. . . it's just that I wouldn't want to leave Mom alone, but what if I have to go out, like to do the shopping or something?

Social Worker One of the services that hospice offers is respite care. That means they'll send a volunteer to stay with your mom if you need a break. Also a home health aide will be available to you, so you could always step out while the aide is there.

Daughter Well, that's a relief! Also, who will be her doctor? We've had so many here at the hospital, then there's her primary care doctor and doesn't the hospice team have a doctor too?

Social Worker That's a good question. I'm not sure. Let me check on who will be following your mom's overall care. But don't worry – we won't leave you without a doctor!

Daughter You all have been so helpful. We're really very grateful.

Practice #3

Chaplain consult with patient

Chaplain Good morning! It's good to see you again. How are you feeling today?

Patient (male) ¿Por qué todo el mundo me pregunta eso? Me siento de lo peor. Como quisiera que me dejaran en paz.

Chaplain I'm so sorry to hear you're not doing well. Tell me about it. What's up?

Patient y ¿a tí qué te importa?

Chaplain I do care. This is the first time I've seen you so down. Has something happened?

(From here on, do NOT pause for the interpreter to interpret)

Patient *(sarcastically, angrily)* Quieres decir, ¿aparte del accidente? ¿Aparte de haber recibido la grata noticia que van a pasar años para que me

recupere totalmente? ¡Si es que acaso lo logro! ¿Aparte de los gastos y del hecho que no puedo ver a mi familia y voy a perder me trabajo? ¿Aparte de todo eso? ¡No, aparte de eso, todo anda perfectamente bien! ¡Me encanta estar aquí, echado en la cama en un hospital! Tú te metes aquí, todo sol y sonrisas, ¿qué sabes tú de todo esto? Mi vida se acabó. Mejor me hubieran dejado morir en ese accidente, eso hubiera sido mejor para todos – para mi familia y para mis hijos ¿Qué clase de esposo puedo ser así? ¿Qué clase de padre? Sólo vete y déjame en paz; no quiero hablar contigo ni con nadie.

Handout #9, MN
Practice Interpreting, Chuchotage
English-Simplified Chinese

Chuchotage Practice #1:
Physician consult with patient and her husband.

Doctor: So, how have you been feeling over the past several days? How's the pain been?

Patient 嗯，我能真切地感觉到。...

Doctor: OK. On scale from one to ten, how bad would you say it was?

Patient 我不知道。..我猜，可能是四。.

(From here on, do NOT pause for the interpreter to interpret)

Husband 四？！你知道自己昨晚疼得很厉害！把情况告诉医生吧！

Patient 噢，没那么糟糕。而且，他们能做什么呢？我当时全身烧伤，当然很痛。

Husband 是的，亲爱的，这就是问题所在！他们可以帮助控制疼痛，但是如果疼痛加剧，你必须告诉他们。

Patient 他们可能会认为我是一个可怕的抱怨者。

Husband 不，他们不会的。这就是他们来这儿的目的。还记得吗？医生说过你需要如实反映疼痛状况。别这样，好不好？我就是不愿看到你这样。

Patient 好吧，在那种情况下，是 10。太糟糕了。你真的认为他们还能做点什么吗？

Chuchotage Practice #2
Social Worker consult with patient and her daughter

Social Worker I understand you've decided that a home hospice program would work for you. I'd be happy to help you find one.

Patient 谢谢你。我真的想再回次家。 嗯，我是指回我女儿的家。我只希望这对她来说不会是太大的负担。

(From here on, do NOT pause for the interpreter to interpret)

Daughter *(to patient)*别傻了，妈！ 会好起来的。*(to social worker)* Actually, I do have some questions, though.

Social Worker Ask away! That's why I stopped by.

Daughter Well, I mean . . will I have to . . . um. . . it's just that I wouldn't want to leave Mom alone, but what if I have to go out, like to do the shopping or something?

Social Worker One of the services that hospice offers is respite care. That means they'll send a volunteer to stay with your mom if you need a break. Also a home health aide will be available to you, so you could always step out while the aide is there.

Daughter Well, that's a relief! Also, who will be her doctor? We've had so many here at the hospital, then there's her primary care doctor and doesn't the hospice team have a doctor too?

Social Worker That's a good question. I'm not sure. Let me check on who will be following your mom's overall care. But don't worry – we won't leave you without a doctor!

Daughter You all have been so helpful. We're really very grateful.

Chuchotage Practice #3

Chaplain consult with patient

Chaplain Good morning! It's good to see you again. How are you feeling today?

Patient (male) 为什么每个人都不停地问我这个问题？我感觉很糟糕。我真希望你们全都走。

Chaplain I'm so sorry to hear you're not doing well. Tell me about it. What's up?

Patient 你们在乎什么？

Chaplain I do care. This is the first time I've seen you so down. Has something happened?

(From here on, do NOT pause for the interpreter to interpret)

Patient *(sarcastically, angrily)*您是指除了事故之外？除了被告知要数年时间我才能站起来？如果我还能站起来的话！除了账单以及我无法再和家人在

一起，我会失去工作外？除了这些以外？不，除了这些以外，一切都很好！我喜欢这样，躺在医院里！你们来了，个个面带笑容，可是你们知道什么？我的生命结束了。他们应该就让我死在事故现场，那样对所有人都更好，对我的家人，我的孩子们都更好。这个样子我会成为一个什么样的丈夫呢？什么样的父亲？都走吧，让我一个人呆一会儿，我不想和你们或者任何其他人谈了。

Handout #9, CA
Practice Interpreting, Chuchotage
English-Traditional Chinese

Chuchotage Practice #1:
Physician consult with patient and her husband.

Doctor: So, how have you been feeling over the past several days? How's the pain been?

Patient 嗯，我能真切地感覺到。...

Doctor: OK. On scale from one to ten, how bad would you say it was?

Patient 我不知道。..我猜，可能是四。.

(From here on, do NOT pause for the interpreter to interpret)

Husband 四？！你知道自己昨晚疼得很厲害！把情況告訴醫生吧！

Patient 噢，沒那麼糟糕。而且，他們能做什麼呢？我當時全身燒傷，當然很痛。

Husband 是的，親愛的，這就是問題所在！他們可以幫助控制疼痛，但是如果疼痛加劇，你必須告訴他們。

Patient 他們可能會認為我是一個可怕的抱怨者。

Husband 不，他們不會的。這就是他們來這兒的目的。還記得嗎？醫生說過你需要如實反映疼痛狀況。別這樣，好不好？我就是不願看到你這樣。

Patient 好吧，在那種情況下，是10。太糟糕了。你真的認為他們還能做點什麼嗎？

Chuchotage Practice #2
Social Worker consult with patient and her daughter

Social Worker I understand you've decided that a home hospice program would work for you. I'd be happy to help you find one.

Patient 謝謝你。我真的想再回次家。嗯，我是指回我女兒的家。我只希望這對她來說不會是太大的負擔。

(From here on, do NOT pause for the interpreter to interpret)

Daughter *(to patient)*別傻了，媽！會好起來的。*(to social worker)* Actually, I do have some questions, though.

Social Worker Ask away! That's why I stopped by.

Daughter Well, I mean . . will I have to . . . um. . . it's just that I wouldn't want to leave Mom alone, but what if I have to go out, like to do the shopping or something?

Social Worker One of the services that hospice offers is respite care. That means they'll send a volunteer to stay with your mom if you need a break. Also a home health aide will be available to you, so you could always step out while the aide is there.

Daughter Well, that's a relief! Also, who will be her doctor? We've had so many here at the hospital, then there's her primary care doctor and doesn't the hospice team have a doctor too?

Social Worker That's a good question. I'm not sure. Let me check on who will be following your mom's overall care. But don't worry – we won't leave you without a doctor!

Daughter You all have been so helpful. We're really very grateful.

Chuchotage Practice #3

Chaplain consult with patient

Chaplain Good morning! It's good to see you again. How are you feeling today?

Patient (male) 為什麼每個人都不停地問我這個問題？我感覺很糟糕。我真希望你們全都走。

Chaplain I'm so sorry to hear you're not doing well. Tell me about it. What's up?

Patient 你們在乎什麼？

Chaplain I do care. This is the first time I've seen you so down. Has something happened?

(From here on, do NOT pause for the interpreter to interpret)

Patient *(sarcastically, angrily)*您是指除了事故之外？除了被告知要數年時間我才能站起來？如果我還能站起來的話！除了帳單以及我無法再和家人在

一起，我會失去工作外？除了這些以外？不，除了這些以外，一切都很好！我喜歡這樣，躺在醫院裡！你們來了，個個面帶笑容，可是你們知道什麼？我的生命結束了。他們應該就讓我死在事故現場，那樣對所有人都更好，對我的家人，我的孩子們都更好。這個樣子我會成為一個什麼樣的丈夫呢？什麼樣的父親？都走吧，讓我一個人呆一會兒，我不想和你們或者任何其他人談了。

Handout #9, VT
Practice Interpreting, Chuchotage, English-Vietnamese

Chuchotage Practice #1:
Physician consult with patient and her husband.

Doctor: So, how have you been feeling over the past several days? How's the pain been?

Patient Tôi chắc chắn có thể cảm nhận điều đó. . . .

Doctor: OK. On scale from one to ten, how bad would you say it was?

Patient Tôi không biết nữa. . . Tôi nghĩ có thể là bốn . .

(From here on, do NOT pause for the interpreter to interpret)

Husband Bốn ư?! Tối qua mẹ đau rất nặng, mẹ biết không! Hãy nói cho bác sĩ biết việc đó!

Patient Ôi, không tệ thế đâu. Ngoài ra, họ có thể làm gì? Mẹ bị phỏng khắp nơi trên người, dĩ nhiên rất đau.

Husband Ôi, trời, đó chính là vấn đề! Họ có thể giúp kiểm soát đau đớn, nhưng mẹ phải cho họ biết nếu bệnh trở nặng.

Patient Họ sẽ cho rằng mẹ là kẻ gây phiền hà.

Husband Không, không đâu. Vì thế họ mới có mặt ở đây mà. Nhớ không? Bác sĩ bảo rằng mẹ cần phải trung thực khi cho biết mình đau thế nào. Được không? Con không muốn thấy mẹ thế này.

Patient Vậy, trong trường hợp đó, thì là một số 10. Quá tệ. Con có cho rằng họ có thể làm gì đó không?

Chuchotage Practice #2
Social Worker consult with patient and her daughter

Social Worker I understand you've decided that a home hospice program would work for you. I'd be happy to help you find one.

Patient Cám ơn. Tôi thực sự muốn về nhà lại. Ý tôi là về nhà con gái tôi. Tôi chỉ mong rằng tôi không là gánh nặng quá lớn đối với nó.

(From here on, do NOT pause for the interpreter to interpret)

Daughter *(to patient)* Đừng thế mà Mẹ! Sẽ ổn thôi. *(to social worker)* Actually, I do have some questions, though.

Social Worker Ask away! That's why I stopped by.

Daughter Well, I mean . . will I have to . . . um. . . it's just that I wouldn't want to leave Mom alone, but what if I have to go out, like to do the shopping or something?

Social Worker One of the services that hospice offers is respite care. That means they'll send a volunteer to stay with your mom if you need a break. Also a home health aide will be available to you, so you could always step out while the aide is there.

Daughter Well, that's a relief! Also, who will be her doctor? We've had so many here at the hospital, then there's her primary care doctor and doesn't the hospice team have a doctor too?

Social Worker That's a good question. I'm not sure. Let me check on who will be following your mom's overall care. But don't worry – we won't leave you without a doctor!

Daughter You all have been so helpful. We're really very grateful.

Chuchotage Practice #3

Chaplain consult with patient

Chaplain Good morning! It's good to see you again. How are you feeling today?

Patient (male) Tại sao mọi người lúc nào cũng hỏi tôi như thế? Tôi cảm thấy rất tệ. Tôi ước chi tất cả các người đi hết đi.

Chaplain I'm so sorry to hear you're not doing well. Tell me about it. What's up?

Patient Ông quan tâm chuyện gì?

Chaplain I do care. This is the first time I've seen you so down. Has something happened?

(From here on, do NOT pause for the interpreter to interpret)

Patient *(sarcastically, angrily)* Có phải bà muốn nói ngoài tai nạn đó? Ngoài việc được cho biết là sẽ mất nhiều năm để có thể tự đứng lại được?

Nếu tôi làm được! Ngoài đống hóa đơn và việc tôi không thể ở cùng với gia đình và sẽ mất việc? Ngoài việc đó? Không, ngoài việc đó, mọi thứ đều ổn! Tôi rất thích nằm đây trong bệnh viện! Các người vào đây, đều vui vẻ, các người biết gì? Đời tôi thế là hết. Họ lẽ ra nên để tôi chết trong tai nạn đó, điều đó sẽ tốt hơn cho mọi người — cho gia đình tôi, cho các con tôi. Tôi là người chồng kiểu gì không biết? Người cha kiểu gì không biết? Hãy đi đi và để tôi một mình — tôi không muốn nói chuyện với các người hay bất kỳ ai.

Handout #9, Korean
Practice Interpreting, Chuchotage, English-Korean

Chuchotage Practice #1:
Physician consult with patient and her husband.

Doctor: So, how have you been feeling over the past several days? How's the pain been?

Patient 글쎄요, 통증은 확실히 느낄 수 있어요...

Doctor: OK. On scale from one to ten, how bad would you say it was?

Patient 잘 모르겠어요... 어쩌면 한 4정도요...

(From here on, do NOT pause for the interpreter to interpret)

Husband 4라고?! 간 밤에 엄청 고통스러워 했잖아! 의사 선생님께 말씀 드려요!

Patient 아, 그렇게 심하지 않았어요. 더군다나, 의사들이 무엇을 할 수 있겠어요? 전신에 화상을 입었는데 아픈 건 당연하잖아요.

Husband 아니야, 여보, 바로 그게 요점이야! 의사들은 통증을 억제할 수 있어, 그렇지만 통증이 심해지면 당신이 말씀을 드려야 해.

Patient 의사들은 내가 끔찍한 불평꾼이라고 생각할 거예요.

Husband 아니야, 그렇게 생각하지 않아. 의사들이 무엇 때문에 여기 있는데. 기억하지? 통증에 대해서 솔직할 필요가 있다고 의사 선생님이 말씀하셨잖아. 제발 말 해요. 나 당신 이러는 거 정말 싫어.

Patient 그렇다면, 통증은 10이었어요. 너무 아팠어요. 정말 의사들이 통증에 대해 뭔가 할 수 있다고 생각해요?

Chuchotage Practice #2
Social Worker consult with patient and her daughter

Social Worker I understand you've decided that a home hospice program would work for you. I'd be happy to help you find one.

Patient 고마워요. 전 정말 다시 집에 가고 싶어요. 그러니까, 제 말은 딸네 집에요. 다만, 딸에게 큰 짐이 되지 않기만 바랄 뿐이예요.

(From here on, do NOT pause for the interpreter to interpret)

Daughter *(to patient)* 별 말씀을 다 하세요, 엄마! 괜찮을 거예요. *(to social worker)* Actually, I do have some questions, though.

Social Worker Ask away! That's why I stopped by.

Daughter Well, I mean... will I have to... um... it's just that I wouldn't want to leave Mom alone, but what if I have to go out, like to do the shopping or something?

Social Worker One of the services that hospice offers is respite care. That means they'll send a volunteer to stay with your mom if you need a break. Also a home health aide will be available to you, so you could always step out while the aide is there.

Daughter Well, that's a relief! Also, who will be her doctor? We've had so many here at the hospital, then there's her primary care doctor and doesn't the hospice team have a doctor too?

Social Worker That's a good question. I'm not sure. Let me check on who will be following your mom's overall care. But don't worry – we won't leave you without a doctor!

Daughter You all have been so helpful. We're really very grateful.

Chuchotage Practice #3

Chaplain consult with patient

Chaplain Good morning! It's good to see you again. How are you feeling today?

Patient (male) 왜 다 모두들 나에게 그렇게 물어보죠? 기분이 나빠요. 모두들 다 가버렸으면 좋겠어.

Chaplain I'm so sorry to hear you're not doing well. Tell me about it. What's up?

Patient 무슨 상관이세요?

Chaplain I do care. This is the first time I've seen you so down. Has something happened?

(From here on, do NOT pause for the interpreter to interpret)

Patient *(sarcastically, angrily)* 사고 난 거는 제쳐놓고요? 두 발로 다시 서는데 몇 년 걸릴 거라는 말은 제쳐놓고요? 설령 다시 선다 해도! 치료비며, 가족과 함께 있을 수 없고 또 직장을 잃게 된다는 사실들은 제쳐놓고요? 그것들을 제쳐놓고요? 네, 그것들을 제외하면, 아무 문제도 없어요! 병원에서 이렇게 누워있는 거 아주 좋습니다! 모두들 명랑하게 여기 들어오는데, 도데체 당신들이 뭘 알아? 내 인생은 이제 끝났어. 사고로 그냥 죽도록 내버려 두었으면 내 가족, 내 자식들을 위해 더 좋았을 텐데. 이래가지고 어떤 남편이 될 수 있겠어? 어떤 아버지가? 모두들 나가고 날 혼자 있게 해줘 - 당신도 그 누구와도 이야기하고 싶지 않아.

Handout #9, TG
Practice Interpreting, Chuchotage, English-Tagalog

Chuchotage Practice #1:

Physician consult with patient and her husband.

Doctor: So, how have you been feeling over the past several days? How's the pain been?

Patient Kasi, nararamdaman ko talaga ito. . . .

Doctor: OK. On scale from one to ten, how bad would you say it was?

Patient Hindi ko alam. . . Tantiya ko, siguro apat. .

(From here on, do NOT pause for the interpreter to interpret)

Husband Apat?! Alam mong matindi ang sakit na naramdaman mo kagabi! Sabihin mo ito sa doktor!

Patient Hindi naman ganoon kagrabe. Isa pa, ano'ng magagawa nila? Marami akong paso sa buong katawan, siyempre masakit.

Husband Hindi, 'yan nga ang sinasabi ko! Makakatulong sila na kontrolin ang pananakit, pero dapat mong sabihin sa kanila kapag lumalala ito.

Patient Baka isipin nila masyado akong mareklamo.

Husband Siyempre hindi. Kaya nga sila nandito. Hindi ba? Sinabi sa iyo ng doktor na kailangan mong maging matapat tungkol sa sakit. Pakiusap? Ayaw ko lang nakikitang ganyan ka.

Patient Kung ganoon, nasa 10 ito. Grabe talaga. Sa palagay mo ba talagang may magagawa sila dito?

Chuchotage Practice #2

Social Worker consult with patient and her daughter

Social Worker I understand you've decided that a home hospice program would work for you. I'd be happy to help you find one.

Patient Salamat. Gusto ko na talagang umuwing muli. Ang ibig kong sabihin sa bahay ng anak ko. Sana lang hindi ako maging masyadong pabigat sa kanya.

(From here on, do NOT pause for the interpreter to interpret)

Daughter *(to patient)* Huwag ka ngang magpatawa, Inay! Magiging maayos din 'yan. *(to social worker)* Actually, I do have some questions, though.

Social Worker Ask away! That's why I stopped by.

Daughter Well, I mean . . will I have to . . . um. . . it's just that I wouldn't want to leave Mom alone, but what if I have to go out, like to do the shopping or something?

Social Worker One of the services that hospice offers is respite care. That means they'll send a volunteer to stay with your mom if you need a break. Also a home health aide will be available to you, so you could always step out while the aide is there.

Daughter Well, that's a relief! Also, who will be her doctor? We've had so many here at the hospital, then there's her primary care doctor and doesn't the hospice team have a doctor too?

Social Worker That's a good question. I'm not sure. Let me check on who will be following your mom's overall care. But don't worry – we won't leave you without a doctor!

Daughter You all have been so helpful. We're really very grateful.

Chuchotage Practice #3

Chaplain consult with patient

Chaplain Good morning! It's good to see you again. How are you feeling today?

Patient (male) Bakit iyan ang tinatanong ng lahat sa akin? Ang sama ng pakiramdam ko. Sana umalis na lang kayong lahat.

Chaplain I'm so sorry to hear you're not doing well. Tell me about it. What's up?

Patient Ano ba'ng pakialam mo?

Chaplain I do care. This is the first time I've seen you so down. Has something happened?

(From here on, do NOT pause for the interpreter to interpret)

Patient *(sarcastically, angrily)* Ang ibig mong sabihin, maliban pa sa aksidente? Maliban sa masabihang magtatagal nang ilang taon bago

ako makatayong muli? Kung mangyayari pa ‘yon! Maliban sa mga babayaran at sa katotohanan na hindi ko makakapiling ang aking pamilya at mawawalan ako ng trabaho? Maliban pa diyan? Hindi, maliban pa diyan, maayos naman ang lahat! Gustong-gusto kong nakahiga lang dito sa ospital! Pupunta kayo dito, ang saya-saya n’yo, ano ba’ng alam ninyo? Tapos na ang buhay ko. Sana hinayaan na lang nila akong mamatay sa aksidente, mas makakabuti ang ganoon sa lahat - para sa aking pamilya, para sa aking mga anak. Anong klaseng asawa ako kung ganito ako? Anong klaseng ama? Umalis na kayo at iwanan n’yo akong mag-isa – ayokong makipag-usap sa iyo o sa sinuman.

Handout #9, RS
Practice Interpreting, Chuchotage, English-Russian

Chuchotage Practice #1:

Physician consult with patient and her husband.

Doctor: So, how have you been feeling over the past several days? How's the pain been?

Patient Ну, я немогу сказать с уверенностью, что чувствую это. . . .

Doctor: OK. On scale from one to ten, how bad would you say it was?

Patient Не знаю. . .Возможно четыре. .

(From here on, do NOT pause for the interpreter to interpret)

Husband Четыре?! Знаете, прошлой ночью она так мучилась. Такие сильные боли! Скажи об этом врачу!

Patient Да все было не так плохо.Да и что они могут сделать? У меня ожоги по всемутелу – конечно, мне больно.

Husband Нет, моя дорогая, в том-товсе и дело! Они могут помочь справиться с болью, но ты должны скпзать им, когда тебе хуже.

Patient Они подумают, что я – ужасная жалобщица.

Husband Вовсе нет.Они здесь именно для этого и находятся.Помнишь? Врач сказала тебе, что ты должна честно сообщать о боли Пожалуйста. Для меня просто невыносимо видеть тебя такой.

Patient Ну, в таком случае, было 10. Было так плохо. Ты и правда думаешь, что они смогут что-нибудь сделать с этим?

Chuchotage Practice #2

Social Worker consult with patient and her daughter

Social Worker I understand you've decided that a home hospice program would work for you. I'd be happy to help you find one.

Patient Спасибо. Я, правда, хочу вернуться домой.Ну, я имею в виду в дом дочери.Я простонадеюсь, что это небудет для нее слишком большой обузой.

(From here on, do NOT pause for the interpreter to interpret)

Daughter *(to patient)* Мам, не смеши меня! Все будет в порядке.*(to social worker)* Actually, I do have some questions, though.

Social Worker Ask away! That's why I stopped by.

Daughter Well, I mean . . will I have to . . . um. . . it's just that I wouldn't want to leave Mom alone, but what if I have to go out, like to do the shopping or something?

Social Worker One of the services that hospice offers is respite care. That means they'll send a volunteer to stay with your mom if you need a break. Also a home health aide will be available to you, so you could always step out while the aide is there.

Daughter Well, that's a relief! Also, who will be her doctor? We've had so many here at the hospital, then there's her primary care doctor and doesn't the hospice team have a doctor too?

Social Worker That's a good question. I'm not sure. Let me check on who will be following your mom's overall care. But don't worry – we won't leave you without a doctor!

Daughter You all have been so helpful. We're really very grateful.

Chuchotage Practice #3

Chaplain consult with patient

Chaplain Good morning! It's good to see you again. How are you feeling today?

Patient (male) Почему все постоянно спрашивают меня об этом? Я чувствую себя ужасно.Я хочу, чтобы вы все ушли.

Chaplain I'm so sorry to hear you're not doing well. Tell me about it. What's up?

Patient Какое Вам дело?

Chaplain I do care. This is the first time I've seen you so down. Has something happened?

(From here on, do NOT pause for the interpreter to interpret)

Patient *(sarcastically, angrily)*Вы имеете в виду, кроме несчастного случая? Крометого, чтобы постоянно Вы говорите мне о том,

чтоуйдут годы, пока я невстану на ноги? Если это вообще когда-нибудь произойдет! Кроме счетов и того, что я немогу быть со своей семьей, и что я потеряю работу? Кроме этого? Нет, за исключением этого все просто отлично! Да мне просто нравится лежать тут в больнице! Вы приходите такие радостные, откуда вам знать? Моя жизнь кончена. Лучше бы мне дали умереть в аварии, так было бы лучше для всех – для моей семьи, для моих детей.Каким мужем я могубыть в таком состоянии? Каким отцом? Уходите и оставьте меня одного – я не хочу разговаривать ни с Вами, ни с кем-либо вообще.

Handout #9, EN
Practice Interpreting, Chuchotage, English-English

Practice #1
Physician consult with patient and her husband

Doctor: So, how have you been feeling over the past several days? How's the pain been?

Patient Well, I can certainly feel it . . . .

Doctor: OK. On scale from one to ten, how bad would you say it was?

Patient I don't know . . . I guess, maybe a four . .

(From here on, do NOT pause for the interpreter to interpret)

Husband A four?! You know you were in terrible pain last night, dear. Tell the doctor about it.

Patient Oh, it wasn't so bad. Besides, what can they do? I've got burns all over my body, of course I hurt.

Husband No, that's the whole point. They can help control the pain, but you have to tell them when it's getting worse.

Patient They're going to think I'm a terrible complainer.

Husband No, they're not. That's what they're here for. Remember? The doctor told you that you need to be honest about the pain. Please? I just hate to see you like this.

Patient Well, in that case, it was a 10. It was so bad. Do you really think they could do something for it?

Practice #2
Social Worker consult with patient and her daughter

Social Worker I understand you've decided that a home hospice program would work for you. I'd be happy to help you find one.

Patient Thank you. I really want to go home again. Well, to my daughter's home, I mean. I just hope that I won't be too much of a burden on her.

(From here on, do NOT pause for the interpreter to interpret)

Daughter *(to patient)* Don't be ridiculous, Mom! It'll be fine. *(to social worker)* Actually, I do have some questions, though.

Social Worker Ask away! That's why I stopped by.

Daughter Well, I mean . . . will I have to . . . um . . . it's just that I wouldn't want to leave Mom alone, but what if I have to go out, like to do the shopping or something?

Social Worker One of the services that hospice offers is respite care. That means they'll send a volunteer to stay with your mom if you need a break. Also a home health aide will be available to you, so you could always step out while the aide is there.

Daughter Well, that's a relief! Also, who will be her doctor? We've had so many here at the hospital, then there's her primary care doctor and doesn't the hospice team have a doctor too?

Social Worker That's a good question. I'm not sure. Let me check on who will be following your mom's overall care. But don't worry – we won't leave you without a doctor!

Daughter You all have been so helpful. We're really very grateful.

Practice #3

Chaplain consult with patient

Chaplain Good morning! It's good to see you again. How are you feeling today?

Patient (male) Why does everybody keep asking me that? I feel awful. I wish you would all just go away.

Chaplain I'm so sorry to hear you're not doing well. Tell me about it. What's up?

Patient What do you care?

Chaplain I do care. This is the first time I've seen you so down. Has something happened?

(From here on, do NOT pause for the interpreter to interpret)

Patient *(sarcastically, angrily)* Aside from the accident, you mean? Aside from being told that it's going to take years to get back on my feet? If I ever

do! Aside from the bills and the fact that I can't be with my family and I'm going to lose my job? Aside from that? No, aside from that, everything's just fine! I just love it, lying around here in the hospital! You come in here, all cheery, what do you know? My life is over. They should have just let me die in the accident, that would have been better for everyone – for my family, for my kids. What kind of husband can I be like this? What kind of father? Just go away and leave me alone – I don't want to talk to you or to anyone.

Handout #10
Practice Sight Translation Feedback form

Interpreter: _____

Language pair: _____

Evaluator: _____

Date: _____

Criteria	Examples
Aspects of the sight translation that the interpreter did well	
Omissions	
Additions	
Meaning changes	
Linguistic proficiency (e.g. false cognates, inserted English, work-arounds, etc)	
Delivery (e.g. stammering, pausing, backtracking, insecure facial expressions)	

	Yes	No
Began by scanning the document for difficult words or concepts.		
Asked for clarification of difficult concepts.		
Interpreted at a steady rate, without long pauses between phrases or sentences.		
The interpretation sounded natural in the target language.		

Handout #11
Sight Translation Exercise, POLST

Divide into groups of two to four students with others who speak your language pair. Divide the first page of the English-language POLST into equal sections. Each of you should sight translate one section while the others listen for potential additions, deletions, changes in meaning and overall fluency. Mark your observations on the attached feedback form. After each section, and keeping in mind the guidelines for feedback discussed earlier, provide feedback to the “interpreter.” Then continue with the next section and the next “interpreter.”

Sight translation only page one of the POLST. Page two includes instructions for providers. This is included for your information only, and you may review it at home.

When completed, refer to the pre-translated version of the POLST in your language pair, if there is one, with a particular eye for difficult terminology. We have provided the POLST here in Chinese, Korean, Russian, Spanish, Tagalog and Vietnamese.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 4/1/2011)

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. A copy of the signed POLST form is legal and valid. POLST complements an Advance Directive and is not intended to replace that document. Everyone shall be treated with dignity and respect.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — CARDIOPULMONARY RESUSCITATION (CPR): *If person has no pulse and is not breathing. When NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

Check One

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)
☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — MEDICAL INTERVENTIONS: *If person has pulse and/or is breathing.*

Check One

☐ **Comfort Measures Only** Relieve pain and suffering through the use of medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Transfer to hospital only*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
  ☐ ***Transfer to hospital only*** *if comfort needs cannot be met in current location.*

☐ **Full Treatment** In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/ cardioversion as indicated. ***Transfer to hospital*** *if indicated. Includes intensive care.*

Additional Orders: _____

_____

C — ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Check One

☐ No artificial means of nutrition, including feeding tubes.
☐ Trial period of artificial nutrition, including feeding tubes.
☐ Long-term artificial nutrition, including feeding tubes.

Additional Orders: _____

_____

_____

D — INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____ available and reviewed →
☐ Advance Directive not available
☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician

My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Physician Name:	Physician Phone Number:	Physician License Number:
Physician Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker

By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*		Date:
Address:	Daytime Phone Number:	Evening Phone Number:

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: M F

Health Care Provider Assisting with Form Preparation

Name:	Title:	Phone Number:

Additional Contact

Name:	Relationship to Patient:	Phone Number:

Directions for Health Care Provider

Completing POLST

- Completing a POLST form is voluntary. California law requires that a POLST form be followed by health care providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders.
- POLST does not replace the Advance Directive. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- POLST must be signed by a physician and the patient or decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- Certain medical conditions or treatments may prohibit a person from residing in a residential care facility for the elderly.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a person who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort Measures."
- Treatment of dehydration prolongs life. If person desires IV fluids, indicate "Limited Interventions" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment.
- A patient with capacity can, at any time, revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician, based on the known desires of the individual or, if unknown, the individual's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force. For more information or a copy of the form, visit **www.caPOLST.org**.

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

醫療保險流通及責任法案(HIPAA) 允許此 POLST 文件在必要時可公開給其他的醫療照護提供者

EMSA #111 B
(Effective 4/1/2011)

維持生命治療醫囑 Physician Orders for Life-Sustaining Treatment (POLST)

先執行這些醫囑，而後再聯絡醫生。這是一份依照當事者個人目前的健康狀況和意願而填寫的醫囑單。任何沒有填寫完成的項目將被視為願意接受該項全部治療。一份簽署完成的維持生命治療醫囑是合法有效的。維持生命治療醫囑不是取代而是配合醫療照護事前指示使用。每個人都應該得到有尊嚴及被尊重的對待。

病人的姓	表格填寫日期
病人的名	病人的出生日期
病人的中間名字	病歷號碼：(自由填寫)

A 選一項

人工心肺復甦術 CARDIOPULMONARY RESUSCITATION (CPR)：如果當事人沒有脈搏而且沒有呼吸。 當心肺功能沒有停止時，遵照 B 和 C 部分的醫囑。

- ☐ 試圖做人工心肺復甦術 (需要勾選 B 部分的 "全程療護"， Full Treatment)
- ☐ 不希望做人工心肺復甦術 ("允許自然死亡" Allow Natural Death)

B 選一項

醫療處理 MEDICAL INTERVENTIONS：當事人有脈搏而且/或有呼吸

- ☐ **只要舒適療護**: 任何方式的給藥、翻身、傷口照顧和其他措施，以減除疼痛和受苦。必要時，可使用氧氣、抽痰及手操作方式治療呼吸道阻塞，以得到舒適。只有在目前的處所無法得到安適時，才**轉送醫院**。
- ☐ **有限制的附加醫療處理**: 除了以上所陳述的 "只要舒適療護" ，提供醫療、抗生素並按需要給予靜脈輸液。不做呼吸插管。可使用非侵入性的正壓呼吸器。避免接受重症療護。
- ☐ **轉院**: 只有在目前的處所無法得到安適時。
- ☐ **全程療護**: 除了包括 "只要舒適療護" 和 "有限制的附加醫療處理" 的療護外，使用氣管內插管、呼吸道處理、人工呼吸輔助器，和心臟電擊器。如有需要，**轉送醫院**。包括重症療護。

其他醫囑：_____

C 選一項

人工營養提供 ARTIFICIALLY ADMINISTERED NUTRITION： 如果可行並願意，可由口腔進食

- ☐ 不使用人工方式提供營養，包括灌食管。 **其他醫囑**：_____
- ☐ 試著提供人工營養一段時間，包括灌食管。_____
- ☐ 長期提供人工營養，包括灌食管。_____

D

資料和簽名 INFORMATION AND SIGNATURES:

中文表格僅可做參考，請務必填寫英文表格並在英文表格上簽名以便急救人員了解您的醫療意願

The signed POLST form must be in English so that emergency personnel can read and follow orders.

已和下列人員討論：

☐ 病人(病人有能力) ☐ 法律認定的醫療決定代言人

☐ 醫療照護事前指示 日期_____ 有而且複閱過 → 在醫療照護事前指示內的醫療決定代言人:

☐ 有醫療照護事前指示，但不在身邊 代言人姓名：_____

☐ 沒有醫療照護事前指示 代言人電話：_____

醫生的簽名

本人在下面的簽名表示盡我所知，這些醫囑與當事者的醫療狀況和意願是一致的。

醫生姓名(正楷填寫)	醫生電話號碼	醫生執照號碼
醫生簽名(必須)	日期	

病人或法律認定的醫療決定代言人簽名

在這份表格簽了名，法律上認定的醫療決定代言人認知這份有關復甦術措施的要求，是和當事人的意願一致的，同時也符合當事人的最大利益。

姓名(正楷填寫)		關係 (如為病人自己, 請寫 "本人")
簽名(必須)		日期
地址	日間聯絡電話	夜間聯絡電話

病人轉院或出院時，此份表格必須隨同病人一起。

한국어 버전은 교육 목적으로만 사용됩니다 (Korean version is for educational purposes only).
HIPAA는 필요한 경우 POLST를 다른 의료제공자에게 공개하는 것을 허용합니다

생명 유지 치료에 대한 의사 지시서
(Physician Orders for Life-Sustaining Treatment, POLST)

먼저 이 지시서를 따른 후에 의사에게 연락하십시오.
이 양식은 환자의 현재 의학적 상태와 희망에 따른 의사 지시서입니다. 작성하지 않은 섹션은 그 섹션에 기재된 모든 치료를 받아야 한다는 것을 의미합니다. 서명된 POLST 양식의 사본은 적법 및 유효합니다. POLST는 사전지시서(Advance Directive)를 보충하나 그 문서를 대체하지는 않습니다. 모든 환자는 존엄성과 존중심으로 치료받아야 합니다.

EMSA #111 B
(유효일: 2011년 4월 1일)

환자 성:	양식 작성 날짜:
환자 이름:	환자 생년월일:
환자 중간이름:	의료기록 #: (선택 항목)

A 하나만 선택

심폐 소생술(CPR): 환자가 맥박이 뛰지 않고 숨을 쉬지 않는 경우 심폐정지가 아닌 경우에는 섹션 B와 C의 지시를 따르십시오.

☐ **심폐 소생술/CPR** 시도(섹션 A에서 CPR 시도에 표시한 경우에는 **반드시** 섹션 B에 기재된 모든 치료를 해야 합니다)
☐ **심폐 소생술을 시도하지 않음/DNR** (자연사 허용)

B 하나만 선택

의학적 개입: 환자가 맥박이 뛰고 숨을 쉬는 경우

☐ **통증 완화만 시도.** 모든 경로, 자세, 상처 치료 및 다른 조치를 통해서 약물을 투여하여 통증과 고통을 완화하십시오. 통증 완화를 위해 필요한 경우에는 산소, 흡입 및 기도폐쇄 도수치료법을 사용하십시오. 현재 위치에서 고통을 완화시킬 수 없는 **경우에만 병원으로 이송하십시오.**

☐ **제한적 추가 개입.** "통증 완화만 시도" 항목에서 설명한 치료에 추가하여, 필요에 따라 의학적 치료, 항생제 및 정맥 수액을 사용하십시오. 삽관을 하지 마십시오. 비침습성 기도 양압술은 사용할 수 있습니다. 일반적으로 집중 치료를 피하십시오.

☐ 현재 위치에서 고통을 완화할 수 없는 **경우에만 병원으로 이송하십시오.**

☐ **완전한 치료.** "통증 완화만 시도" 외 "제한적 추가 개입" 항목에서 설명한 치료에 추가하여, 필요에 따라 삽관, 전문 기도 개입, 기계 환기, 제세동/심율동전환술을 사용하십시오. 필요한 경우에는 **병원으로 이송하십시오.** 집중 치료를 포함시키십시오.

추가 지시: _____

_____

C 하나만 선택

인공 영양 공급: 가능하고 바람직한 경우 입을 통해서 음식물을 공급

☐ 인공 영양 공급 방법(급식관 포함) 사용 금지
☐ 인공 영양 시도 기간 동안 영양 공급(급식관 포함)
☐ 장기 인공 영양 공급(급식관 포함)

추가 지시: _____

D

정보 및 서명:

상의자: ☐ 환자(환자가 정신 능력이 있는 경우) ☐ 법적으로 인정된 의사결정자

☐ _____에 작성된 사전지시서를 재검토 →
☐ 사전지시서를 제공하지 않았음
☐ 사전지시서를 작성하지 않았음

사전지시서에 지명된 건강 관리 대리인:
이름: _____
전화번호: _____

의사 서명
아래의 본인 서명은 본인이 아는 한 위의 지시가 환자의 의학적 상태 및 선호도와 관련하여 적합하다는 것을 나타냅니다.

의사 정자 이름:	의사 전화번호:	의사 면허번호:
의사 서명: (필수)		날짜:

환자 또는 법적으로 인정된 의사결정자 서명
법적으로 인정된 의사결정자는 이 양식에 서명함으로써 심폐 소생 조치와 관련된 이 치료 요청이 이 양식에 기재된 환자에 대해 본인이 알고 있는 희망사항, 그리고 환자에게 가장 이익이 되는 조치와 일치한다는 것을 확인합니다.

정자 이름:		관계: (환자인 경우 "본인" 이라고 기재)
서명: (필수)		날짜:
주소:	주간 전화번호:	야간 전화번호:

환자를 이송하거나 퇴원시킬 때마다 이 양식을 함께 보내십시오

Русскоязычная версия предназначена для использования только в информационных целях (Russian version is for educational purposes only).
HIPAA ПОЗВОЛЯЕТ ПЕРЕДАЧУ СОДЕРЖАЩЕЙСЯ В ФОРМЕ POLST ИНФОРМАЦИИ ДРУГИМ МЕДИЦИНСКИМ РАБОТНИКАМ ПО МЕРЕ НЕОБХОДИМОСТИ

EMSA #111 B
(вступает в силу 4 января 2011 г.)

Распоряжения врача об искусственном поддержании жизни
(Physician Orders for Life-Sustaining Treatment, POLST)

Сначала следуйте этим распоряжениям, а затем свяжитесь с лечащим врачом. Данный документ содержит распоряжения врача, основанные на текущем состоянии здоровья пациента и его пожеланиях. Любой незаполненный раздел означает полное лечение, указанное в данном разделе. Копия подписанной формы POLST является официальным и действующим документом. POLST дополняет предварительное распоряжение (Advance Directive), но не заменяет данный документ. Отношение к любому пациенту должно быть уважительным и не унижать его человеческое достоинство.

Фамилия пациента:	Дата подготовки формы:
Имя пациента:	Дата рождения пациента:
Второе имя пациента:	Номер истории болезни: *(по выбору)*

A *Выбрать один вариант*

СЕРДЕЧНО-ЛЕГОЧНАЯ РЕАНИМАЦИЯ (CPR): ***Если у пациента отсутствуют пульс и дыхание. Если пациент НЕ находится в состоянии кардиопульмонального шока, следовать распоряжениям в разделах B и C.***

- ☐ **Пытаться реанимировать/CPR** (выбор CPR в разделе A **требует** выбора «полного лечения» в разделе B)
- ☐ **Не реанимировать/DNR** (позволить умереть естественной смертью)

B *Выбрать один вариант*

МЕДИЦИНСКОЕ ВМЕШАТЕЛЬСТВО: ***Если у пациента есть пульс и/или пациент дышит.***

- ☐ **Только симптоматическая терапия.** Использовать любой способ введения лекарственных препаратов в организм, удобное положение пациента, уход за раной и другие меры по облегчению боли и страданий. Применять кислород, аспирацию и устранение непроходимости дыхательных путей вручную по мере необходимости с целью обеспечения комфорта пациента. ***Перевести в больницу, только*** *если нет возможности предоставить необходимые для пациента уход и лечение там, где он находится в настоящее время.*
- ☐ **Ограниченные дополнительные вмешательства.** В дополнение к мерам, описанным в пункте «Только симптоматическая терапия», использовать медикаментозное лечение, антибиотики и внутривенное введение жидкостей по мере необходимости. Не интубировать. Допускается использование неинвазивного метода вентиляции дыхательных путей с положительным давлением. В большинстве случаев избегать интенсивной терапии.
  - ☐ ***Перевести в больницу, только*** *если нет возможности предоставить необходимые для пациента уход и лечение там, где он находится в настоящее время.*
- ☐ **Полное лечение.** В дополнение к мерам, описанным в пункте «Только симптоматическая терапия» и «Ограниченные дополнительные вмешательства», применять интубацию, интенсивные методы воздействия на дыхательные пути, механическую вентиляцию и дефибрилляцию/электроимпульсную кардиологическую терапию по мере необходимости. ***Перевести в больницу,*** *если необходимо. Включает в себя интенсивную терапию.*

Дополнительные распоряжения: _____

C *Выбрать один вариант*

ИСКУССТВЕННОЕ ПИТАНИЕ: ***При возможности и при желании пациента предложить принятие пищи через рот.***

- ☐ Не проводить искусственное питание, включая питание через зонд.
- ☐ Искусственное питание, включая питание через зонд, в течение определенного пробного периода.
- ☐ Долговременное искусственное питание, включая питание через зонд.

Дополнительные распоряжения: _____

D

ИНФОРМАЦИЯ И ПОДПИСИ:

Обсуждено с: ☐ Пациентом (пациент способен) ☐ Лицом, имеющим право принимать решения о лечении от имени пациента

- ☐ Предварительное распоряжение от _____ есть в наличии → и пересмотрено
- ☐ Предварительного распоряжения нет в наличии
- ☐ Предварительное распоряжение не составлено

Представитель по вопросам оказания медицинской помощи, если указан в предварительном распоряжении:
Имя и фамилия: _____
Телефон: _____

Подпись врача
Моя подпись ниже подтверждает, что, насколько мне известно, настоящие распоряжения основаны на состоянии здоровья пациента и его пожеланиях.

Имя и фамилия врача печатными буквами:	Телефон врача:	Номер лицензии врача:
Подпись врача: *(обязательно)*		Дата:

Подпись пациента или лица, имеющего право принимать решения о лечении от имени пациента
Ставя свою подпись на этой форме, лицо, имеющее право принимать решения о лечении от имени пациента, подтверждает, что указанные в настоящем документе реанимационные меры, соответствуют известным желаниям и наилучшим интересам пациента, названного в настоящем документе.

Имя и фамилия печатными буквами:		Степень родства: *(если сам пациент, напишите «сам»)*
Подпись: *(обязательно)*		Дата:
Адрес:	Телефон в дневное время:	Телефон в вечернее время:

ДАННАЯ ФОРМА ДОЛЖНА БЫТЬ С ПАЦИЕНТОМ ПРИ ЕГО ПЕРЕВОДЕ ИЛИ ВЫПИСКЕ

La versión en español solo se debe usar con fines educativos (Spanish version is for educational purposes only).
La ley HIPAA permite la revelación de las POLST a otros profesionales de atención de la salud en la medida que sea necesario

Órdenes del médico de tratamiento para el mantenimiento de la vida
(Physician Orders for Life-Sustaining Treatment, POLST)

EMSA #111 B
(En vigor 4/1/2011)

Primero siga estas órdenes y después póngase en contacto con el médico. Esta es una Hoja de órdenes del médico basada en el estado médico y deseos actuales de la persona. Toda sección que no esté completada implica tratamiento completo para esa sección. Una copia del formulario POLST firmado es legal y válido. Las POLST son un complemento a una directiva anticipada y no tienen el objetivo de reemplazar ese documento. Se debe tratar a todos con dignidad y respeto.

Apellido del paciente:	Fecha de preparación del formulario:
Nombre del paciente:	Fecha de nacimiento del paciente:
Segundo nombre del paciente:	Nº de registro médico: *(opcional)*

A — Resucitación cardiopulmonar (RCP):
Marque uno

Si la persona no tiene pulso y no está respirando.
Cuando NO se halla en paro cardiopulmonar, seguir las órdenes en las secciones B y C.

☐ **Intentar resucitación/RCP** (Si selecciona RCP en la sección A **tiene que** seleccionar Tratamiento completo en la sección B)
☐ **No intentar resucitación/DNR** (permitir la muerte natural)

B — Intervenciones médicas:
Marque uno

Si la persona tiene pulso y/o está respirando.

☐ **Solo medidas paliativas** Aliviar el dolor y el sufrimiento por medio del uso de medicación por cualquier vía, posicionamiento, cuidado de las heridas y otras medidas. Usar oxígeno, succión y tratamiento manual de la obstrucción de las vías respiratorias según sea necesario para el confort del paciente. ***Trasladar al hospital solamente*** *si las necesidades paliativas no se pueden cumplir en la ubicación actual.*

☐ **Intervenciones adicionales limitadas** Además de la atención descrita en Solo medidas paliativas, usar tratamiento médico, antibióticos y fluidos intravenosos según esté indicado. No entubar. Se puede usar presión positiva no invasora en las vías respiratorias. Evitar en general cuidados intensivos.

☐ ***Trasladar al hospital solamente*** *si las necesidades paliativas no se pueden cumplir en la ubicación actual.*

☐ **Tratamiento completo** Además de la atención descrita en Solo medidas paliativas e Intervenciones adicionales limitadas, usar entubación, intervenciones avanzadas en las vías respiratorias, ventilación mecánica y desfibrilación y cardioversión según esté indicado. ***Trasladar al hospital*** *si está indicado. Incluye cuidados intensivos.*

Órdenes adicionales: _____

_____

C — Nutrición administrada artificialmente:
Marque uno

Ofrecer alimentos por boca, si es posible y deseado.

☐ No administrar nutrición por medios artificiales, incluyendo la alimentación por tubo.
☐ Período de prueba de nutrición artificial, incluyendo la alimentación por tubo.
☐ Administrar nutrición artificial a largo plazo, incluyendo la alimentación por tubo.

Órdenes adicionales: _____
_____
_____

D — Información y firmas:

Hablado con: ☐ Paciente (paciente tiene capacidad de hacerlo) ☐ Encargado de tomar decisiones reconocido legalmente

☐ Directiva anticipada con fecha _____, disponible y revisada →
☐ Directiva anticipada no está disponible
☐ No hay una directiva anticipada

Agente para la atención de la salud, si fue nombrado en la directiva anticipada:
Nombre: _____
Teléfono: _____

Firma del Médico
Mi firma a continuación indica que a mi mejor saber y entender estas órdenes son consecuentes con el estado médico y las preferencias de la persona.

Nombre del médico en letra de molde:	Nº de teléfono del médico:	Nº de licencia profesional del médico:
Firma del médico: *(requerida)*		Fecha:

Firma del paciente o encargado de tomar decisiones reconocido legalmente
Al firmar este formulario, el encargado de tomar decisiones reconocido legalmente reconoce que este pedido relativo a medidas de resucitación es consecuente con los deseos conocidos y el mejor interés de la persona que es objeto del formulario.

Nombre en letra de molde:		Relación: *(escribir Sí mismo si es el paciente)*
Firma: *(requerida)*		Fecha:
Dirección:	Nº de teléfono de día:	Nº de teléfono de noche:

Enviar el formulario con la persona si se le trasladada o da de alta

Ang bersiyon sa Tagalog ay para sa layuning pang-edukasyon lamang (Tagalog version is for educational purposes only).
ANG HIPAA AY NAGPAPAHINTULOT NG PAGSISIWALAT NG POLST SA IBANG MGA TAGAPAGKALOOB NG PANGANGALAGANG PANGKALUSUGAN GAYA NG KAILANGAN

EMSA #111 B
(Magkakabisa sa 4/1/2011)

Mga Utos ng Doktor para sa Paggamot na Nagpapatuloy ng Buhay
(Physician Orders for Life-Sustaining Treatment, POLST)

Una ay sundin ang mga utos na ito, at saka tawagan ang doktor. Ito ay isang Papel ng Utos ng Doktor (Physician Order Sheet) batay sa kasalukuyang kondisyong medikal at mga nais ng tao. Anumang seksyon na hindi nakumpleto ay nagpapahiwatig ng buong paggamot para sa seksyon. Ang isang kopya ng pinirmahang porma ng POLST ay ayon sa batas at may-bisa. Ang POLST ay tumutulong sa Maagang Tagubilin (Advance Directive) at hindi hinahangad na palitan ang dokumentong ito. Ang lahat ay dapat tratuhin nang may dignidad at paggalang.

Apelyido ng Pasyente:	Petsa Inihanda ang Porma:
Unang Pangalan ng Pasyente:	Petsa ng Kapanganakan ng Pasyente:
Gitnang Pangalan ng Pasyente:	Numero ng Rekord na Medikal *(di-sapilitan)*:

A
Markahan ang Isa

Pagbabalik Ng Malay-Tao Na Kaugnay Ng Puso At Baga (Cardiopulmonary Resuscitation, CPR): ***Kung ang tao ay walang pulso at hindi humihinga. Kapag HINDI dumaranas ng paghadlang ng pagganap ng puso at baga, sundin ang mga utos sa mga Seksyon B at C.***

☐ **Subukan ang Pagbabalik ng Malay-Tao/CPR** (Ang pagpili ng CPR sa Seksyon A ay nangangailangan ng pagpili ng Buong Paggamot sa Seksyon B)

☐ **Huwag Tangkain ang Pagbabalik ng Malay-Tao** (Hayaan ang Natural na Pagkamatay)

B
Markahan ang Isa

Mga Pamamagitang Medikal: ***Kung ang tao ay may pulso at/o humihinga.***

☐ **Mga Hakbang na Pampaginhawa Lamang** Bawasan ang pananakit at paghihirap sa pamamagitan ng paggamit ng gamot sa anumang ruta, posisyon, pangangalaga ng sugat at ibang mga hakbang. Gumamit ng oxygen, paghigop at manwal na paggamot ng bara sa paghinga gaya ng kailangan para guminhawa. ***Ilipat lamang ng ospital*** *kung ang mga pangangailangan ng ginhawa ay hindi matugunan sa kasalukuyang lokasyon.*

☐ **Mga Limitadong Karagdagang Pamamagitan** Bilang karagdagan sa pangangalagang inilarawan sa Mga Hakbang na Pampaginhawa Lamang, gumamit ng mga paggamot na medikal, antibayotiko, at mga likidong IV gaya ng ipinabatid. Huwag tusukan ng tubo. Maaaring gumamit ng di-sumasalakay na positibong puwersa sa daanan ng hangin. Pangkaraniwang iniiwasan ang matinding pangangalaga.

☐ ***Ilipat lamang ng ospital*** *kung ang mga pangangailangan ng ginhawa ay hindi matugunan sa kasalukuyang lokasyon.*

☐ **Buong Paggamot** Bilang karagdagan sa pangangalagang inilarawan sa Mga Hakbang na Pampaginhawa Lamang at Mga Limitadong Karagdagang Pamamagitan, gumamit ng pagtusok ng tubo, mga matataas na pamamagitan sa daanan ng hangin, mekanikal na bentilasyon, at defibrillation/cardioversion gaya ng ipinabatid. ***Ilipat ng ospital*** *kung ipinabatid. Kabilang ang matinding pangangalaga.*

Mga Karagdagang Utos: _____

C
Markahan ang Isa

Artipisyal Na Ibinibigay Na Nutrisyon: ***Mag-alok ng pagkain sa pamamagitan ng bibig kung magagawa at hinahangad.***

☐ Walang artipisyal na paraan ng nutrisyon, kabilang ang mga tubo sa pagpapakain.

☐ Pagsubok na panahon ng artipisyal na nutrisyon, kabilang ang mga tubo sa pagpapakain.

☐ Pangmatagalang artipisyal na nutrisyon, kabilang ang mga tubo sa pagpapakain.

Mga Karagdagang Utos: _____

D

Impormasyon At Mga Pirma:

Tinalakay sa: ☐ Pasyente (May Kakayahan ang Pasyente) ☐ Legal na Kinikilalang Tagagawa ng Desisyon

☐ Maagang Tagubilin na may petsang _____ makukuha at nirepaso →

☐ Maagang Tagubilin hindi makukuha

☐ Walang Maagang Tagubilin

Ahente sa Pangangalagang Pangkalusugan na tinukoy sa Maagang Tagubilin

Pangalan: _____

Telepono: _____

Pirma ng Doktor

Ang pirma sa ibaba ay nagpapabatid sa abot ng aking kaalaman na ang mga utos na ito ay umaayon sa mga kondisyong medikal at mga nais ng tao.

Ilimbag ang Pangalan ng Doktor:	Numero ng Telepono ng Doktor:	Numero ng Lisensiya ng Doktor:
Pirma ng Doktor: *(Kinakailangan)*		Petsa:

Pirma ng Pasyenteng Legal na Kinikilalang Tagagawa ng Desisyon

Sa pagpirma sa pormang ito, tinatanggap ng legal na kinikilalang tagagawa ng desisyon na ang kahilingang ito tungkol sa mga hakbang na pagbabalik ng malay-tao ay umaayon sa mga alam na hinahangad ng, at makakabuti sa, taong tinutukoy sa pormang ito.

Ilimbag ang pangalan:		Relasyon: *(isulat ang sarili kung pasyente)*
Pirma: *(kinakailangan)*		Petsa:
Tirahan:	Numero ng Telepono sa Araw:	Numero ng Telepono sa Gabi:

IPADALA ANG PORMA SA TAO TUWING INILILIPAT O INILALABAS

Bản tiếng Việt chỉ dành cho các mục đích giáo dục (Vietnamese version is for educational purposes only).

HIPAA CHO PHÉP TIẾT LỘ POLST CHO CÁC CHUYÊN VIÊN CHĂM SÓC SỨC KHỎE KHÁC NẾU CẦN

Lệnh Bác Sĩ Điều Trị Duy Trì Mạng Sống

(Physician Orders for Life-Sustaining Treatment, POLST)

EMSA #111 B
(Có hiệu lực 4/1/2011)

Trước hết hãy tuân hành các lệnh này, sau đó liên lạc với bác sĩ. Đây là Tờ Lệnh Bác Sĩ dựa trên tình trạng y khoa hiện nay và ý nguyện của bệnh nhân. Bất cứ đoạn nào không điền thì hàm ý là điều trị toàn bộ cho đoạn đó. Bản sao của mẫu POLST có chữ ký là hợp pháp và hợp lệ. POLST bổ túc Chỉ Thị Trước và không có mục đích thay thế văn kiện đó. Mọi người phải được đối xử trọn nhân phẩm và tôn trọng.

Họ Bệnh Nhân:	Ngày Lập Mẫu:
Tên Bệnh Nhân:	Ngày Sinh của Bệnh Nhân:
Tên Lót của Bệnh Nhân:	Số Hồ Sơ Y Khoa: *(tùy ý)*

A *Đánh Dấu Vào Một*

Hồi Sinh Tim Phổi (CPR): ***Nếu người này không có mạch đập và không thở. Khi KHÔNG bị ngưng hoạt động tim phổi, hãy áp dụng các lệnh trong Đoạn B và C.***

☐ **Cố Hồi Sinh/CPR** (Chọn CPR trong Đoạn A **thì phải** chọn Điều Trị Toàn Bộ trong Đoạn B)

☐ **Đừng Cố Hồi Sinh/DNR** (Allow Natural Death) (Để Chết Tự Nhiên)

B *Đánh Dấu Vào Một*

Can Thiệp Y Khoa: ***Nếu người này có mạch đang đập và/hoặc đang thở.***

☐ **Chỉ Áp Dụng Các Biện Pháp Giúp Thoải Mái** Giảm đau và khổ sở bằng cách dùng thuốc theo bất cứ cách, tư thế nào, chăm sóc vết thương và các biện pháp khác. Dùng dưỡng khí, hút và thông vật cản khí quản bằng tay nếu cần để được thoải mái. ***Chỉ thuyên chuyển tới bệnh viện*** *nếu không thể đáp ứng được các nhu cầu thoải mái tại địa điểm hiện nay.*

☐ **Can Thiệp Bổ Túc Giới Hạn** Ngoài dịch vụ chăm sóc nêu trong đoạn Chỉ Áp Dụng Các Biện Pháp Giúp Thoải Mái, hãy áp dụng biện pháp điều trị y khoa, thuốc trụ sinh, và chất lỏng truyền IV theo chỉ dẫn. Đừng luồn ống. Có thể dùng cách bơm không khí có áp suất cao vào khí quản mà không xâm phạm đến cơ thể. Nói chung tránh chăm sóc cấp tính.

☐ ***Chỉ thuyên chuyển tới bệnh viện*** *nếu không thể đáp ứng được các nhu cầu thoải mái tại địa điểm hiện nay.*

☐ **Điều Trị Toàn Bộ** Ngoài dịch vụ chăm sóc nêu trong các đoạn Chỉ Áp Dụng Các Biện Pháp Giúp Thoải Mái và Can Thiệp Bổ Túc Giới Hạn, hãy sử dụng ống luồn, các biện pháp can thiệp khí quản tân tiến, thông khí bằng dụng cụ, và kích thích tim bằng điện theo chỉ thị. ***Thuyên chuyển tới bệnh viện*** *nếu cần. Gồm cả chăm sóc cấp tính.*

Các Lệnh Khác: _____

_____

C *Đánh Dấu Vào Một*

Tiếp Dinh Dưỡng Nhân Tạo: ***Chỉ cho ăn bằng miệng nếu có thể được và nếu muốn.***

☐ Không có phương tiện tiếp dinh dưỡng nhân tạo, kể cả ống truyền thức ăn.

☐ Giai đoạn thử tiếp dinh dưỡng nhân tạo, kể cả ống truyền thức ăn.

☐ Tiếp dinh dưỡng nhân tạo dài hạn, kể cả ống truyền thức ăn.

Các Lệnh Khác: _____

_____

_____

D

Chi Tiết Và Chữ Ký:

Đã thảo luận với: ☐ Bệnh Nhân (Bệnh Nhân Minh Mẫn) ☐ Người Quyết Định Được Công Nhận Hợp Pháp

☐ Chỉ Thị Trước làm ngày _____ có và đã xem →

☐ Chỉ Thị Trước không có ở đây

☐ Không có Chỉ Thị Trước

Đại Diện Chăm Sóc Sức Khỏe nếu có tên trong Chỉ Thị Trước:

Tên: _____

Điện Thoại: _____

Chữ Ký Bác Sĩ

Chữ ký của tôi dưới đây cho biết là theo hết khả năng hiểu biết của tôi thì các lệnh này phù hợp với tình trạng y khoa và ý nguyện của bệnh nhân.

Viết Tên Bác Sĩ Bằng Chữ In:	Số Điện Thoại của Bác Sĩ:	Số Giấy Phép Hành Nghề của Bác Sĩ:
Chữ Ký Bác Sĩ: *(phải có)*		Ngày:

Chữ Ký Bệnh Nhân hoặc của Người Quyết Định Được Công Nhận Hợp Pháp

Khi ký vào mẫu này, người quyết định được công nhận hợp pháp nhìn nhận rằng yêu cầu này về các biện pháp hồi sinh phù hợp với các ý muốn được biết, và cho quyền lợi tốt nhất, của người là đối tượng trong mẫu này.

Viết Tên Chữ In:		Liên Hệ: *(viết chính bản thân tôi nếu là bệnh nhân)*
Chữ Ký: *(phải có)*		Ngày:
Địa Chỉ:	Số Điện Thoại Ban Ngày:	Số Điện Thoại Buổi Tối:

GỬI MẪU THEO VỚI NGƯỜI NÀY BẤT CỨ KHI NÀO THUYÊN CHUYỂN HOẶC XUẤT VIỆN

Handout #12
Sight Translation Exercise: Pre-hospital DNR

Divide into groups of two to four students with others who speak your language pair. Divide the first page of the English-language pre-hospital DNR into equal sections. Each of you should sight translate one section while the others listen for potential additions, deletions, changes in meaning and overall fluency. Mark your observations on the attached feedback form. After each section, and keeping in mind the guidelines for giving feedback discussed earlier, provide feedback to the “interpreter.” Then continue with the next section and the next “interpreter.”

When completed, refer to the pre-translated version of the pre-hospital DNR in your language pair, if there is one, with a particular eye for difficult terminology. We have provided the DNR here in Chinese, Korean, Russian, Spanish, Tagalog and Vietnamese.

EMERGENCY MEDICAL SERVICES
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM

PURPOSE

The Prehospital Do Not Resuscitate (DNR) Form has been developed by the California Emergency Medical Services Authority, in concert with the California Medical Association and emergency medical services (EMS) providers, for the purpose of instructing EMS personnel to forgo resuscitation attempts in the event of a patient's cardiopulmonary arrest. Resuscitative measures to be withheld include chest compressions, assisted ventilation, endotracheal intubation, defibrillation, and cardiotonic drugs. The form does **not** affect the provision of other emergency medical care, including palliative treatment for pain, dyspnea, major hemorrhage, or other medical conditions.

APPLICABILITY

This form was designed for use in **prehospital settings** -- e.g., in a patient's home, in a long-term care facility, during transport to or from a health care facility, and in other locations outside acute care hospitals. However, hospitals are encouraged to honor the form when a patient is transported to an emergency room. California law protects any health care provider (including emergency response personnel) who honors a properly completed Prehospital Do Not Resuscitate Form (or an approved wrist or neck medallion) from criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction, or any other sanction, if the provider believes in good faith that the action or decision is consistent with the law and the provider has no knowledge that the action or decision would be inconsistent with a health care decision that the individual signing the request would have made on his or her own behalf under like circumstances. This form does not replace other DNR orders that may be required pursuant to a health care facility's own policies and procedures governing resuscitation attempts by facility personnel. Patients should be advised that their prehospital DNR instruction might not be honored in other states or jurisdictions.

INSTRUCTIONS

The Prehospital Do Not Resuscitate (DNR) Form must be signed by the patient or by an appropriate surrogate decision-maker if the patient is unable to make or communicate informed health care decisions. The surrogate should be the patient's legal representative (e.g., a Durable Power of Attorney for Health Care agent, a court-appointed conservator, a spouse or other family member) if one exists. The patient's physician must also sign the form, affirming that the patient/surrogate has given informed consent to the DNR instruction.

The original of the form should be retained by the patient. The completed form (or the approved wrist or neck medallion -- see below) must be readily available to EMS personnel in order for the DNR instruction to be honored. Resuscitation attempts may be initiated until the form (or medallion) is presented and the identity of the patient is confirmed.

A copy of the form should be retained by the signing physician and made part of the patient's permanent medical record.

A copy of the form may be used by the patient to order an optional wrist or neck medallion inscribed with the words "DO NOT RESUSCITATE-EMS." The Medic Alert Foundation (2323 Colorado Avenue, Turlock, CA 95381) is an EMS Authority-approved supplier of the medallions, which will be issued only upon receipt of a properly completed Prehospital Do Not Resuscitate (DNR) Form (together with an enrollment form and the appropriate fee). *Although optional, use of a wrist or neck medallion facilitates prompt identification of the patient, avoids the problem of lost or misplaced forms, and is strongly encouraged.*

REVOCATION

If a decision is made to revoke the DNR instruction, the patient's physician should be notified immediately and all copies of the form should be destroyed, including any copies on file with the Medic Alert Foundation or other EMS Authority-approved supplier. Medallions and associated wallet cards should also be destroyed or returned to the supplier.

Questions about implementation of the Prehospital Do Not Resuscitate (DNR) Form should be directed to the local EMS agency

EMERGENCY MEDICAL SERVICES
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM

CALIFORNIA MEDICAL ASSOCIATION

An Advance Request to Limit the Scope of Emergency Medical Care

I, _____ request limited emergency care as herein described.
(Print patient's name and medical record number)

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will not prevent me from obtaining other emergency medical care by pre-hospital emergency medical care personnel and/or medical care directed by a physician prior to my death.

I understand I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.

I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

_____ _____
Patient/Surrogate Signature Date

_____
Print Surrogate's name Relationship to Patient Surrogate's phone number

By signing this form, the surrogate acknowledges that this request to forego resuscitative measures is consistent with the known desires of and with the best interest of the individual who is the subject of this form.

I affirm that this patient/surrogate is making an informed decision and that this directive is the expressed wish of the patient/surrogate. A copy of this form is in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotonic medications are to be initiated.

_____ _____
Physician Signature Date

_____
Print Name California License number Telephone

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY

PREHOSPITAL DNR REQUEST FORM

Original is to be kept by patient
Submit a copy to be kept in patient's permanent medical record
If an authorized DNR medallion is desired, submit a copy of this form, with Medic Alert enrollment form, to Medic Alert Foundation, 2323 Colorado Avenue, Turlock, CA 95381.
To obtain the Medic Alert enrollment form, call 1-800-432-5378

SERVICIOS MÉDICOS DE EMERGENCIA
FORMULARIO DE NO RESUCITAR (DO NOT RESUCITATE (DNR))
ANTES DE INGRESAR AL HOSPITAL
(Spanish Form)

Una solicitud anticipada para limitar el alcance del cuidado médico de emergencia

Yo, _____ solicito cuidado de emergencia limitado de conformidad con lo que aquí se describe. (Escribir con letra del molde el nombre del paciente y el número de expediente médico)

Entiendo que DNR significa que si mi corazón deja de latir o si dejo de respirar, no se instituirá ningún procedimiento médico para reactivar la respiración o el funcionamiento del corazón.

Entiendo que esta decisión no evitará que reciba otro tipo de cuidado médico de emergencia de parte de personal de cuidado médico de emergencia antes de ingresar al hospital o de cuidado médico dirigido por un médico antes de mi fallecimiento.

Entiendo que puedo revocar esta instrucción en cualquier momento si destruyo este formulario y me quito cualquier medalla que me identifique como "DNR".

Doy mi autorización para que esta información se entregue al personal , médicos, enfermeras y demás personal médico de cuidado de emergencia antes de ingresar al hospital, según sea necesario para implementar esta instrucción.

Por este medio estoy de acuerdo con la orden de "No resucitar (DNR)".

_____ _____
Firma del paciente/sustituto Fecha

_____
Nombre en letra de molde del sustituto Relación con el paciente Número de teléfono del sustituto

Al firmar este formulario, el sustituto reconoce que esta solicitud de renunciar a las medidas de resucitación es consistente con el deseo conocido y en el mejor interés de la persona referida en este formulario.

Ratifico que este paciente/sustituto está tomando una decisión informada y que esta instrucción es el deseo expreso del paciente/sustituto. Una copia de este formulario se guardó en el expediente médico permanente del paciente.

En el caso de un paro cardíaco o respiratorio, no se llevará a cabo masaje cardíaco, respiración artificial, intubación, desfibrilación o medicamentos cardiotónicos.

_____ _____
Firma del médico Fecha

_____
Nombre en letra de molde Número de licencia de California
Teléfono

ESTE FORMULARIO NO SE ACEPTARÁ SI ESTÁ ENMENDADO O ALTERADO DE ALGUNA FORMA

FORMULARIO DE SOLICITUD DE DNR ANTES DE INGRESAR AL HOSPITAL

El paciente debe conservar el original.
Se debe entregar una copia para el expediente médico permanente del paciente.
Si desea una medalla autorizada que identifique al paciente como DNR, se debe presentar una copia de este formulario con el formulario de inscripción de Medic Alert, a:
Medic Alert Foundation, 2323 Colorado Avenue, Turlock, CA 95381.
Para obtener el formulario de inscripción de Medic Alert, llame al 1-800-432-5378.

紧急医疗服务
住院前不施行心肺复苏术
(DO NOT RESUSCITATE (DNR)) 表格
(Simplified Chinese Form)

预先申请限制紧急医疗护理范围

本人，_____ 特此申请此表中所述的限制紧急护理。
（正楷填写患者姓名及病历编号）

本人理解 DNR 的意思，即如果本人的心脏停止跳动或本人停止呼吸，将不会对本人施行心肺复苏术医疗程序。

本人理解，该决定将不会妨碍本人获得由院前紧急医疗护理人员提供及/或医师在本人临终前指示的其他紧急医疗护理。

本人理解，本人可以通过撕毁该表和取下任何“DNR”标牌的方式随时撤销该指示。

本人允许在必要时向院前紧急护理人员、医生、护士或其他医护人员提供此信息以施行该指示。

本人特此同意“不施行心肺复苏术 (DNR)”医嘱。

_____ _____
患者/代理人签名 日期

_____
代理人姓名（正楷） 与患者关系 代理人电话号码
通过签署此表，代理人即承认放弃复苏术的申请符合与此表主体的意愿及其个人最佳利益。

本人确认，该患者/代理人的此决定在充分知情的情况下做出，并且该指示表达了患者/代理人的意愿。此表副本存于患者的永久病历中。

在心脏或呼吸骤停情况下，将不会施行胸部按压、辅助呼吸、插管、去心脏纤颤或使用强心药。

_____ _____
医师签名 日期

_____
姓名（正楷） 加州许可证号 电话

此表若被以任何方式命名或改动，将不予受理。

院前 DNR 申请表

本表原件由患者保管
请提交保存在患者永久病历中的副本
如需授权的 DNR 标牌，请将此表副本连同Medic Alert报名表提交至
Medic Alert Foundation, 2323 Colorado Avenue, Turlock, CA 95381。
如需获取Medic Alert报名表，请致电1-800-432-5378

緊急醫療服務
住院前不施行心肺復蘇術
(DO NOT RESUSCITATE (DNR)) 表格
(Traditional Chinese Form)

預先申請限制緊急醫療照護範圍

本人, _____ 特此申請此表中所述的限制緊急照護。
(正楷填寫病患姓名及病歷編號)

本人理解 DNR 的意思，即如果本人的心臟停止跳動或本人停止呼吸，將不會對本人施行心肺復蘇術醫療程序。

本人理解，該決定將不會妨礙本人獲得由院前緊急醫療照護人員提供及/或醫師在本人臨終前指示的其他緊急醫療照護。

本人理解，本人可以透過撕毀該表和取下任何「DNR」標牌的方式隨時撤銷該指示。

本人允許在必要時向院前緊急照護人員、醫生、護士或其他醫護人員提供此資訊以施行該指示。

本人特此同意「不施行心肺復蘇術 (DNR)」醫囑。

_____ _____
病患/代理人簽名 **日期**

_____ _____ _____
代理人姓名 (正楷) **與病患關係** **代理人電話號碼**

透過簽署此表，代理人即承認放棄復蘇術的申請符合與此表主體的意願及其個人最佳利益。

本人確認，該病患/代理人的此決定在充分知情的情況下做出，並且該指示表達了病患/代理人的意願。此表副本存于病患的永久病歷中。

在心臟或呼吸驟停情況下，將不會施行胸部按壓、輔助呼吸、插管、去心臟纖顫或使用強心藥。

_____ _____
醫師簽名 **日期**

_____ _____ _____
姓名 (正楷) **加州許可證號** **電話**

此表若被以任何方式命名或改動，將不予受理。

院前 DNR 申請表

本表原件由病患保管
請保存在病患永久病歷中的副本
如需授權的 DNR 標牌，請將此表副本連同 Medic Alert 報名表提交至
Medic Alert Foundation, 2323 Colorado Avenue, Turlock, CA 95381。
如需獲取 Medic Alert 報名表，請致電 1-800-432-5378

응급 의료 서비스

병원 전 심폐소생술 금지
(DO NOT RESUSCITATE (DNR)) 양식
(Korean Form)

CALIFORNIA MEDICAL ASSOCIATION

응급 의료 범위 제한 사전 요청

본인 _____은(는) 여기 기술된 바와 같이 응급 의료 제한을
(환자명 및 의료 기록 번호를 정자체로 기입하십시오)

요청합니다.

본인은 DNR이 본인의 심장이 박동을 멈추거나 호흡이 정지될 경우, 호흡을 소생시키거나 심장 기능을 재개시키는 의료 처치를 금지한다는 것을 알고 있습니다.

본인은 이 결정으로 인해 병원 전 응급 의료 요원에 의한 응급 의료 및/또는 본인의 사망 전에 의사가 지시하는 의료를 받는 것이 금지되지 않을 것임을 알고 있습니다.

본인은 이 양식을 파기하고 "DNR" 표시를 제거함으로써 언제든지 이 지시를 취소할 수 있음을 알고 있습니다.

본인은 이 지시를 시행하기 위해 필요에 따라 이 정보를 병원 전 응급 의료 요원, 의사, 간호사 또는 기타 보건 요원에게 제공하는 것을 허락합니다.

본인은 "심폐소생술 금지"(DNR) 명령에 동의합니다.

_____ _____
환자/대리인 서명 일자

_____ _____
대리인 성명 정자체 환자와의 관계 대리인의 전화번호

이 양식에 서명함으로써, 대리인은 본 심폐소생술 금지 요청이 본 양식의 주체인 사람의 알려진 희망 및 최선의 이익에 부합함을 인정합니다.

본인은 이 환자/대리인이 정보에 입각한 결정을 내리고 있으며 이 지시서가 환자/대리인의 표현된 희망임을 확언합니다. 이 양식의 사본이 환자의 영구 의료 기록에 있습니다.

심장 또는 호흡 정지의 경우, 흉부 압박, 보조 환기, 삽관, 세동제거 또는 강심제 투여를 해서는 안 됩니다.

_____ _____
의사 서명 일자

_____
정자체 성명 캘리포니아주 면허 번호 전화번호

이 양식은 어떤 식으로든 수정 또는 변경된 경우에는 수락되지 않을 것입니다.

병원 전 DNR 요청서

원본은 환자 보관
환자의 영구 의료 기록에 보관하도록 사본을 제출하십시오.
인가된 DNR 표시를 원하는 경우에는 이 양식 1부를 Medic Alert 등록 양식과 함께
Medic Alert Foundation에 제출하십시오2323 Colorado Avenue, Turlock, CA 9538의.
Medic Alert 등록 양식을 입수하려면 1-800-432-5378에 전화하십시오.

CÁC DỊCH VỤ CẤP CỨU
GIẤY YÊU CẦU KHÔNG HỒI SINH TRƯỚC KHI NHẬP VIỆN (DO NOT RESUSCITATE (DNR))

Vietnamese Form

Yêu Cầu Trước Về Việc Giới Hạn Phạm Vi Chăm Sóc Cấp Cứu

Tôi, _____ yêu cầu chỉ nhận các dịch vụ chăm sóc cấp cứu hạn chế như
(Viết in tên bệnh nhân và số hồ sơ y tế)
mô tả trong giấy này.

Tôi hiểu rằng DNR có nghĩa là nếu tim tôi ngừng đập hoặc nếu tôi ngừng thở, không một thủ thuật y tế nào sẽ được thực hiện để giúp tôi thở lại hay giúp tim tôi đập lại.

Tôi hiểu rằng quyết định này sẽ không ngăn cản tôi nhận các dịch vụ cấp cứu khác của nhân viên chăm sóc cấp cứu trước khi nhập viện và/hoặc các biện pháp chăm sóc y tế theo chỉ định của bác sĩ trước khi tôi tử vong.

Tôi hiểu rằng tôi có thể rút lại quyết định này vào bất kỳ lúc nào bằng cách hủy giấy này và cởi ra biểu tượng "DNR", nếu có.

Tôi cho phép cung cấp thông tin này cho nhân viên chăm sóc cấp cứu trước khi nhập viện cũng như các bác sĩ, y tá hoặc nhân viên y tế khác khi cần thiết để thực hiện quyết định này.

Bằng giấy này tôi đồng ý với lệnh "Không Hồi Sinh" (DNR).

_____ _____
Chữ Ký của Bệnh Nhân/Người Đại Diện Ngày

_____
Viết chữ in tên của Người Đại Diện Quan Hệ với Bệnh Nhân Số điện thoại của Người Đại Diện

Khi ký tên vào giấy này, người đại diện xác nhận rằng yêu cầu bỏ qua các biện pháp hồi sinh này phù hợp với nguyện vọng đã bày tỏ của và vì lợi ích cao nhất của đối tượng của giấy này.

Tôi xác nhận rằng bệnh nhân/người đại diện này đang đưa ra một quyết định có cân nhắc và quyết định này là nguyện vọng đã bày tỏ của bệnh nhân/người đại diện đó. Một bản sao của giấy này được đưa vào hồ sơ y tế dài hạn của bệnh nhân.

Trong trường hợp ngừng tim hoặc ngừng thở, không cần tiến hành ép ngực, thông đường thở, đặt ống, khử rung tim, hoặc dùng các loại thuốc trợ tim.

_____ _____
Chữ Ký của Bác Sĩ Ngày

_____
Tên Viết Chữ In Số Giấy Phép của California Điện Thoại

GIẤY NÀY SẼ KHÔNG ĐƯỢC CHẤP NHẬN NẾU ĐÃ BỊ SỬA ĐỔI HAY THAY ĐỔI DƯỚI BẤT KỲ HÌNH THỨC NÀO

GIẤY YÊU CẦU DNR TRƯỚC KHI NHẬP VIỆN

Bản gốc do bệnh nhân giữ
Gửi một bản sao để lưu vào hồ sơ y tế dài hạn của bệnh nhân
Nếu muốn có biểu tượng DNR chính thức, hãy nộp một bản sao của giấy này cùng với giấy ghi danh Medic Alert cho Medic Alert Foundation, 2323 Colorado Avenue, Turlock, CA 95381.
Để lấy giấy ghi danh Medic Alert, hãy gọi số 1-800-432-5378

MGA EMERHENSIYANG SERBISYONG MEDIKAL
FORM NG BILIN BAGO MAOSPITAL NA HUWAG NANG SIKAPING IBALIK ANG PAGHINGA
(DO NOT RESUSCITATE, DNR)

Tagalog Form

Isang Maagang Kahilingan na Limitahan ang Saklaw ng Emerhensiyang Pangangalagang Medikal

Ako, si _____, ay humihingi ng limitadong emerhensiyang
(*Ilimbag ang pangalan at numero ng medikal na rekord ng pasyente)*
pangangalaga katulad ng nakalarawan dito.

Nauunawaan ko na ang DNR ay nangangahulugan na kung tumigil sa pagtibok ang aking puso o kung tumigil ang aking paghinga, walang gagawing medikal na pamamaraan upang muling ibalik ang hininga o patibukin ang puso.

Nauunawaan ko na ang desisyong ito ay hindi magiging hadlang sa akin para makakuha ako ng iba pang emerhensiyang pangangalagang medikal mula sa mga tauhan sa emerhensiyang pangangalagang medikal bago
maospital at/o pangangalagang medikal na ibinibilin ng isang doktor bago ang aking pagkamatay.

Nauunawaan ko na maaari kong bawiin ang tagubiling ito anumang oras sa pamamagitan ng pagsira sa form na ito at pagtanggal sa anumang medalyon na "DNR".

Ibinibigay ko ang pahintulot para maibigay ang impormasyong ito sa mga tauhan sa emerhensiyang pangangalaga bago maospital, mga doktor, mga nars o iba pang mga tauhang pangkalusugan kung kinakailangan upang ipatupad ang tagubiling ito.

Sa pamamagitan nito sumasang-ayon ako sa utos na "Huwag Nang Sikaping Ibalik ang Paghinga" (DNR).

_____ _____
Pirma ng Pasyente/Kahalili Petsa

_____
Ilimbag ang Pangalan ng Kahalili | Relasyon sa Pasyente | Numero ng Telepono ng Kahalili

Sa pamamagitan ng pagpirma sa form na ito, tinatanggap ng kahalili na ang kahilingang ito na huwag gamitin ang mga pamamaraang pagpapabalik ng paghinga ay naaayon sa mga nalalamang kagustuhan at ayon sa pinakamabuting interes ng indibidwal na paksa ng form na ito.

Pinatutunayan ko na ang pasyente/kahalili ay gumagawa ng napaliwanagang desisyon at ang tagubiling ito ay isang hayag na kagustuhan ng pasyente/kahalili. Ang isang kopya ng form na ito ang nasa permanenteng medikal na rekord ng pasyente.

Kapag nagkaroon ng pagtigil ng normal na sirkulasyon ng dugo dahil sa kabiguan ng puso na epektibong gumalaw (cardiac o respiratory arrest), walang gagawing mga kumpresyon ng dibdib, tinutulungang paghinga, paglalagay ng tubo, paggamit ng elektrikal na enerhiya (defibrillation), o mga gamot na nagpapalakas ng paghila ng kalamnan na nagbobomba ng dugo mula sa puso (cardiotonic medications).

_____ _____
Lagda ng Doktor Petsa

_____
Ilimbag ang Pangalan | Numero ng Lisensya sa California | Telepono

HINDI TATANGGAPIN ANG FORM NA ITO KUNG ITO AY NAAMYENDAHAN O BINAGO SA ANUMANG PARAAN

FORM NG KAHILINGAN PARA SA BILIN BAGO MAOSPITAL NA HUWAG NANG SIKAPING IBALIK ANG PAGHINGA (DNR)

Ang orihinal ay itatago ng pasyente
Isumite ang isang kopya para maitago sa permanenteng medikal na rekord ng pasyente
Kung gusto ninyo ng awtorisadong medalyon ng DNR, magsumite ng kopya ng form na ito, kasama ang form ng pagpapalista para sa Medic Alert, sa Medic Alert Foundation, 2323 Colorado Avenue, Turlock, CA 95381.
Para kumuha ng form ng pagpapalista sa Medic Alert, tumawag sa 1-800-432-5378

ЭКСТРЕННЫЕ МЕДИЦИНСКИЕ УСЛУГИ
ДОГОСПИТАЛИЗАЦИОННАЯ ФОРМА РАСПОРЯЖЕНИЯ
«НЕ ПРОВОДИТЬ РЕАНИМАЦИОННЫЕ МЕРОПРИЯТИЯ»
(DO NOT RESUSCITATE (DNR))
Russian Form

Заблаговременная просьба ограничить объем оказания экстренных медицинских услуг

Я, _____, прошу предоставить мне ограниченный объем экстренных

(Вписать печатными буквами имя и фамилию пациента и номер его карты)

медицинских услуг, как указано в данном документе.

Я понимаю, что DNR означает, что в случае остановки моего сердца или дыхания не будут проводиться какие-либо медицинские процедуры для восстановления данных функций.

Я понимаю, что данное решение не помешает мне получать прочие экстренные медицинские услуги, оказываемые сотрудниками неотложной медицинской помощи до госпитализации, и/или медицинские услуги, назначенные врачом до моей смерти.

Я понимаю, что могу в любое время отозвать данное распоряжение, уничтожив данную форму, и сняв медальоны “DNR”.

Я разрешаю предоставить данную информацию сотрудникам догоспитализационной службы экстренной медицинской помощи, врачам, медсестрам, а также прочему медперсоналу в целях осуществления данного распоряжения.

Настоящим я даю свое согласие на распоряжение «Не проводить реанимационные мероприятия» (DNR).

_____ _____
Подпись пациента / представителя Дата

_____
Вписать имя представителя печатными буквами Кем приходится пациенту Телефон представителя

Подписывая данную форму, представитель подтверждает, что данная просьба в отношении отказа от реанимационных мероприятий соответствует известным пожеланиям и интересам указанного в данной форме лица.

Я подтверждаю, что данный пациент / представитель принимает информированное решение, и что данное распоряжение является открытым желанием пациента / представителя. Копия данной формы приложена к постоянной медицинской карте пациента.

В случае остановки сердца или дыхания не следует осуществлять закрытый массаж сердца, искусственную вентиляцию лёгких, интубацию, дефибриляцию или вводить кардиотонические препараты.

_____ _____
Подпись врача Дата

_____
Имя и фамилия печатными буквами Номер лицензии в штате Калифорния Телефон

ДАННАЯ ФОРМА С КАКИМИ-ЛИБО ИЗМЕНЕНИЯМИ ПРИЕМУ НЕ ПОДЛЕЖИТ
ДОГОСПИТАЛИЗАЦИОННАЯ ФОРМА РАСПОРЯЖЕНИЯ DNR

Оригинал должен сохраниться у пациента.
Отправить копию и приложить к постоянной медицинской карте пациента.
При желании получить медальон “DNR” следует отправить копию данной формы и форму зачисления в Medic Alert в фонд
Medic Alert Foundation по адресу 2323 Colorado Avenue, Turlock, CA 95381.
Чтобы получить форму зачисления в Medic Alert, позвоните по телефону 1-800-432-5378.

Handout #13
When the End of Life Becomes Personal

For most people, talking about death and dying is not easy. However, as interpreters who may be working with patients who are close to the end of their lives, it is important for us to think about how our own experiences and beliefs could potentially affect our interpreting, and how the experience of interpreting for someone who is dying may affect us personally.

We asked about these issues in a 2011 survey of working interpreters who have provided end-of-life care, and, with their permission, we have included some of their answers here. There are no "right" answers to these questions, but hearing the voices of other interpreters may help you find your own.

For some people, it is easier to think about this alone, while others may find it more helpful to talk about it out loud, so you may do this exercise alone or in pairs.

In the survey, we asked our interviewees how the experience of interpreting for someone they knew to be at the end of life affected them personally.

> *It took an emotional toll on me. I, of course, always want to be the bearer of positive news, of "lights at the end of the tunnel" after devastating diagnoses. I want to be able to convey hope. Having to have the end of life conversations with patients and families is always very emotionally exhausting. Seeing the patient / family grasp at straws, begging for "whatever it takes" to save their loved one……well……it can break you if you're not careful. If I go into a situation knowing from the beginning that the patient is terminal, I tend to be a little more guarded.*
>
> - Nicole Marr, Spanish healthcare interpreter
> University of Mississippi Health Care, Jackson, MS

> *One instance in which it affected me personally was when a baby passed away in the NICU two years ago. I had worked with the family several times and seen the child go through a lot of ups and downs. Intellectually, I knew that the baby was not going to survive, but when the doctor gave him to his mom and essentially said that he needed to be present as he [the baby] passed to mark the time of death, I lost it. I started crying because the reality hit me that this mom was going to lose her child. I barely got the words out to interpret them. It's one thing to hear the words, but then to have to repeat them again, knowing what you have to say... it's extremely difficult at times to hold it together. The family had a strong faith and were very close. Despite their profound sadness, they seemed like a strong unit that would grieve the loss and eventually come out of it, which I think helped me to see their strength. I tend to feel the responses of others and when they don't do well, it tends to affect me, but I do my best to remain professional and focused. To be honest, the more situations in which I see patients die, ones with whom I have established a relationship, the harder it gets. I used to be better about holding up a "wall" until an appropriate time to grieve, but it seems like lately, that has been more difficult. I don't necessarily think that it harms my reputation to cry in front of the family; it's not like I'm a sobbing mess incapable of doing my job; it shows I am empathetic, but I do wish that I had better control over it at times. After that baby died, I*

got called to interpret in the NICU again a week later and my heart skipped a beat. I could tell I was nervous that I would have to go through that again so soon, but it was just a routine visit, thankfully. It is certainly true that when you see a series of bad cases, especially being a full-time in-house interpreter, it can weigh heavily on you. I have relied on my colleagues, chaplains, nurses, and providers to talk things through and that always helps too.

- Anonymous healthcare interpreter
Portland, OR

In this case the dying patient took her situation in with a great deal of acceptance which I found inspirational. It was sad to see that a great deal of the acceptance came from her no longer wanting to be a burden on her family, but she seemed tranquil. It has been hard for me to deal with the family's grief and to draw appropriate role boundaries because I did want to see how they were doing shortly after their mother passed.

-Anonymous healthcare interpreter
Bend, OR

In the 3 years I have worked at the UWMC, I have interpreted for 2 patients who were dying. It is very difficult to be the bearer of bad news. Even when the words are not mine, I am still the messenger. Sometimes an unintentional bond develops when interpreting for the same patient over a long period of time. I interpret for tests, procedures, exams, consultations with the care team, and everything else in between. I do not have a personal connection with the patient, yet I am present during some of the most intimate details of the patient's care. Because of this, it is challenging not to internalize the emotional magnitude of knowing a patient is dying. Interpreting at a patient's bedside with family members in attendance, and translating the words of a priest administering last rites is a humbling experience. At times I have felt like an intruder, witnessing such private moments. The additional pressure of making sure my affect and words/signs are chosen correctly is equally important. However difficult it may be, I must remember that my role is that of communication facilitator, and to ensure that our patients have equal access to care by bridging the communication gap.

- Julie Green, ASL interpreter
University of Washington Medical Center, Seattle, WA

Interpreting in these sorts of situations can affect people in different ways. Have you ever had an interpreting experience that affected you emotionally? *(Write your answer here.)*

We asked our interviewees how they dealt with these difficult encounters.

> *With this case, I sometimes found myself crying with the patient and the family. When I first began interpreting, I tried to control this side of my personality. I had heard people say not to get too emotionally attached, but how can someone be around death -- literally watch some take their last breath, watch the family hold their hand and grieve -- and not be affected emotionally? Having to be the bearer of bad news at times took its toll on me. I would sometimes cry when I would see the family cry,* [and] *I would talk with the other interpreters on my team. They, better than anyone else, can relate to this particular emotional strain. I'm a big advocate of "sharing the burden" and not trying to take on all of this by myself. We frequently meet to have coffee and "decompress."*
>
> Nicole Marr, Spanish healthcare interpreter
> University of Mississippi Health Care, Jackson, MS

> *When I start to cry or feel like I might cry during an interpreted visit for a dying patient, or for one that has just passed away, I try to take notes as the speaker talks, because I know that I will not remember what is being said if I am not able to hold it together. Most times, I can remain focused, but I take notes in case I get triggered unexpectedly. . . . If I do start to cry, I just take a minute to refocus myself, to talk myself through it, remember that I am there to interpret accurately and not get personally involved, and that although the situation may be sad, I can grieve when I leave the room. That usually helps . . . Another tactic I use to stay focused is to not look at the family. Sometimes I will look at my notes to stay concentrated and only look up now and again to show I care.*
>
> - Anonymous healthcare interpreter
> Portland, OR

> *After a particularly challenging experience, I deal with my emotions by confiding in my manager. She understands the intensity of our work environment and is a compassionate confidant. After a difficult day, I decompress by putting on my headphones and going for a walk, sometimes accompanied by some Kleenex. Or I might spend time working in the yard. Pulling dandelions can be quite therapeutic. My cat is also a very good listener. Tears illustrate that we are emotional beings, capable of empathy and concern. However, the patient and family should not feel obligated to console an upset interpreter. They have enough to worry about. My best advice, don't fall apart during the assignment, fall apart when you get home.*
>
> - Julie Green, ASL interpreter
> University of Washington Medical Center, Seattle, WA

How have you dealt with emotionally difficult interpretations? What actions can you take to help yourself deal with them? Who could you talk to at work? What about outside of work? (Write your answer here.)

Then we asked our respondents how they thought personal beliefs about death and experience with death might affect an interpreter's performance.

> *For me, personally, experiencing the death of anyone is always a sad, deeply emotional experience. However, my own beliefs reflect the fact that I don't believe death is the end. I believe in life after death. With that being said, I can honestly say that, although watching someone I've grown to care about pass away can be traumatic, it can also be a relief at times. I know that their suffering has ended, and I take comfort in my belief that there is more after this life.*
>
> - Nicole Marr, Spanish healthcare interpreter
> University of Mississippi Health Care, Jackson, MS

> *I have interpreted in several situations in which the patient was dying. In one instance, within the last three years, I did not have any prior experience working with the patient and I was present in the final moments of his life, as he was surrounded by all of his family. It did not affect me very deeply because I had no relationship with the patient, but I definitely felt the grief emanating from the room, and it did make me sad to think about losing someone close. (My grandfather passed away in 1997.) Frequently, I feel like an intruder in those very private moments and I try to be an unobtrusive as possible and step away when it is clear I do not need to be there.*
>
> - Anonymous healthcare interpreter
> Portland, OR

> *While raised Catholic, I no longer practice any one religion. My view on death and dying is influenced by a variety of belief systems as well as my own lack of a definitive belief regarding end of life. Basically, I believe that we are spiritual beings in physical bodies and that upon death we re-integrate into the universe as a form of energy. Therefore, it is interesting for me to encounter people who have definite beliefs regarding death and spiritual continuity thereafter. I think it is wonderful that people can be reassured by a belief in a set paradigm at such a difficult time. I recently helped a Hispanic family pass through this as an interpreter in their primary care clinic. I was able to recognize the importance of last rites and grieving for the family. I did not feel a conflict of interests.*
>
> - Anonymous healthcare interpreter
> Bend, OR

What personal experiences, if any, have you had with death (e.g. perhaps the death of a loved one)?

What do you believe happens to a person after he or she dies?

How do you think your beliefs and experiences might affect your interpreting for patients who are at the end of life?

Handout #14
Post-test

Name: _____

Circle the letter of the best answer to the question.

1. Which is the best definition of palliative care?
   a. An approach to health care aimed at keeping a patient comfortable at the end of life.
   b. A program to provide support for patients to die at home.
   c. An approach to health care aimed at treating symptoms instead of the cause of disease.
   d. An approach to managing pain.

2. Which is a reason that a provider might ask for a palliative care consult?
   a. The provider needs guidance about how to tell a new mother that her newborn baby has died.
   b. The patient's recovery is going to be long and painful.
   c. A patient has asked to see the chaplain.
   d. The provider would like a social worker to be present when he talks to the patient's family about sending him home after a knee replacement surgery.

3. Which of the following professionals are commonly part of a palliative care team?
   a. Physician, home health aide, counselor
   b. Physician, nurse, social worker, chaplain
   c. Physician, nurse, physical therapist, social worker
   d. Physician, home health aide, social worker, chaplain

4. What does it mean when a palliative care provider says, "We are going to keep you as comfortable as possible during your remaining time."
   a. The provider is going to order a better hospital bed so the patient is more comfortable until she is discharged to go home.
   b. The hospital is going to provide special meals and other additional services until the patient's insurance runs out.
   c. The staff is going to control the patient's symptoms so that she feels as good as possible until she dies.
   d. The chaplain is going to say prayers with the patient.

5. What should you do if the provider infers, but doesn't say directly, that the patient is going to die?
   a. Don't interpret this part, since in many cultures it is not appropriate for patients to be told they are dying.
   b. Ask for clarification.
   c. Interpret into equally vague language.
   d. B or C

6. As an interpreter, what would be the most professional response if a family starts a discussion among themselves in a family conference?
   a. Move next to the provider and switch to whispered simultaneous interpreting.
   b. Don't interpret this, as it is not meant for the provider.
   c. Wait until they are done and then summarize the main points for the provider.
   d. Intervene and ask them to pause between speaking to allow you to interpret.

7. What is an appropriate role for an interpreter if the patient's family is angrily resisting the advice of the provider?
   a. To convince the family to do what the provider suggests.
   b. To mediate the disagreement and help the provider and family find a solution.
   c. To interpret the argument faithfully, and allow the provider and the family to find a solution.
   d. To soften the family's words so that the provider doesn't get offended.

8. What should you do if asked to interpret a prayer with frozen register that you don't know in the target language?
   a. Interpret the meaning, not the words.
   b. Intervene and explain that you will have to withdraw.
   c. Explain that you are not familiar with the prayer and suggest that the prayer not be interpreted.
   d. Excuse yourself to go look up the prayer on the internet.

9. What should you do if asked to interpret a patient's explanation of religious beliefs that you believe are wrong.
   a. Intervene and explain that you will have to withdraw.
   b. Gently explain to the patient why his beliefs are wrong.
   c. Just leave out the part that you don't believe.
   d. Interpret what the patient is saying.

10. Of the following options, which is the most appropriate way to culture broker if the patient's family is resisting having the provider tell the patient that she is dying.
    a. "Doctor, please don't tell the patient that she's dying – it's against her culture."
    b. "Doctor, in this family's culture, patients are often not told that they are dying, as it is feared that the patient will lose hope and die sooner. You might want to ask the family if this is the case here."
    c. "Doctor, she can't hear that she's dying, or she'll die sooner."
    d. "Doctor, the family is upset.."

Describe a cultural barrier related to end-of-life care that might come up in the patient population for which you interpret.

11. _____

    _____

    _____

Name three situations in which it would be appropriate to intervene to ask for clarification when interpreting in palliative care.

12. _____

_____

13. _____

_____

14. _____

_____

In front of each term, write the letter of the best definition. Not all definitions will be used.

15. ____ advance directive
16. ____ DNR
17. ____ goals of care
18. ____ surrogate decision maker
19. ____ POLST
20. ____ chaplain
21. ____ quality of life
22. ____ respite care

A. A person who has been specially trained to offer support, prayer, and spiritual guidance to patients and their families.
B. An expression of the things that make life worth living for an individual patient.
C. A member of the clergy, such as a minister, a priest, a rabbi or a mullah.
D. A physician's order that stops healthcare staff from reviving a patient whose heart stops.
E. A legal document that authorizes a particular person to make decisions for a patient if he or she cannot make them for him-or herself.
F. Care that takes place in a long-term nursing facility.
G. A legal document that describe a patient's treatment preferences if he should be unable to communicate those preferences at some future time.
H. The degree to which a patient is free of pain.
I. A program that provides alternate care for a patient being cared for at home, in order to give the family caregivers a break.
J. A physician's order that specifies the limits to the types of interventions that a patient wants to have at the end of his or her life.
K. The person who has been legally designated to make decisions for a patient who cannot make them for him or herself.
L. A patient or family's desired outcome from a course of care.

Name one way in which an interpreter's personal experience with death and dying could affect her interpreting in palliative care, either for better or for worse.

23. _____

_____

_____

_____

24. Why is it important to control your emotions when interpreting for difficult encounters?
    a. If the interpreter become so upset that he or she cannot interpret, the patient and provider will have no way to communicate with each other, making the encounter all the more traumatic for them.
    b. Interpreters should never show their emotions when they interpret, because they should be invisible.
    c. As a rule, healthcare professionals do not show their emotions to patients.
    d. Crying is a sign of weakness and poor practice for an interpreter.

25. You have been the principal interpreter for a patient who, after a long and difficult illness, finally dies. You feel emotionally drained and deeply saddened by the death. Which of the following would **NOT** be an appropriate thing to do to deal with your grief.
    a. Talk to the hospital chaplain.
    b. Take a vacation day.
    c. Go to the patient's funeral.
    d. Write about the patient and his brave struggle with his illness on your blog.

Handout #15
Evaluation Form

Date _____

Location_____

Overall, how would you rat e this course? (circle one)

Very useful Somewhat useful Not useful

Had you received training as an interpreter prior to this course? Yes No

Would you recommend this course to other interpreters Yes No

What was most useful to you in this course?

What would you like to see done differently?

What will you change in your own interpreting practice based on what you learned in this course?

Test Answer Sheet

Pre-test

1. C
2. H
3. G
4. A
5. B
6. F

Post-test

1. C
2. B
3. B
4. C
5. D
6. A
7. C
8. C
9. D
10. B
11. Accept any reasonable answer.
12-14. Accept any of the following: lack of linguistic equivalent, lack of conceptual equivalent, patient seems confused, cultural bump, interpreter doesn't understand.
15. G
16. D
17. L
18. K
19. J
20. A
21. B
22. I
23. Accept any reasonable answer.
24. A
25. D

Certificate of Completion

Presented to:

NAME

In Recognition of Completing
Seven Hours of Instruction
with a passing grade in
Interpreting in Palliative Care

California HealthCare Foundation

Signature

Date