Healthcare Interpreter's Critical Incident Report #002

Submission Time: January 8, 2021

Section 2: Critical Incident Report

Incident Title	Provider asking interpreter to omit info
1. Provide relevant demographic information about the interpreter	Interpreter is a 38-year-old white female.
2. Provide relevant professional information about the interpreter	Interpreter is a beginner medical interpreter with less than 1 year on-site experience in medical settings.
3. Provide relevant cultural information about the interpreter	Interpreter was born in U.S.A. but has traveled worldwide and is culturally sensitive.
4. Provide relevant information related to the facility and appointment at which the incident took place	The on-site (face-to-face) incident occurred during a routine pre-operative assessment appointment at a pre-anesthesia clinic in a building complex with many clinics at a large, urban healthcare facility. The provider was a pre-op nurse charged with taking patient history.
5. Provide relevant demographic information about the patient and/or their family member(s)	Patient was a middle-aged Latina female who attended the visit alone.
6. Provide relevant cultural information about the patient and/or their family member(s)	Patient is Mexican; has lived in the U.S. city for 10 years and been a regular patient (via on-site interpreter services) and at the various clinics in the healthcare facility.
7. Provide relevant demographic information about the provider(s) involved the critical incident	Provider is a middle-aged, white, male nurse working as a full-time staff member of the healthcare clinic.
8. Provide relevant cultural information about the provider(s) involved the critical incident	Unknown cultural info about provider; he is a full-time staff member of the healthcare clinic who performs these type visits routinely, as this is a pre-anesthesia clinic.
9. Provide relevant medical information: medical specialty, patient's condition/diagnosis,	Patient has suffered from various minor medical issues regarding endometriosis of the uterus. She is diabetic but has no other major medical issues. She was recommended by her gynecologist to undergo a hysterectomy as a solution to the painful endometriosis and bleeding

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stage of treatment, prognosis.	from same. Prognosis is expected to be good following recovery from surgery.

Element 1. B. Critical Incident

1. Describe what happened	Provider took patient's medical history without trouble and proceeded to give an overview of the upcoming surgical procedure. Medical interpreter provided usual, professional, consecutive interpreting services but had failed to give the provider a pre-session at the beginning of the patient's visit. During the explanation of the upcoming surgical procedure, the provider unexpectedly turned to the interpreter and said, "They're going to use the robot to take out her uterus, but don't tell HER that."
2. What were your thoughts and assumptions during and after the incident?	I, the interpreter, was shocked and felt self-imposed societal pressure to cover up the egregiously inappropriate comment the provider had made, but I also felt conflicted professionally because of my ethical duty to interpret everything that is said accurately for all parties. I had failed to give the provider a pre-session at the beginning of the patient's visit because I had assumed that he had surely worked with medical interpreters routinely and would have known the protocols regarding interpreter's duty to interpret everything that is said. I also assumed that the patient did not understand any English - she didn't - and that by my simply omitting the provider's inappropriate comment, no harm would be done. I assumed that it would not make a difference to the patient if the surgeons would use the surgical robot to assist in the upcoming procedure.
3. What were your feelings during and after the incident?	I felt bad for having shirked my professional duties as follows: I had failed to give a pre-session, and I failed to interpret everything that was said for all parties. I felt guilty for hiding info from the patient, whether or not it was harmful to her (it seemingly was not harmful).
4. What did you do in connection with the incident?	I made careful notes of it and later used the incident in training new medical interpreters about potential pitfalls of failing to give a pre-session.
5. What has this incident meant to you since?	It caused me to develop my own method of handling future, similar, inappropriate comments by providers which could potentially occur even with a proper pre-session while still upholding professional standards and practices and ethics. It has helped me train new interpreters about same.
6. Identify the “interpreting problem” or the interpreter’s actions or omissions of actions or other limitations in the system that had an important	The interpreter had failed to give a pre-session and also failed to interpret everything that was said for all parties.

role in the critical incident.	

Element 2: Explain the incident

1. Why was the incident critical to you?	Because it caused me to see in real life how crucial it is to follow our professional standards and ethics.
2. What did you consider the most demanding aspect of the incident?	The most demanding aspect was my inner conflict in feeling badly that by shirking my professional duties I was poorly serving the patient and giving a poor example to the provider (by allowing him to get away with such an inappropriate comment with no repercussions / no comment by me).
3. How does the incident relate to the healthcare interpreting?	The incident is related to the demands of the healthcare interpreter's code of ethics
If yes, choose which ethical principles or values are applicable to the incident (check all that apply):	Accuracy and fidelity (to the speaker's message) Respect for all parties Professionalism and abiding by ethics
4. What is the incident's criticality level?	No harm incident (Event reached patient, but no harm was evident.)

Element 3: Compare the incident to existing information

Compare the incident to existing standards of practice or application of ethical principles or organizational protocols.	Incident illustrates the need to uphold standards of practice and ethical principles by giving a pre-session and to uphold ethical standards by interpreting everything that is said accurately to all parties.
Supporting Quote 1. Passage (copy exactly from the source)	The interpreter advises parties that everything said will be interpreted. The interpreter renders all messages accurately and completely, without adding, omitting, or substituting.
Title of the publication or source for Quote 1	NCIHC. National Standards of Practice for Interpreters in Health Care
Page # for a publication OR URL of the specific webpage on which the quoted text appears for Quote 1	5

Supporting Quote 2. Passage (copy exactly from the source)	The interpreter strives to render the message accurately, conveying the content and spirit of the original message, taking into consideration its cultural context.
Title of the publication or source for Quote 2	NCIHC. A National Code of Ethics for Interpreters in Health Care
Page # for a publication OR URL of the specific webpage on which the quoted text appears for Quote 2	3

Element 4: Reflect about the incident

Why do I view the situation like that? How else could I interpret the situation?	I view the incident like that because professional interpreter standards and ethics are extremely important to me as a professional medical interpreter and interpreter trainer. I suppose another way I could have interpreted the situation was to simply brush it off as no harm done to the patient and that the provider was a culturally inconsiderate or insensitive person.
What factors (process, human, equipment, environmental) have contributed to the incident?	I think that some prejudicial, societal beliefs that people who don't speak English / non-Caucasians are not as respected / valued as English-speakers contributed to the provider's disregard for the patient's right to know more info about her upcoming procedure. I believe that if the patient were a white female, the provider would have told her about the surgical robot to be used in her upcoming procedure.
Do you think the incident could have been avoided or prevented? If yes, how?	I think the incident could potentially have been prevented if I had given a pre-session stating that it is my duty to interpret everything that is said, accurately, to all parties.
Are there any factors that minimized or aggravated the severity of the incident? (Consider personal, organizational, or profession-level factors)	I think if I had had a higher self-esteem to believe that it is OK for me to speak up to defend my beliefs and if I had had more medical interpreting experience then the severity of the incident could have been reduced.
What are the root causes for the incident and what systems are involved in them ("lessons learned")?	The root cause of the incident is that I did not uphold my professional duty to the medical interpreter standard of practice to give a pre-session and inform all parties of my duty to accuracy.
Formulate possible risk reduction or improvement actions (What needs to	I think there is a need to warn. I have developed my own method of "warning" a party by reminding them that it is my duty to interpret everything that is said. There are 2 ways I do this, and I think the profession could consider adopting such methods:

change?).	I sometimes flesh out my pre-session further by adding, "So if you do not want something interpreted to the other party, please don't say it." I also have done this: when a provider makes an inappropriate comment that I should interpret, I give the provider a chance to revise before I interpret. I say, "It is my duty to interpret exactly what you say; would you like to revise your comment before I interpret it?" I realize that this method is not an "approved/accepted" method.
Provide suggestions about how to ensure that the action plan is accepted by responsible parties.	My suggestion is for interpreter profession to understand that human providers are fallible and do not always follow rules despite being told the rules only moments before.

Element 5: Implicate – provide recommendations

1. What have you considered doing in this situation? Share any thoughts or suggestions on how to avoid a similar situation in the future or what steps are needed to prevent such incidents from occurring in the future.	See my above examples.
2. How would you know that your proposed plan of action is working? Share your suggestions about evaluation of the effectiveness of a possible action plan.	I'd know my action plan is working if the provider did indeed revise his statement after being given an opportunity, or I'd know that after having said often enough in my pre-session, "So if you don't want something interpreted to the other party, please don't say it" if I did not hear any more inappropriate comments that it must be a good statement to include in my pre-session.