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.

gh) 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.
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 bloodstream, 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/
Interpreting in Palliative Care

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
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
Interpreting in Palliative Care

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
Interpreting in Palliative Care
<table>
<thead>
<tr>
<th>Term</th>
<th>English Definition</th>
<th>Spanish Equivalent</th>
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<tbody>
<tr>
<td>advance directive</td>
<td>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).</td>
<td>directivas (f) médicas por adelantado declairación (f) de voluntades anticipadas</td>
</tr>
<tr>
<td>advance care planning</td>
<td>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.</td>
<td>planificación (f) de cuidado anticipado</td>
</tr>
<tr>
<td>artificial nutrition and hydration</td>
<td>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.</td>
<td>hidratación (f) y nutrición (f) artificial</td>
</tr>
<tr>
<td>autopsy</td>
<td>An examination of the body in order to determine the cause of death, involving dissection of the remains.</td>
<td>autopsia (f)</td>
</tr>
<tr>
<td>bereavement counseling</td>
<td>Counseling to help deal with on-going sadness regarding a loved one who has died or who is dying.</td>
<td>consejería (f) por duelo</td>
</tr>
<tr>
<td>brain death</td>
<td>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.</td>
<td>muerte (f) cerebral</td>
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<tr>
<td>caregiver</td>
<td>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.</td>
<td>encargado(m) del cuidado</td>
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<td>chaplain®</td>
<td>An individual ordained or consecrated for religious ministry, specially trained to offer support, prayer, and spiritual guidance to patients and their families.</td>
<td>capellán (m) consejero (m) espiritual</td>
</tr>
<tr>
<td>coma</td>
<td>A state of profound unconsciousness caused by disease, injury or poison.</td>
<td>coma (m)</td>
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<tr>
<td>code status</td>
<td>A patient’s “code status” tells providers whether a patient should be resuscitated or not should cardiac or respiratory arrest occur.</td>
<td>clave (f) de estado del paciente</td>
</tr>
<tr>
<td>comfort care</td>
<td>treatments that focus only on promoting comfort, not prolonging life artificially</td>
<td>cuidado (m) de confort</td>
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<td>coping skills</td>
<td>The skills needed to emotionally handle difficult situations in life</td>
<td>destrezas (f) para afrontar a una situación difícil</td>
</tr>
<tr>
<td>coroner</td>
<td>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.</td>
<td>official (m) de justicia que investiga los casos de muerte inexplicada</td>
</tr>
<tr>
<td>CPR (cardiopulmonary</td>
<td>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).</td>
<td>resuscitación (f) cardiopulmonar</td>
</tr>
<tr>
<td>resuscitation)iii</td>
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</tr>
<tr>
<td>do-not-resuscitate order</td>
<td>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).</td>
<td>orden (f) de no resucitar</td>
</tr>
<tr>
<td>(DNR)iii</td>
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<tr>
<td>durable power of attorney</td>
<td>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.”</td>
<td>poder(m) legal</td>
</tr>
<tr>
<td>durable power of attorney for health care</td>
<td>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.</td>
<td>poder (m) legal para cuidado de salud</td>
</tr>
<tr>
<td>feeding tube</td>
<td>A tube placed into the stomach or small intestine to provide nutrition to a person who cannot eat or drink.</td>
<td>sonda (f) de alimentación</td>
</tr>
<tr>
<td>funeral home</td>
<td>A commercial entity that prepares the deceased for burial or cremation and assists in preparing a funeral.</td>
<td>funeraria (f)</td>
</tr>
<tr>
<td>goals of care</td>
<td>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.</td>
<td>objetivos del cuidado</td>
</tr>
<tr>
<td>health proxy</td>
<td>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.</td>
<td>documento (m) legal nombrando a un apoderado para decisiones médicas apoderado (m) para decisiones médicas</td>
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## Interpreting in Palliative Care

| 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 extracorporeal                                                               |
| 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          | 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) | A specialized part of the hospital designed for care of the critically ill whose conditions require constant monitoring.                                                                                       | unidad (f) de cuidados intensivos                                                                       |
| intubation            | 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 |

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<td>living will</td>
<td>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.</td>
<td>testamento (m) en vida</td>
</tr>
<tr>
<td>long-term care</td>
<td>A healthcare facility that provides nursing care to patients over an extended period of time.</td>
<td>cuidado (m) de largo plazo</td>
</tr>
<tr>
<td>Medical Examiner</td>
<td>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.</td>
<td>médico (m) forense</td>
</tr>
<tr>
<td>metastasis</td>
<td>The spread of a disease (usually cancer) from the initial site to another part of the body.</td>
<td>metástasis (m)</td>
</tr>
<tr>
<td>morgue</td>
<td>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.</td>
<td>morgue (f)</td>
</tr>
<tr>
<td>next of kin</td>
<td>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.”</td>
<td>familiar (m) más cercano</td>
</tr>
<tr>
<td>organ donation</td>
<td>The act of giving permission for a patient’s organs to be harvested after his death for transplantation into another individual</td>
<td>donación (f) de órganos</td>
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## Interpreting in Palliative Care

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<tr>
<td>palliative care</td>
<td>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.</td>
<td>cuidados(m) paliativos atención (f) paliativa</td>
</tr>
<tr>
<td>persistent vegetative state (PVS)</td>
<td>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.</td>
<td>estado (m) vegetativo persistente estado (m) de coma</td>
</tr>
<tr>
<td>POLST</td>
<td>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.</td>
<td>órdenes (f) del médico para el tratamiento de mantenimiento artificial de la vida</td>
</tr>
<tr>
<td>pre-hospital DNR</td>
<td>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.</td>
<td>órden (f) de no resucitar ortorgada antes de ingresar al hospital</td>
</tr>
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<tr>
<td>prognosis</td>
<td>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 &quot;prognosis&quot; to mean &quot;the estimated time remaining to live.&quot;</td>
<td>pronóstico (m)</td>
</tr>
<tr>
<td>quality of life</td>
<td>An expression of the actions, experiences, or feelings that make life worth living, for an individual patient.</td>
<td>calidad (f) de vida</td>
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<tr>
<td>respite care</td>
<td>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.</td>
<td>cuidado (m) temporal de reemplazo</td>
</tr>
<tr>
<td>restlessness</td>
<td>The inability to stay still, often involuntary</td>
<td>agitación (f)</td>
</tr>
<tr>
<td>skilled nursing facility(^1)</td>
<td>A residential facility that provides professional nursing care around the clock, usually along with rehabilitation</td>
<td>centro (m) de enfermería especializada</td>
</tr>
<tr>
<td>support</td>
<td>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.</td>
<td>apoyo (m)</td>
</tr>
<tr>
<td>surrogate decision-maker(^2)</td>
<td>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.</td>
<td>sustituto (m) para la toma de decisiones</td>
</tr>
<tr>
<td>ventilator(^3)</td>
<td>A machine that takes over breathing for the patient, controlling the intake and expiration of air</td>
<td>respirador (m)</td>
</tr>
<tr>
<td>withdrawal of support</td>
<td>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.</td>
<td>retiro (m) del mantenimiento artificial de la vida</td>
</tr>
</tbody>
</table>

\(^1\) Definition from [www.eMedicinehealth.com](http://www.eMedicinehealth.com).
\(^2\) Definition from [http://www.mywhatever.com/cifwriter/content/66/4620.html](http://www.mywhatever.com/cifwriter/content/66/4620.html).
\(^3\) Definition from [http://www.pbs.org/secondopinion/episodes/endoflife/medicalglossary](http://www.pbs.org/secondopinion/episodes/endoflife/medicalglossary).
\(^4\) Definition from [http://www.dickinson.edu/endoflife/Glossary.html](http://www.dickinson.edu/endoflife/Glossary.html).
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<tr>
<td>advance directive</td>
<td>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).</td>
<td>医护服务事前指示书</td>
</tr>
<tr>
<td>advance care planning</td>
<td>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.</td>
<td>事前护理计划</td>
</tr>
<tr>
<td>artificial nutrition and hydration</td>
<td>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.</td>
<td>人工营养和维持水分</td>
</tr>
<tr>
<td>autopsy</td>
<td>An examination of the body in order to determine the cause of death, involving dissection of the remains.</td>
<td>验尸</td>
</tr>
<tr>
<td>bereavement counseling</td>
<td>Counseling to help deal with on-going sadness regarding a loved one who has died or who is dying.</td>
<td>丧亲咨询</td>
</tr>
<tr>
<td>braindeath</td>
<td>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.</td>
<td>脑死亡</td>
</tr>
<tr>
<td>caregiver</td>
<td>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.</td>
<td>护理者</td>
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<td>chaplain</td>
<td>An individual ordained or consecrated for religious ministry, specially trained to offer support, prayer, and spiritual guidance to patients and their families.</td>
<td>牧师</td>
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<td>coma</td>
<td>A state of profound unconsciousness caused by disease, injury or poison.</td>
<td>昏迷</td>
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<td>code status</td>
<td>A patient’s &quot;code status&quot; tells providers whether a patient should be resuscitated or not should cardiac or respiratory arrest occur.</td>
<td>病者的维生决定</td>
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<td>comfort care</td>
<td>treatments that focus only on promoting comfort, not prolonging life artificially</td>
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<td>coping skills</td>
<td>The skills needed to emotionally handle difficult situations in life</td>
<td>应对技能</td>
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<td>coroner</td>
<td>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.</td>
<td>验尸官</td>
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<td>CPR (cardiopulmonary resuscitation)</td>
<td>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).</td>
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<td>prognosis</td>
<td>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 &quot;prognosis&quot; to mean &quot;the estimated time remaining to live.&quot;</td>
<td>预后</td>
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<td>quality of life</td>
<td>An expression of the actions, experiences, or feelings that make life worth living, for an individual patient.</td>
<td>生活素质</td>
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<td>respite care</td>
<td>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.</td>
<td>暂缓护理</td>
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<tr>
<td>restlessness</td>
<td>The inability to stay still, often involuntary</td>
<td>不安/心神不定</td>
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<tr>
<td>skilled nursing facility</td>
<td>A residential facility that provides professional nursing care around the clock, usually along with rehabilitation</td>
<td>专业护理机构</td>
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<td>support</td>
<td>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.</td>
<td>支撑/扶持</td>
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<tr>
<td>surrogate decision-maker</td>
<td>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.</td>
<td>有权做决定的代理人</td>
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<tr>
<td>ventilator</td>
<td>A machine that takes over breathing for the patient, controlling the intake and expiration of air</td>
<td>呼吸机</td>
</tr>
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<td>withdrawal of support</td>
<td>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.</td>
<td>撤走维持生命的仪器</td>
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1. Definition from [www.eMedicinehealth.com](http://www.eMedicinehealth.com).
2. Definition from [http://www.mywhatever.com/cifwriter/content/66/4620.html](http://www.mywhatever.com/cifwriter/content/66/4620.html).
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<td>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).</td>
<td>醫護服務事前指示書</td>
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<td>advance care planning</td>
<td>Decisions made by patients about their wishes regarding interventions and care if a physical condition made it impossible for them to communicate their wishes in the moment.</td>
<td>事前護理計劃</td>
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<td>artificial nutrition and hydration</td>
<td>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.</td>
<td>人工營養和維持水分</td>
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<td>autopsy</td>
<td>An examination of the body in order to determine the cause of death, involving dissection of the remains.</td>
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<td>bereavement counseling</td>
<td>Counseling to help deal with on-going sadness regarding a loved one who has died or who is dying.</td>
<td>喪親諮詢</td>
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<td>braindeath</td>
<td>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.</td>
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<td>caregiver</td>
<td>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.</td>
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<td>chaplain</td>
<td>An individual ordained or consecrated for religious ministry, specially trained to offer support, prayer, and spiritual guidance to patients and their families.</td>
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<td>coma</td>
<td>A state of profound unconsciousness caused by disease, injury or poison.</td>
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<td>code status</td>
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<td>comfort care</td>
<td>treatments that focus only on promoting comfort, not prolonging life artificially</td>
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<td>The skills needed to emotionally handle difficult situations in life</td>
<td>應對技能</td>
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<td>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.</td>
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<td>prognosis</td>
<td>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.”</td>
<td>預後</td>
</tr>
<tr>
<td>quality of life</td>
<td>An expression of the actions, experiences, or feelings that make life worth living, for an individual patient.</td>
<td>生活素質</td>
</tr>
<tr>
<td>respite care</td>
<td>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.</td>
<td>暫緩護理</td>
</tr>
<tr>
<td>restlessness</td>
<td>The inability to stay still, often involuntary</td>
<td>不安/心神不定</td>
</tr>
<tr>
<td>skilled nursing facility²</td>
<td>A residential facility that provides professional nursing care around the clock, usually along with rehabilitation</td>
<td>專業護理機構</td>
</tr>
<tr>
<td>support</td>
<td>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.</td>
<td>支撐/扶持</td>
</tr>
<tr>
<td>surrogate decision-maker</td>
<td>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.</td>
<td>有權做決定的代理人</td>
</tr>
<tr>
<td>ventilator²</td>
<td>A machine that takes over breathing for the patient, controlling the intake and expiration of air</td>
<td>呼吸機</td>
</tr>
<tr>
<td>withdrawal of support</td>
<td>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.</td>
<td>撤走維持生命的儀器</td>
</tr>
</tbody>
</table>

### Advance Directive

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).

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<td>advance directive</td>
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<td>chỉ thị trước</td>
</tr>
<tr>
<td>advance care planning</td>
<td>Decisions made by a patient about their wishes regarding interventions and care if a physical condition made it impossible for them to communicate their wishes in the moment.</td>
<td>lập kế hoạch chăm sóc trước</td>
</tr>
<tr>
<td>artificial nutrition and hydration</td>
<td>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.</td>
<td>truyền dinh dưỡng và nước nhân tạo</td>
</tr>
<tr>
<td>autopsy</td>
<td>An examination of the body in order to determine the cause of death, involving dissection of the remains.</td>
<td>khám nghiệm tử thi</td>
</tr>
<tr>
<td>bereavement counseling</td>
<td>Counseling to help deal with on-going sadness regarding a loved one who has died or who is dying.</td>
<td>tư vấn về việc mất người thân</td>
</tr>
<tr>
<td>brain death</td>
<td>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.</td>
<td>chết não</td>
</tr>
<tr>
<td>caregiver</td>
<td>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.</td>
<td>người chăm sóc</td>
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<td>chaplain</td>
<td>An individual ordained or consecrated for religious ministry, specially trained to offer support, prayer, and spiritual guidance to patients and their families.</td>
<td>cha tuyên úy</td>
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<tr>
<td>coma</td>
<td>A state of profound unconsciousness caused by disease, injury or poison.</td>
<td>hôn mê</td>
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<tr>
<td>code status</td>
<td>A patient’s “code status” tells providers whether a patient should be resuscitated or not should cardiac or respiratory arrest occur.</td>
<td>mã chỉ định hồi sinh</td>
</tr>
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<td>comfort care</td>
<td>treatments that focus only on promoting comfort, not prolonging life artificially</td>
<td>chăm sóc an ủi</td>
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<td>coping skills</td>
<td>The skills needed to emotionally handle difficult situations in life</td>
<td>kỹ năng đối phó</td>
</tr>
<tr>
<td>coroner</td>
<td>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.</td>
<td>nhân viên điều tra các vụ chết bất thường</td>
</tr>
<tr>
<td>CPR (cardiopulmonary resuscitation)</td>
<td>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).</td>
<td>hồi sức tim phổi</td>
</tr>
<tr>
<td>do-not-resuscitate order (DNR)</td>
<td>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).</td>
<td>chỉ định không hồi sinh</td>
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<td>durable power of attorney</td>
<td>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.”</td>
<td>quyền đại diện dài hạn</td>
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<tr>
<td>durable power of attorney for health care</td>
<td>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.</td>
<td>quyền đại diện dài hạn về chăm sóc sức khỏe</td>
</tr>
<tr>
<td>feeding tube</td>
<td>A tube placed into the stomach or small intestine to provide nutrition to a person who cannot eat or drink.</td>
<td>ống nuôi ăn</td>
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<td>funeral home</td>
<td>A commercial entity that prepares the deceased for burial or cremation and assists in preparing a funeral.</td>
<td>nhà tang lễ</td>
</tr>
<tr>
<td>goals of care</td>
<td>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.</td>
<td>mục tiêu chăm sóc</td>
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<tr>
<td>health proxy</td>
<td>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. 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.</td>
<td>ủy quyền chăm sóc sức khỏe</td>
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<tr>
<td>health status</td>
<td>The condition of an individual's health.</td>
<td>tinh hình sức khỏe</td>
</tr>
<tr>
<td>heart/lung machine</td>
<td>A machine that artificially takes over the function of the lungs and heart.</td>
<td>máy trợ tim/phổi</td>
</tr>
<tr>
<td>home health aide</td>
<td>A trained and certified healthcare worker who monitors a home-bound patient's condition and assists with personal hygiene and light housework.</td>
<td>người hỗ trợ chăm sóc sức khỏe tại gia</td>
</tr>
<tr>
<td>hospice care</td>
<td>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.</td>
<td>chăm sóc cuối đời</td>
</tr>
<tr>
<td>immediate family</td>
<td>A patient's closest relatives, usually considered to be parents, siblings, spouse and children.</td>
<td>gia đình trực hệ</td>
</tr>
<tr>
<td>intensive care unit (ICU)</td>
<td>A specialized part of the hospital designed for care of the critically ill whose conditions require constant monitoring.</td>
<td>khoa chăm sóc tập trung</td>
</tr>
<tr>
<td>intubation</td>
<td>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.”</td>
<td>đặt ống</td>
</tr>
<tr>
<td>life support</td>
<td>Equipment, material or treatment used to keep a seriously ill patient alive: e.g. artificial nutrition such as a feeding tube, mechanical ventilation, dialysis.</td>
<td>hỗ trợ sự sống</td>
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<tr>
<td>living will†</td>
<td>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.</td>
<td>di chúc sống</td>
</tr>
<tr>
<td>long-term care</td>
<td>A healthcare facility that provides nursing care to patients over an extended period of time.</td>
<td>chambre dài hạn</td>
</tr>
<tr>
<td>Medical Examiner</td>
<td>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.</td>
<td>Nhân Viên Pháp Y</td>
</tr>
<tr>
<td>metastasis</td>
<td>The spread of a disease (usually cancer) from the initial site to another part of the body.</td>
<td>di căn</td>
</tr>
<tr>
<td>morgue</td>
<td>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.</td>
<td>nhà xác</td>
</tr>
<tr>
<td>next of kin</td>
<td>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.”</td>
<td>người có quan hệ thân thuộc nhất</td>
</tr>
<tr>
<td>organ donation</td>
<td>The act of giving permission for a patient's organs to be harvested after his death for transplantation into another individual</td>
<td>hiến tặng nội tạng</td>
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<tr>
<td>palliative care</td>
<td>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.</td>
<td>chăm sóc giảm đau / chăm sóc an ủi</td>
</tr>
<tr>
<td>persistent vegetative state (PVS)</td>
<td>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.</td>
<td>trạng thái thực vật lâu dài</td>
</tr>
<tr>
<td>POLST</td>
<td>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.</td>
<td>Lệnh Bác Sĩ Điều Trị Duy Trị Mạng Sống</td>
</tr>
<tr>
<td>pre-hospital DNR</td>
<td>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.</td>
<td>DNR trước khi nhập viện</td>
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</tbody>
</table>
### Interpreting in Palliative Care

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<td>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.</td>
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<td>restlessness</td>
<td>The inability to stay still, often involuntary</td>
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<td>skilled nursing facility</td>
<td>A residential facility that provides professional nursing care around the clock, usually along with rehabilitation</td>
<td>cơ sở điều dưỡng chuyên môn</td>
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<td>người ra quyết định thay thế</td>
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<td>maker</td>
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<td>ventilator</td>
<td>A machine that takes over breathing for the patient, controlling the intake and expiration of air</td>
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<td>withdrawal of support</td>
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<td>rút lại sự hỗ trợ</td>
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1. Definition from [www.eMedicinehealth.com](http://www.eMedicinehealth.com).
2. Definition from [http://www.mywhatever.com/cifwriter/content/66/4620.html](http://www.mywhatever.com/cifwriter/content/66/4620.html).
# Handout #5, KR
## Bilingual Glossary of Palliative Care Terms
### English-Korean

<p>| Term                        | English Definition                                                                                                                                                                                                 | Korean Equivalent |
|-----------------------------|--------------------------------------------------------------------------------------------------------------------------------Adam                                                                                                                                        | 사전의료지시서       |
| advance directive           | 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). | 사전의료계획       |
| advance care planning       | Decisions made by patients about their wishes regarding interventions and care if a physical condition made it impossible for them to communicate their wishes in the moment.                                                                                               | 부검                   |
| 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.                                                                                                                                                              | 사별 카운셀링       |
| 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.                                                                                                           | 논사                   |
| 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                |</p>
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<td>An individual ordained or consecrated for religious ministry, specially trained to offer support, prayer, and spiritual guidance to patients and their families.</td>
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<td>coma</td>
<td>A state of profound unconsciousness caused by disease, injury or poison.</td>
<td>혼수상태</td>
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<td>The skills needed to emotionally handle difficult situations in life</td>
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<td>coroner</td>
<td>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.</td>
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<td>CPR (cardiopulmonary resuscitation)</td>
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<td>심폐소생술</td>
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<td>do-not-resuscitate order (DNR)</td>
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<td>의료관련 법적위임장</td>
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<td>feeding tube</td>
<td>A tube placed into the stomach or small intestine to provide nutrition to a person who cannot eat or drink.</td>
<td>급식관</td>
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<td>A commercial entity that prepares the deceased for burial or cremation and assists in preparing a funeral.</td>
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<td>goals of care</td>
<td>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.</td>
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<td>health proxy</td>
<td>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.</td>
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<td>home health aide</td>
<td>A trained and certified healthcare worker who monitors a home-bound patient's condition and assists with personal hygiene and light housework.</td>
<td>가정간호인</td>
</tr>
<tr>
<td>hospice care</td>
<td>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.</td>
<td>호스피스 간호</td>
</tr>
<tr>
<td>immediate family</td>
<td>A patient's closest relatives, usually considered to be parents, siblings, spouse and children.</td>
<td>직계 가족</td>
</tr>
<tr>
<td>intensive care unit</td>
<td>A specialized part of the hospital designed for care of the critically ill whose conditions require constant monitoring.</td>
<td>중환자실</td>
</tr>
<tr>
<td>intubation</td>
<td>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.”</td>
<td>삽관</td>
</tr>
<tr>
<td>life support</td>
<td>Equipment, material or treatment used to keep a seriously ill patient alive: e.g. artificial nutrition such as a feeding tube, mechanical ventilation, dialysis.</td>
<td>생명유지 보조장치</td>
</tr>
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<td>living will</td>
<td>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.</td>
<td>사망선택 유언장</td>
</tr>
<tr>
<td>long-term care</td>
<td>A healthcare facility that provides nursing care to patients over an extended period of time.</td>
<td>장기요양원</td>
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<td>Medical Examiner</td>
<td>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.</td>
<td>법의관</td>
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<tr>
<td>metastasis</td>
<td>The spread of a disease (usually cancer) from the initial site to another part of the body.</td>
<td>전이</td>
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<tr>
<td>morgue</td>
<td>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.</td>
<td>시신안치소</td>
</tr>
<tr>
<td>next of kin</td>
<td>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 &quot;next of kin.&quot;</td>
<td>근친자 (부모, 자식, 형제, 자매, 배우자)</td>
</tr>
<tr>
<td>organ donation</td>
<td>The act of giving permission for a patient’s organs to be harvested after his death for transplantation into another individual</td>
<td>장기 기증</td>
</tr>
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<td>Term</td>
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<td>palliative care</td>
<td>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.</td>
<td>완화의료</td>
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<td>persistent vegetative state (PVS)</td>
<td>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.</td>
<td>지속적식물인간상태</td>
</tr>
<tr>
<td>POLST</td>
<td>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.</td>
<td>POLST (생명유지치료에 대한 의사 지시서)</td>
</tr>
<tr>
<td>pre-hospital DNR</td>
<td>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.</td>
<td>병원 전 DNR (심정지 시 응급요원에 의한 심폐소생술 금지서)</td>
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### Interpreting in Palliative Care

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<td>prognosis</td>
<td>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 &quot;prognosis&quot; to mean &quot;the estimated time remaining to live.&quot;</td>
<td>예후</td>
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<td>quality of life</td>
<td>An expression of the actions, experiences, or feelings that make life worth living, for an individual patient.</td>
<td>삶의 질</td>
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<td>respite care</td>
<td>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.</td>
<td>일시적 위탁 프로그램</td>
</tr>
<tr>
<td>restlessness</td>
<td>The inability to stay still, often involuntary</td>
<td>안절부절증</td>
</tr>
<tr>
<td>skilled nursing facility^ii</td>
<td>A residential facility that provides professional nursing care around the clock, usually along with rehabilitation</td>
<td>전문요양시설</td>
</tr>
<tr>
<td>support</td>
<td>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.</td>
<td>지지 (완화의료에서는 의료진의 정서적 지지나 관리적 지원을 의미한다)</td>
</tr>
<tr>
<td>surrogate decision-maker</td>
<td>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.</td>
<td>대리결정권자</td>
</tr>
<tr>
<td>ventilator^ii</td>
<td>A machine that takes over breathing for the patient, controlling the intake and expiration of air</td>
<td>인공호흡기</td>
</tr>
<tr>
<td>withdrawal of support</td>
<td>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.</td>
<td>생명유지장치 제거</td>
</tr>
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^i Definition from [www.eMedicinehealth.com](http://www.eMedicinehealth.com).  
^iii Definition from [http://www.mywhatever.com/cifwriter/content/66/4620.html](http://www.mywhatever.com/cifwriter/content/66/4620.html).  
^iv Definition from [http://www.dickinson.edu/endoflife/Glossary.html](http://www.dickinson.edu/endoflife/Glossary.html).
Interpreting in Palliative Care
# Handout #5, TG
### Bilingual Glossary of Palliative Care Terms
#### English-Tagalog

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<thead>
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<th>Term</th>
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<th>Tagalog Equivalent</th>
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<tbody>
<tr>
<td>advance directive</td>
<td>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).</td>
<td>maagang tagubilin</td>
</tr>
<tr>
<td>advance care planning</td>
<td>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.</td>
<td>maagang pagpaplano ng pangangalaga</td>
</tr>
<tr>
<td>artificial nutrition and hydration</td>
<td>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.</td>
<td>artipisyal na nutrisyon at pagbibigay ng tubig</td>
</tr>
<tr>
<td>autopsy</td>
<td>An examination of the body in order to determine the cause of death, involving dissection of the remains.</td>
<td>awtopsiya</td>
</tr>
<tr>
<td>bereavement counseling</td>
<td>Counseling to help deal with on-going sadness regarding a loved one who has died or who is dying.</td>
<td>pagpapayo para sa pagdadamhati</td>
</tr>
<tr>
<td>brain death</td>
<td>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.</td>
<td>pagkamatay ng utak</td>
</tr>
<tr>
<td>caregiver</td>
<td>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.</td>
<td>tagapag-alaga</td>
</tr>
<tr>
<td><strong>Term</strong></td>
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</tr>
<tr>
<td>chaplain</td>
<td>An individual ordained or consecrated for religious ministry, specially trained to offer support, prayer, and spiritual guidance to patients and their families.</td>
<td>pari o pastor</td>
</tr>
<tr>
<td>coma</td>
<td>A state of profound unconsciousness caused by disease, injury or poison.</td>
<td>pagkawalang-malay</td>
</tr>
<tr>
<td>code status</td>
<td>A patient’s &quot;code status&quot; tells providers whether a patient should be resuscitated or not should cardiac or respiratory arrest occur.</td>
<td>kodigo ng kalagayan</td>
</tr>
<tr>
<td>comfort care</td>
<td>treatments that focus only on promoting comfort, not prolonging life artificially</td>
<td>pangangalagang pagbibigay-ginhawa</td>
</tr>
<tr>
<td>coping skills</td>
<td>The skills needed to emotionally handle difficult situations in life</td>
<td>mga kasanayan sa pagharap sa hirap</td>
</tr>
<tr>
<td>coroner</td>
<td>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.</td>
<td>tagasiyasat ng dahilan ng pagkamatay</td>
</tr>
<tr>
<td>CPR (cardiopulmonary resuscitation)</td>
<td>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).</td>
<td>pagsisikap para maibalik ang paghina</td>
</tr>
<tr>
<td>do-not-resuscitate order (DNR)</td>
<td>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).</td>
<td>tagubilin ng doktor na huwag nang sikaping ibalik ang paghina</td>
</tr>
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<tr>
<td>durable power of attorney</td>
<td>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.”</td>
<td>dokumentong nagbibigay ng kapangyarihan sa isang kinatawan</td>
</tr>
<tr>
<td>durable power of attorney for health care</td>
<td>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.</td>
<td>dokumentong nagbibigay ng kapangyarihan sa isang kinatawan para sa pangangalagang pangkalusugan</td>
</tr>
<tr>
<td>feeding tube</td>
<td>A tube placed into the stomach or small intestine to provide nutrition to a person who cannot eat or drink.</td>
<td>tubo para sa pagpapakain</td>
</tr>
<tr>
<td>funeral home</td>
<td>A commercial entity that prepares the deceased for burial or cremation and assists in preparing a funeral.</td>
<td>punerarya</td>
</tr>
<tr>
<td>goals of care</td>
<td>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.</td>
<td>mga hangarin ng pangangalaga</td>
</tr>
<tr>
<td>health proxy</td>
<td>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.</td>
<td>kinatawan ng pasyente sa paggawa ng desisyon sa paggamot</td>
</tr>
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</tr>
<tr>
<td>health status</td>
<td>The condition of an individual's health.</td>
<td>kalagayan ng kalusugan</td>
</tr>
<tr>
<td>heart/lung machine</td>
<td>A machine that artificially takes over the function of the lungs and heart.</td>
<td>makinang nagsisilbing puso at baga</td>
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<td>home health aide</td>
<td>A trained and certified healthcare worker who monitors a home-bound patient's condition and assists with personal hygiene and light housework.</td>
<td>katulong na pangkalusugan sa bahay</td>
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<td>hospice care</td>
<td>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.</td>
<td>pangangalaga sa hospisyo</td>
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<td>immediate family</td>
<td>A patient's closest relatives, usually considered to be parents, siblings, spouse and children.</td>
<td>malapit na kapamilya</td>
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<td>intensive care unit (ICU)</td>
<td>A specialized part of the hospital designed for care of the critically ill whose conditions require constant monitoring.</td>
<td>yunit ng masusing pangangalaga</td>
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<td>intubation</td>
<td>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.”</td>
<td>paghinga sa pamamagitan ng tubo</td>
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<td>life support</td>
<td>Equipment, material or treatment used to keep a seriously ill patient alive: e.g. artificial nutrition such as a feeding tube, mechanical ventilation, dialysis.</td>
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### Interpreting in Palliative Care

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<td>habilin sa nais na pangangalaga</td>
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<td>long-term care</td>
<td>A healthcare facility that provides nursing care to patients over an extended period of time.</td>
<td>pangmatagalang pangangalaga</td>
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<td>Medical Examiner</td>
<td>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.</td>
<td>Tagasiyasat ng Di-likas na Pagkamatay</td>
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<td>metastasis</td>
<td>The spread of a disease (usually cancer) from the initial site to another part of the body.</td>
<td>pagkalat ng sakit sa katawan</td>
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<td>morgue</td>
<td>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.</td>
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<td>next of kin</td>
<td>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.”</td>
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<td>pampaginhawang pangangalaga</td>
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<td>persistent vegetative state (PVS)⁴</td>
<td>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.</td>
<td>patuloy na kawalan ng malay</td>
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<td>POLST</td>
<td>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.</td>
<td>Mga Utos ng Doktor para sa Paggamot na Nagpapatuloy ng Buhay</td>
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<td>pre-hospital DNR</td>
<td>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.</td>
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<td>tinatayang kalalabasan ng sakit</td>
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<td>An expression of the actions, experiences, or feelings that make life worth living, for an individual patient.</td>
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<td>respite care</td>
<td>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.</td>
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<td>The inability to stay still, often involuntary</td>
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<td>A residential facility that provides professional nursing care around the clock, usually along with rehabilitation</td>
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<td>support</td>
<td>Actions and attitudes that help an individual or group. In palliative care, when providers talk about patient &quot;support,&quot; they do not mean financial help but usually emotional and logistical help.</td>
<td>suporta</td>
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<td>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.</td>
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<td>ventilator</td>
<td>A machine that takes over breathing for the patient, controlling the intake and expiration of air</td>
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<td>withdrawal of support</td>
<td>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.</td>
<td>pagtanggal ng suporta sa buhay</td>
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Interpreting in Palliative Care
## Handout #5, RS
### Bilingual Glossary of Palliative Care Terms
#### English-Russian

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<td>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.</td>
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<td>Искусственное питание и поддержание водного баланса</td>
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<td>autopsy</td>
<td>An examination of the body in order to determine the cause of death, involving dissection of the remains.</td>
<td>вскрытие</td>
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<td>bereavement counseling</td>
<td>Counseling to help deal with on-going sadness regarding a loved one who has died or who is dying.</td>
<td>психологическая помощь в связи с переживанием утраты близкого человека</td>
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<td>A patient’s “code status” tells providers whether a patient should be resuscitated or not should cardiac or respiratory arrest occur.</td>
<td>Статус кода (указания для проведения реанимационных мероприятий)</td>
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<td>treatments that focus only on promoting comfort, not prolonging life artificially</td>
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<td>The skills needed to emotionally handle difficult situations in life</td>
<td>Навыки переживания трудных ситуаций</td>
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<td>coroner</td>
<td>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.</td>
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<td>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).</td>
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<td>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).</td>
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<td>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.”</td>
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<td>Долгосрочная доверенность на осуществление медицинского обслуживания</td>
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<td>feeding tube</td>
<td>A tube placed into the stomach or small intestine to provide nutrition to a person who cannot eat or drink.</td>
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<td>Похоронное бюро</td>
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<td>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.</td>
<td>Цели лечения</td>
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<td>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.</td>
<td>Медицинская доверенность / лицо, уполномоченное принимать решения о медицинском обслуживании</td>
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<td>health status</td>
<td>The condition of an individual's health.</td>
<td>Медицинский статус</td>
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<td>heart/lung machine</td>
<td>A machine that artificially takes over the function of the lungs and heart.</td>
<td>Аппарат искусственного кровообращения (АИК)</td>
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<td>home health aide</td>
<td>A trained and certified healthcare worker who monitors a home-bound patient's condition and assists with personal hygiene and light housework.</td>
<td>Медико-санитарная помощь на дому</td>
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<td>hospice care</td>
<td>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.</td>
<td>лечение в хосписе</td>
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<td>A patient's closest relatives, usually considered to be parents, siblings, spouse and children.</td>
<td>Ближайшие родственники</td>
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<td>intensive care unit</td>
<td>A specialized part of the hospital designed for care of the critically ill whose conditions require constant monitoring.</td>
<td>Отделение интенсивной терапии</td>
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<td>(ICU)</td>
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<td>intubation</td>
<td>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.”</td>
<td>интубация</td>
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<td>life support</td>
<td>Equipment, material or treatment used to keep a seriously ill patient alive: e.g. artificial nutrition such as a feeding tube, mechanical ventilation, dialysis.</td>
<td>Поддержание жизненных функций</td>
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<td>living will</td>
<td>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.</td>
<td>«завещание о жизни»</td>
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<td>long-term care</td>
<td>A healthcare facility that provides nursing care to patients over an extended period of time.</td>
<td>Долговременное лечение</td>
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<td>Medical Examiner</td>
<td>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.</td>
<td>судебно-медицинскский эксперт</td>
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<td>metastasis</td>
<td>The spread of a disease (usually cancer) from the initial site to another part of the body.</td>
<td>метастаз</td>
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<td>morgue</td>
<td>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.</td>
<td>морг</td>
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<td>next of kin</td>
<td>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.”</td>
<td>Ближайшие родственники</td>
</tr>
<tr>
<td>organ donation</td>
<td>The act of giving permission for a patient’s organs to be harvested after his death for transplantation into another individual</td>
<td>Донорство органа</td>
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<td>palliative care</td>
<td>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.</td>
<td>Паллиативная терапия</td>
</tr>
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<td>persistent vegetative state (PVS)</td>
<td>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.</td>
<td>Персистирующее вегетативное состояние</td>
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<td>POLST</td>
<td>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.</td>
<td>Распоряжение для врача об искусственном поддержании жизни</td>
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### Interpreting in Palliative Care

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<td>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.</td>
<td>распоряжение DNR до госпитализации</td>
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<td>prognosis</td>
<td>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 &quot;prognosis&quot; to mean “the estimated time remaining to live.”</td>
<td>прогноз</td>
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<tr>
<td>quality of life</td>
<td>An expression of the actions, experiences, or feelings that make life worth living, for an individual patient.</td>
<td>Качество жизни</td>
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<td>respite care</td>
<td>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.</td>
<td>Временный медицинский уход (за больными и инвалидами в период отдыха лиц, обычно осуществляющих за ними уход)</td>
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<td>restlessness</td>
<td>The inability to stay still, often involuntary</td>
<td>возбуждение, беспокойство</td>
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<td>skilled nursing facility*</td>
<td>A residential facility that provides professional nursing care around the clock, usually along with rehabilitation</td>
<td>Учреждение квалифицированного медицинского ухода</td>
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<td>support</td>
<td>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.</td>
<td>поддержка</td>
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<td>surrogate decision-maker</td>
<td>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.</td>
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<td>ventilator</td>
<td>A machine that takes over breathing for the patient, controlling the intake and expiration of air</td>
<td>Аппарат искусственной вентиляции лёгких</td>
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<td>withdrawal of support</td>
<td>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.</td>
<td>Отключение от средств жизнеобеспечения</td>
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i  Definition from [www.eMedicinehealth.com](http://www.eMedicinehealth.com).
ii Definition from [http://www.mywhatever.com/citwriter/content/66/4620.html](http://www.mywhatever.com/citwriter/content/66/4620.html).
iv Definition from [http://www.dickinson.edu/endoflife/Glossary.html](http://www.dickinson.edu/endoflife/Glossary.html).
**Handout #5, EN**  
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<tr>
<td>living will</td>
<td>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.</td>
<td></td>
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<tr>
<td>long-term care</td>
<td>A healthcare facility that provides nursing care to patients over an extended period of time.</td>
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<tr>
<td>Medical Examiner</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>metastasis</td>
<td>The spread of a disease (usually cancer) from the initial site to another part of the body.</td>
<td></td>
</tr>
<tr>
<td>morgue</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>next of kin</td>
<td>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.”</td>
<td></td>
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<tr>
<td>organ donation</td>
<td>The act of giving permission for a patient’s organs to be harvested after his death for transplantation into another individual</td>
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</tr>
<tr>
<td>Term</td>
<td>English Definition</td>
<td>Equivalent</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>persistent vegetative state (PVS)(^w)</td>
<td>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.</td>
<td></td>
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<tr>
<td>POLST</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>pre-hospital DNR</td>
<td>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.</td>
<td></td>
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<tr>
<td>prognosis</td>
<td>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.”</td>
<td></td>
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<tr>
<td>quality of life</td>
<td>An expression of the actions, experiences, or feelings that make life worth living, for an individual patient.</td>
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<tr>
<td>respite care</td>
<td>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.</td>
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</tr>
<tr>
<td><strong>Term</strong></td>
<td><strong>English Definition</strong></td>
<td><strong>Equivalent</strong></td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
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<tr>
<td>restlessness</td>
<td>The inability to stay still, often involuntary</td>
<td></td>
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<tr>
<td>skilled nursing facility\textsuperscript{ii}</td>
<td>A residential facility that provides professional nursing care around the clock, usually along with rehabilitation</td>
<td></td>
</tr>
<tr>
<td>support</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>surrogate decision-maker</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>ventilator\textsuperscript{ii}</td>
<td>A machine that takes over breathing for the patient, controlling the intake and expiration of air</td>
<td></td>
</tr>
<tr>
<td>withdrawal of support</td>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{i} Definition from [www.eMedicinehealth.com](http://www.eMedicinehealth.com).

\textsuperscript{ii} Definition from [http://www.mywhatever.com/cifwriter/content/66/4620.html](http://www.mywhatever.com/cifwriter/content/66/4620.html).

\textsuperscript{iii} Definition from [http://www.pbs.org/secondopinion/episodes/endoflife/medicalglossary/story436.html](http://www.pbs.org/secondopinion/episodes/endoflife/medicalglossary/story436.html).

\textsuperscript{iv} Definition from [http://www.dickinson.edu/endoflife/Glossary.html](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:  

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

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

   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.
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 . . .
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.


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
Interpreting in Palliative Care

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 –

160
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.
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.

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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。
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。...

(DIALOGUE ENDS. 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
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 think it would be wise 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.

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。
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。
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, hospice care is a specialty 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，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: \textit{(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 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.

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  鍾。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。
**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.
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: Miền là không hóa trị nữa! Vây, 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. Vây, 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 som 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: Chì vì gia đình vàn cần có tôi. Và phí bệnh viện này quá đắt. Tôi uróc chi có thể về nhà, nhưng ai sẽ chăm sóc tôi đây? Và rồi lại đau
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?

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 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.


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 cảm 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 thoát 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 đề 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 đây 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 nói! Bác sĩ để mẹ chết mà em thấy được à? Anh thì anh sẽ không bỏ rơi mẹ đâu!


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 thể thực tế 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 cảm ơn bác sĩ. Chúa phù hộ cho [ông/bà].
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: 아니에요, 저에게 말해 주세요.

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

Patient: 뼈가 이상이 있다는 걸 알고 있었어요. 어짐지 그런 느낌이 들었어요.
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 화학요법을 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: 편찮네요! 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 일리...

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

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… 어ềm 이계 최선일지도… 모르겠어요…

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

Dr. Halferty: I could do that.

Patient: (wistfully) 저에게 다섯 명의 자식이 있는 거 아세요? 철수, 민국, 영희, 호기 그리고 미희. 민국과 영희는 텍사스에 살고 철수는 아직 한국에 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 할지 알겨요.
Dialogue #3: Family meeting

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

호기: 아니예요, 우리를 만나주시서 오히려 저희가 감사해야요.

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, 짜증은거네요. 그러면 어떻게 해야 하신다면 문제 없잖아요.

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

호기: 이해하지 못하겠습니다. 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 빼게 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 선생님이도 도와주려고 애쓰시고 있잖아. 그리고 만약 어머니가 동의하신다면 - 

호기  정말 믿을 수가 없어요! 너는 어머니를 그냥 돌아가시게 해도 팬함단 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 알았잖아. 그러나 의사 선생님이 할 수 있는 게 더 이상 없다고 말씀하시잖아... 철수오빠, 민국오빠 그리고 영희언니를 테려와야 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 우리 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 미회말이 옹아요. 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.
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.
Interpreting in Palliative Care


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.

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 it's 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 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.

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 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.
Interpreting in Palliative Care

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 makapaniwa! Payag kayong hayaan siyang mamatay? Pero, hindi ako pumapayag, hindi ko siya iiwan!

Ligaya  

Ronilo  
(disgusted noise) Ha, si Roberto.

Dialoge #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 \textit{(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!


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.
**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 is 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.
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 . . .

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 знаете 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 можете 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 не можете 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 России. 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.
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 is not good. The test showed that the cancer has metastasized to your liver.

Patient: I knew something wasn’t right. I just felt it.
Interpreting in Palliative Care

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 ISN’T 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.
Interpreting in Palliative Care

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 una 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.
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呢？

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。
Interpreting in Palliative Care

(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。
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: Bọn u? Tôi qua mẹ đau rất nặng, mẹ biết không! Hãy nói cho bác sĩ biết việc đó!


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.


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: Cảm ơn. Tôi thực sự muốn về nhà lại. Ươi 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)  T'ai sao moi nguoi luc n'ao cung hoi toi nhu the? T'oi cam thay rat tet. T'oi uoc ch'i tat ca cac nguoi di het di.

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

Patient  Ong quan tam chuyen gi?

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) Co phai b'à muon noi ngoai tai n'an do? Ngoai viéc duoc cho biêt là se mat nhieu nam de co the tư dung lai duoc?
Interpreting in Palliative Care

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... 어째면 한 4정도요...

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

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

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

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

Patient: 의사들은 내가 급작한 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 이리라는 거 정말 싫어.

Patient: 그렇다면, 통증은 10이었어. 너무 아팠어. 정말 의사들이 통증에 대해 못가 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 미네 집에요. 다만, 말에게 큰 점이 되지 않기만 바랄 뿐이에요.

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

Daughter (to patient) 빌 말씀을 다 하세요, 엄마! 편찮을 거에요. (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)
Interpreting in Palliative Care
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!


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.


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.

(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
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 просто надеюсь, что это не будет для нее слишком большой обузой.
Interpreting in Palliative Care

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

Daughter (to patient) Мам, не смешите 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,
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.
Interpreting in Palliative Care
Handout #10
Practice Sight Translation Feedback form

Interpreter: ____________________________
Language pair: ____________________________
Evaluator: ____________________________
Date: ____________________________

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspects of the sight translation that the interpreter did well</td>
<td></td>
</tr>
<tr>
<td>Omissions</td>
<td></td>
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<tr>
<td>Additions</td>
<td></td>
</tr>
<tr>
<td>Meaning changes</td>
<td></td>
</tr>
<tr>
<td>Linguistic proficiency (e.g. false cognates, inserted English, work-arounds, etc)</td>
<td></td>
</tr>
<tr>
<td>Delivery (e.g. stammering, pausing, backtracking, insecure facial expressions)</td>
<td></td>
</tr>
</tbody>
</table>

| | 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.
Interpreting in Palliative Care
Interpreting in Palliative Care

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

<table>
<thead>
<tr>
<th>Patient Information</th>
</tr>
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<tbody>
<tr>
<td>Name (last, first, middle):</td>
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<tr>
<td>Gender:</td>
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</tbody>
</table>

<table>
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<tr>
<th>Health Care Provider Assisting with Form Preparation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
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<td>Phone Number:</td>
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<tr>
<th>Additional Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Phone Number:</td>
</tr>
</tbody>
</table>

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

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Interpreting in Palliative Care

<table>
<thead>
<tr>
<th>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自己的醫療照護提供者。</th>
</tr>
</thead>
</table>

**維持生命治療醫囑**

**Physician Orders for Life-Sustaining Treatment (POLST)**

<table>
<thead>
<tr>
<th>醫師的姓名</th>
<th>表格填寫日期</th>
</tr>
</thead>
<tbody>
<tr>
<td>病人的姓名</td>
<td>病人的出生日期</td>
</tr>
<tr>
<td>病人的中文名字</td>
<td>病歷號碼 (自由塡寫)</td>
</tr>
</tbody>
</table>

A 選項

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時，遵循 B 和 C 部分的醫囑。

- 試圖啟動人工心肺復甦術 (需要選 B 部分的“全療程護”, Full Treatment)
- 不希望做人工心肺復甦術（“允許自然死亡” Allow Natural Death)

B 選項

醫療處理 MEDICAL INTERVENTIONS: 當事人有脈搏而且/或有呼吸

- 只要舒適護理: 任何方式的給藥、翻身、傷口照護和其他措施，以減除痛苦和受苦。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。另有治療處所無法得到時，才轉送醫院。
- 只有在目前處所無法得到時，才轉送護理。
- 除了包括“只要舒適護理”和“有限的附加醫療處理”的治療外，使用氣管內插管、呼吸道處理、人工呼吸機幫忙及心肺電擊器。如有護理，轉送醫院，包括重症護理。

其他醫囑:

C 選項

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。

資料和簽名 INFORMATION AND SIGNATURES:

已和下列人員討論:

- 病人/病人有能力和
- 病人/病人有能力和

醫療照護事先指示 日期______有且且總數過 ➔ 在醫療照護事先指示內的醫療決定代言人:

- 有醫療照護事先指示，但不在現場
  - 代護代理人姓名：
  - 代護代理人電話：

醫生的簽名

本人在下面的簽名表示我所知，這些醫囑與當事者的醫療狀況和意見是一致的。

醫生姓名(必須塡寫)

- 醫生姓名(必須)
  - 醫生電話號碼
  - 醫生執照號碼

病人或法律認定的醫療決定代言人簽名

在這份表格內的名下，法律上認定的醫療決定代理人認定這份有關複甦措施的要求，是當事人的意見一致的，同時也符合當事人的最大利益。

姓名(必須塡寫)

- 病人姓名(必須)
  - 關係 (如為病人自己，請寫“本人”)

簽名(必須)

- 病人姓名(必須)
  - 關係 (如為病人自己，請寫“本人”)

地址

- 醫師轉院或出院時，此份表格必須隨同病人一起。
# Interpreting in Palliative Care

한국어 버전은 교육 목적으로만 사용됩니다 (Korean version is for educational purposes only).
HIPAA는 필요한 경우 POLST를 다른 의료폐지자에게 공개하는 것을 허용합니다.

## 생명 유지 치료에 대한 의사 지시서
(Physician Orders for Life-Sustaining Treatment, POLST)

<table>
<thead>
<tr>
<th>환자 성명</th>
<th>암시 적절 납득</th>
</tr>
</thead>
<tbody>
<tr>
<td>환자 이름</td>
<td>환자 생년월일</td>
</tr>
<tr>
<td>환자 중간이름</td>
<td>의료기록 #1 선택 항목</td>
</tr>
</tbody>
</table>

### 실패 소생응(CPR):
- 환자가 맥박이 뚝지 않고 숨을 쉬지 않는 경우
- 실패정치가 아닌 경우에는 선택 B와 C의 지시를 따르십시오.

### 의학적 개입:
- 환자가 맥박이 뚝지고 숨을 쉬는 경우

- 통증 완화 및 시도
  - 모든 경로, 자세, 상처 치료 및 다른 조치를 통해서 의료를 투여하며 통증과 고증을 완화하십시오. 통증
  - 완화를 위해 필요한 경우에는 신중, 힐링 및 기본적 해독수지치료법을 사용하십시오. 현재 위치에서 고증을 완화시킬 수 없는
  - 경우에만 병원을 이용하십시오.

- 서면적 추가 개입
  - 통증 완화 및 시도
    - 환자에게 설명한 의료에 추가하여, 필요에 따라 의학적 치료, 약물제 및 항병 수술을 사용하십시오. 
    - 환자에게 희망, 비행 및 기여를 위해 약물을 사용할 수 있습니다. 일반적으로 집중 치료를 피하십시오.

- 현재 위치에서 고증을 완화할 수 없는 경우에만 병원을 이용하십시오.

- 전환적 치료
  - 통증 완화 및 시도
    - 환자에게 설명한 의료에 추가하여, 필요에 따라 집중, 전문 치료에, 
    - 기계 환기, 치료 및 상호작용을 사용하십시오. 필요한 경우에는 병원으로 이송하십시오.

### 인공 영양 공급:
- 추가 지시:

| 인공 영양 공급 방법(급식관 포함) 사용 금지 |
| 인공 영양 시도 기간 동안 영양 공급(급식관 포함) |

### 정보 및 서명:
- 삼토(환자가 정신 능력이 있는 경우) 
- 법적으로 인정된 의사결정 대가

| 사전지시서 제정 |
| 사전지시서 제정 |
| 사전지시서 제정 |

### 의사 서명:

<table>
<thead>
<tr>
<th>의사 정보:</th>
<th>의사 전화번호:</th>
<th>의사 연락번호:</th>
</tr>
</thead>
</table>

### 환자 또는 법적으로 인정된 의사결정 자 서명

<table>
<thead>
<tr>
<th>의사 정보:</th>
<th>진료 중 &quot;본인&quot;이라고 하기</th>
<th>환자 이름</th>
</tr>
</thead>
<tbody>
<tr>
<td>진료 중 &quot;본인&quot;이라고 하기</td>
<td>환자 이름</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>주소:</th>
<th>진료 중 &quot;본인&quot;이라고 하기</th>
</tr>
</thead>
<tbody>
<tr>
<td>진료 중 &quot;본인&quot;이라고 하기</td>
<td></td>
</tr>
</tbody>
</table>

환자를 이송하거나 퇴원시킬 때마다 이 양식을 함께 보내십시오.
### Interpreting in Palliative Care

#### Распоряжения врача об искусственном поддержании жизни (Physician Orders for Life-Sustaining Treatment, POLST)

<table>
<thead>
<tr>
<th>Фамилия пациента:</th>
<th>Дата подготовки формы:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Имя пациента:</td>
<td>Дата рождения пациента:</td>
</tr>
<tr>
<td>Второе имя пациента:</td>
<td>Номер истории болезни: (по выбору)</td>
</tr>
</tbody>
</table>

#### Сердечно-легочная реанимация (CPR):

- [ ] Пытаться реанимировать/CPR (выбор CPR в разделе A требует выбора «полного лечения» в разделе B)!
- [ ] Не реанимировать/DNR (позволить умереть естественной смертью)

#### Медицинское вмешательство:

- [ ] Только симптоматическая терапия.
- [ ] Ограниченные дополнительные вмешательства.
- [ ] Полное лечение.

#### Искусственное питание:

- [ ] Не проводить искусственное питание, включая пищу через зонд.
- [ ] Искусственное питание, включая пищу через зонд, в течение определенного периода.
- [ ] Дополнительные распоряжения:

#### Информация и подпись:

- [ ] Обсуждено с: [ ] Пациентом (пациент, способен) [ ] Лицем, имеющим право принимать решения о лечении от имени пациента
- [ ] Предварительное распоряжение от ________ есть в наличии.
- [ ] Предварительное распоряжение не в наличии.
- [ ] Предварительное распоряжение не составлено.

#### Подпись врача

| Имя и фамилия врача печатными буквами: | Телефон врача: | Номер лицензии врача: |

#### Подпись пациента или лица, имеющего право принимать решения о лечении от имени пациента

| Имя и фамилия печатными буквами: | Степень родства: (если сам пациент, напишите «сам») |

#### Подпись (обязательно)

| Адрес: | Телефон в дневное время: | Телефон в вчерашнее время: | Дата: |
Interpreting in Palliative Care

Órdenes del médico de tratamiento para el mantenimiento de la vida (Physician Orders for Life-Sustaining Treatment, POLST)

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.

A) Resucitación cardiopulmonar (RCP):
- Si la persona no tiene pulso y no está respirando, realizar resucitación cardiopulmonar (RCP), seguir las órdenes en las secciones B y C.
- Intentar resucitación/RCP (Si selección RCP en la sección A seleccione Tratamiento completo en la sección B)
- No intentar resucitación/DNR (permitir la muerte natural)

B) Intervenciones médicas:
- 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, sustracción y tratamiento manual de la obstrucción de las vías respiratorias según sea necesario para el confort del paciente. Trasladar al hospital sólo si las necesidades paliativas no se pueden cumplir en la ubicación actual.
- Trasladar al hospital sólo 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.

C) Nutrición administrada artificialmente:
- Si 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.

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:
- Fecha:

Firma del paciente o encargado de tomar decisiones reconocido legalmente
- Nombre en letra de molde:
- Relación: asistir al mismo si es el paciente
- 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.
Interpreting in Palliative Care

Mga Utos ng Doktor para sa Paggamot na Nagpapatuloy ng Buhay (Physician Orders for Life-Sustaining Treatment, POLST)

- Apelrido ng Popeyente:
  - Petsa inhinda ang Porma:
- Unang Panganan ng Popeyente:
  - Petsa ng Kapanganakan ng Popeyente:
- Gitnang Panganan ng Popeyente:
  - Numero ng Rekord na Medical (di-sapilitan):

Kung ang tao ay walang pulso at hindi humihinga,
Kapag HIPNDI dumaranas ng paghahang ng pagganan
ng pulso at baha, sundin ang mga utos sa mga Seksyon B at C.

Mga Pagbabalik na Malay-Tao na Kaugnay Ng Puso at Baha
(CardioPulmonary Resuscitation, CPR):

- Subukan ang Pagbabalik ng Malay-Tao/CPR (Arg papili ng CPR sa Seksyon A av magpapalayan ng papili ng Malay-Tao)
- Huwag Tangkain ang Pagbabalik ng Malay-Tao (Hayaan ang Natural na Pagkamatay)

Mga Pampamagatang Medikal:

Mga Hakbang sa Pampagpinhawa Lamang

- Mag-ako ng pagkain sa pamamagitan ng paggamit ng gamot sa ang asam ng nita, poesiyon, pangangalaga ng sagot at ibang mga hakbang. Gumamit ng oksygen, paghihiyan at manwal sa paggamit ng baro sa paghihiyan gawa ng kalagayan para gumihawha. Ilipat lamang ng ospital kung ang mga pangangalagahan ng ginawa ay hindi matutukoy sa kasalukuyang lokasyon.

- Mga Limitadong Karagdagang Pampamagat

  - Ilipat lamang ng ospital kung ang mga pangangalagahan ng ginawa ay hindi matutukoy sa kasalukuyang lokasyon.

- Buong Paggamot
  - Bilang karagdagang sa pangangalagahan ilalarawan sa Mga Hakbang sa Pampagpinhawa Lamang at Mga Limitadong Karagdagang Pamanagat. Gumamit ng mga pasokae ng tubo, mga matalasa sa pamamagitan sa daan ng gawa ng gawa. Maaaring gumamit ng bentilasyon, at definbrillation/cardioversion gawa ng nasa tabi ng hakbang.

Mga Karagdagang Uutos:

Artipsyal na Isinimbag na Nutrisyon:

- Walang artipsyal na paraan ng nutrisyon, kabiliang ang mga tubo sa pagpapakain.
- Pagsubok sa panahon ng artipsyal na nutrisyon, kabiliang ang mga tubo sa pagpapakain.
- Pangmatagalan artipsyal na nutrisyon, kabiliang ang mga tubo sa pagpapakain.

Importasyon at Mga Pirma:

- Tinalakay sa:
  - Pasyente (May Kakayahan ang Pasyente)
  - Legal na Kinikilalang Tagagawa ng Desisyon
  - Maagang Tagubilin na may peheng matukawa at niirepaso
  - Maagang Tagubilin hindi matukawa
  - Walang Maagang Tagubilin

Pirma ng Doktor

- Ang pirma sa ibata ay nagpapabatid sa abot ng aking kaalaman na ang mga utos na ito ay umaayon sa mga kondisyon medical at mga nais na tao.

Pirma ng Pasyenteng Legal na Kinikilalang Tagagawa ng Desisyon

- Sa paggamit sa pagmamakina, tinatanggap ng legal na kinikilalang tagagawa ng desisyon sa ang kahilingan at ang kahilingan ito tungkol sa mga hakbang na pagbabalik ng malay-tao ay umaayon sa mga alam na hinahangad ng, at makakabili sa, toing tinukoy sa pormang ito.

Pirma (kinikilalang)

Pirma ng Doktor (Kinikilate)

Pirma ng Gobyerno (Gabi)

Numero ng Telepono sa Araw:

Numero ng Telepono sa Unlad:

IPADALA ANG FORMA SA TAO TUWING INILILIPAT O INILALABAS

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Interpreting in Palliative Care

Lệnh Bác Sĩ Điều Trị Duy Trì Mạng Sống
(Physician Orders for Life-Sustaining Treatment, POLST)

Trước hết hãy tuân hành các lệnh này, sau đó liên lạc với bác sĩ. Đây là Lệnh Bác Sĩ đưa ra để định hình y khoa hiện tại và về phần còn lại của bệnh nhân. Bệnh có dấu hiệu không ổn định thì hàm y là điều trị toàn bộ cho điều trị. Bệnh nhân của mẫu POLST có chỉ ký là hợp pháp và hợp lệ. POLST bổ túc Chỉ Thi Trược và không có mục đích thay thế văn kiện đó. Mỗi người phải được đối xử trong nhân phẩm và tôn trọng.

A. Hội Sinh Tim Phổi (CPR):

Khi KHÔNG bi ngưng hô hấp dừng tim phổi, hãy áp dụng các lệnh trong Đoạn B và C.

- Có Hỏi Sinh CPR (Chọn CPR trong Đoạn A thì phải chọn Điều Trị Toàn Bộ trong Đoạn B)
- Đừng Có Hỏi Sinh/DNR (Allow Natural Death) (Để Chfelt Tự Thiền)

B. CAN THIỂP Y KHOA:

- Chỉ Áp Dụng Các Biện Pháp Giúp Thảo Mãi: Giảm đau và khó thở bằng cách dùng thuốc theo lô cốc, cũn thịt, châm sóc về tinh thần và các biện pháp khác. Dùng đường khi, hơi và thông vào cần khi quản hạy nguyện của cần được thỏa mãn.
- Chỉ Thuận chuyển tới bệnh viện nếu không thể đáp ứng được các nhu cầu của người mà đã đính hiện nay.
- Chỉ Thuận chuyển tới bệnh viện nếu không thể đáp ứng được các nhu cầu của người mà đã đính hiện nay.
- Điều Trị Toàn Bộ Không di chuyển chăm sóc nếu trong đoạn Chỉ Áp Dụng Các Biện Pháp Giúp Thảo Mãi và Can Thiệp Bổ Túc Giúp Hành, hãy sử dụng ò ng luon, các biện pháp can thiệp khi quan tâm tác, để thống càng xử lý theo chỉ thị. Thuận chuyển tới bệnh viện nếu cần. Gồm cả chăm sóc cấp tình.

C. TIẾP DỊNH DƯỠNG NHÂN TÁC:

- Không có phương tiện tiếp dinh dưỡng nhân tạo, kể cả ánh truyền thức ăn.
- Giai đoạn thứ tiếp dinh dưỡng nhân tạo, kể cả ánh truyền thức ăn.
- Tiếp dinh dưỡng nhân tạo đã hạn, kể cả ánh truyền thức ăn.

D. CHÍ TẾT VÀ CHÍ KÝ:

- Đã thảo luận với: Bệnh Nhân (Bệnh Nhân Minh Mẫn)  hoặc Người Quyết Định Dưới Công Nhân Hợp Pháp
  - Chỉ Thi Trược làm ngại __________ có và đe xem -> Đại Dien Châm So Sóc Khỏe nếu có tên trong Chỉ Thi Trược:
  - Chỉ Thi Trược không có __________ "dây" -> Diệu Thiọ:
  - Không có Chỉ Thi Trược

Chú Ký Bác Sĩ
Chú ký của tôi dự đoán cho biết là theo hết khả năng niệu biệt của tôi thì các lệnh này phù hợp với tình trạng y khoa và ý nguyện của bệnh nhân.

Việt Tên Bác Sĩ Bằng ማ": Số Điển Thiọ của Bác Sĩ: Số Giữ Pháp Hành Nghe của Bác Sĩ:

Chú Ký Bác Sĩ (phải có)  Ngày:

Chú Ký Bệnh Nhân hoặc của Người Quyết Định Dưới Công Nhân Hợp Pháp
Khi ký vào mẫu này, người quyết định được công nhận hợp pháp nhân 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 cho người ta được trong mẫu này.

Việt Tên Chữ:

Chú Ký: (phải có)  Ngày:

Địa Chỉ: Số Điển Thiọ Bằng Ngày: Số Điển Thiọ Buổi Tối:

GỬI MÃU THEO VỚI NGƯỜI NÀY BẤT CỨ KHI NÃO THUYẾN CHUYÊN HOẠC XUẤT VIỆN

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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 cardioactive 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 (2223 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

An Advance Request to Limit the Scope of Emergency Medical Care

1. ________________ 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

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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 aceptara 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.

252
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。

<table>
<thead>
<tr>
<th>患者/代理人签名</th>
<th>日期</th>
</tr>
</thead>
<tbody>
<tr>
<td>代理人姓名 (正楷)</td>
<td>与患者关系</td>
</tr>
<tr>
<td>代理人电话号码</td>
<td></td>
</tr>
</tbody>
</table>

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。

<table>
<thead>
<tr>
<th>医师签名</th>
<th>日期</th>
</tr>
</thead>
<tbody>
<tr>
<td>姓名 (正楷)</td>
<td>加州许可证号</td>
</tr>
<tr>
<td>电话</td>
<td></td>
</tr>
</tbody>
</table>

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。

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

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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

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

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。

如有獲取 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)

응급 의료 사전 제한 사전 요청

이 양식은 어떤 식으로든 수정 또는 변경된 경우에는 수락되지 않을 것입니다.

병원 전 DNR 요청서

본인 ____________________________
(환자명 및 의료 기록 번호를 명확하게 기입함으로서)

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 처리하는 의료를 받는 것이 금지되지 않을 것임을 알고 있습니다.

본인은 이 양식을 과거하고 "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.

이 양식은 "심폐소생술 금지"(DNR) 명령에 동의합니다.

<table>
<thead>
<tr>
<th>환자/대리인 서명</th>
<th>일자</th>
</tr>
</thead>
<tbody>
<tr>
<td>대리인 성명 정자체</td>
<td>환자와의 관계</td>
</tr>
</tbody>
</table>

이 양식에 서명함으로써, 대리인은 본 심폐소생술 금지 요청이 본 양식의 주체인 사람의 알리진 희망 및 최선의 이익에 부합함을 인정합니다.

<table>
<thead>
<tr>
<th>의사 서명</th>
<th>일자</th>
</tr>
</thead>
<tbody>
<tr>
<td>정자체 성명</td>
<td>갤리포니아주 면허 번호</td>
</tr>
</tbody>
</table>

이 양식은 어떤 식으로든 수정 또는 변경된 경우에는 수락되지 않을 것입니다.

원본은 환자 보관
환자와 의사가 의료 기록에 보관하도록 사본을 제출하십시오.

인가된 DNR 표시를 원하는 경우에는 이 양식 1부를 Medic Alert 등록 양식과 함께 Medic Alert Foundation에 제출하십시오. 2323 Colorado Avenue, Turlock, CA 9538의 Medic Alert 등록 양식을 읽으려면 1-800-432-5378에 전화하십시오.

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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 (Việt in tên bệnh nhân và số hồ sơ y tế) mô tả trong giấy này.

Tôi hiểu rằng DNR có nghĩa là nếu tôi ngừng đáp hoặc ngừng thở, không một thủ thuật y tế nào sẽ được thực hiện để giúp tôi thở lại hay giúp tôi đáp 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 đổi 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.

Bảng giấy này tối đông với lệnh "Không Hồi Sinh" (DNR).

<table>
<thead>
<tr>
<th>Chữ Ký của Bệnh Nhân/Nguời Đại Diện</th>
<th>Ngày</th>
</tr>
</thead>
<tbody>
<tr>
<td>Viết chữ in tên của Người Đại Diện</td>
<td>Quan Hệ với Bệnh Nhân</td>
</tr>
</tbody>
</table>

Khi ký tên vào giấy này, người đại diện xác nhận rằng yêu cầu qua các biện pháp hồi sinh này phù hợp với nguyên vọng đã bày tỏ của và vi lê ich cao nhất của đổi tương của giấy này.

Tôi xác nhận rằng bệnh nhân/người đại diện này đáng được ra một quyết định có căn nhắc và quyết định này là nguyên vọng đã bày tỏ của bệnh nhân/người đại diện đó. Một bản sao của giấy này được đưa vào hồ sơ y tế để đại diện của bệnh nhân.

Trong trường hợp ngừng tim hoặc ngừng thở, không cần tiến hành ép ngực, thông đường thở, đặt ống, kurs tỉnh, hoặc dùng các loại thuốc trợ tim.

<table>
<thead>
<tr>
<th>Chữ Ký của Bác Sĩ</th>
<th>Ngày</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tên Viết Chữ In</td>
<td>Số Giấy Phép của California</td>
</tr>
</tbody>
</table>

GIÁY NÀY SẼ KHÔNG DUỘC CHẤP NHẬN NẾU ĐÃ BỊ SUẤT ĐỞI HAY THAY ĐỔI DUỘI BẤT KỲ HÌNH THỨC NÀO

Bản gốc do bệnh nhân giữ
Gửi một bản sao để lưu vào hồ sơ y tế đại diện 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
Interpreting in Palliative Care

MGA EMERHENSiyang Serbisyon 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 humihindi ng limitadong emerghensiyang
pangangalaga katulad ng nakalarawan dito.

Nauunawaan ko na ang DNR ay nangangahulugan na kung tumigil sa pagtibok ang kung

tumigil ang aking paghinga, walang gagawing medikal na pamamaraan upang muling ibalik ang hininga o
patibukan ang puso.

Nauunawaan ko na ang desisyon ito ay hindi magiging hadlang sa akin para makakuha ako ng iba pang
emerhensiyang pangangalagang medikal mula sa mga tauhan sa emerghensiyang pangangalagang
medikal bago
maospital at/o pangangalagang medikal na ibinibilin ng isang doktor bago ang aking pagkamatay.

Nauunawaan ko na maari kong bawiin ang tagubiling ito anumang oras sa pamamagitan ng kopya sa
form na ito at pagtanggap na anumang medalyon na “DNR”.

Ibinibigay ko ang parangal para malibigay ang impormasyong ito sa mga tauhan sa emerghensiyang
pangangalaga bago maospital, mga doktor, mga nars o iba pang mga tauhan 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 na anumang desisyon nina mga tauhan sa emerghensiyang
pangangalaga at ang kahilingang ito ay isang hayag na kagustuhan ng pasyente/kahalili. Ang isang kopya ng form na ito ang ang nasa permanenteng medikal na
rekord ng pasyente.

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 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 or respiratory arrest), walang gagawing mga kumpresyon ng d dibdib, tinutulun ang paghinga, paglalagay ng

Lagda ng Doktor __________________________ Petsa __________

Ilimbag ang Pangalan _____________________________________________ Numero ng Lisensya sa California __________________________

Telepono __________________________

**HINDI TATANGGAPIN ANG FORM NA ITO KUNG ITO AY NAAMYENDAHAN 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
Isusimula ang isang kopya para maltago sa permanenteng medikal na rekord ng pasyente
Kung gusto na ang awtorisadong Doktor para sa sa Medic Alert, sa Medic Alert Foundation, 2323 Colorado Avenue, Turlock, CA 95381.
Para kumuha ng form ng pagpapalista para sa Medic Alert, tumawag sa 1-800-432-5378

257
**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 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 снять 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).

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<thead>
<tr>
<th>Подпись пациента / представителя</th>
<th>Дата</th>
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Вписать имя представителя печатными буквами | Кем приходится пациенту | Телефон представителя

Подписывающая 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, дефibrилиацию или вводить кардиотонические препараты. |

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<th>Подпись врача</th>
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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 сохраняться 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.

- 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 rate 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

_________________________          ___________________
Signature                      Date