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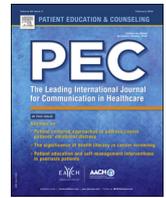
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Response to case study “A case based reflection on communicating end of life information in non-English speaking patients”

This case [1] was of a 56 yr old man who presented to hospital with non-specific symptoms. Following work up it was found that he had an advanced cancer of the pancreas with poor prognosis. Before the diagnosis was made the family informed the team that they were not to discuss medical issues directly with Mr X but instead inform the family who would subsequently inform the patient. The family reported that Mr X was in support of this arrangement. When told the diagnosis the family decided to withhold this from Mr X. The consultant explained the diagnosis to Mr X using an interpreter without the knowledge of the family. The authors then considered the issues that this case raised. They suggested that the family's expressed view of the patient's wishes should have been observed.

There are several important points that this analysis fails to highlight and as a result in my view provides inadequate guidance for future similar cases.

The most important issue to be ignored was the use of a professional interpreter (interpreters work with spoken language, translators with written language) to consult with the patient. During the work up prior to making the diagnosis “communication was via family members who translated (sic) between Mr X and clinical staff” The authors assert that this was at Mr X's request and thus was ethical. The first point is that the assertion that this is what the patient wants cannot be tested by the clinician. The clinician cannot know what the patient thinks, only what the English speaking family tells him. How does the clinician know that this is the patient's request rather than the family request given the language barrier? The decision on whether to work with an interpreter is one that both the clinician and the patient need to have input into. The interpreter role is to impartially assist both the patient and the clinician with communication. Even if the clinician is confident that the patient wishes to work with family members there may still be reasons for the clinician to choose to work with a professional interpreter. A clear cut example of this might be a domineering husband interpreting for his non-English speaking wife. Clearly it would be impossible to find out whether the wife was at risk of abuse from the husband in this setting. If a clinician does not work with a professional interpreter they can have no assurance that the communication is interpreted completely, accurately, nor whether additional opinion has been added. This is crucial when investigating serious illness as it is often the detail in the history that leads to the diagnosis. Whilst we have argued there may be circumstances where adult family members might be appropriate as interpreters [2], the setting of the diagnosis of life threatening disease is not one of them [3].

The authors relied on published guidance on whether or not Chinese people have a tradition of not disclosing serious diagnoses to their elderly family member. The reference cited [4] provides only level C evidence to support this view but also includes advice about not stereotyping and the importance of using interpreters. Nie [5] provides a detailed history of truth telling in China that discounts the view expressed that this is a generalizable feature of Chinese culture. A central tenet of culturally competent care is that in order to avoid stereotyping, if you want to know anything about the culture of the patient in front of you then the best thing to do is to ask that patient [6](p. 121).

The authors report “the doctor in charge disregarded the patients' and family's wishes, and explained the diagnosis to Mr X using an interpreter while his family were away from his bed.” We do not know the content of this consultation. It is entirely plausible that it began with asking Mr X what he wished to know about his diagnosis, and that he expressed a wish to be told the detail. In the discussion the authors in fact cited work that recommended exactly this approach. It would be unthinkable with an English speaking patient that the doctor accepted a family wish that they never talk to the patient alone.

This case study raises important management issues. It rightly highlights the fact that Western views of autonomy do not necessarily apply to other cultures. It also emphasises the importance of trust and the way in which this can be undermined. By failing to recognise the importance of working with interpreters, and that cultural generalisations can be applied to a patient without discussing it with them, this paper provides in my view dubious guidance on similar cases.

Cross cultural consultations have greater risks of misunderstanding that are compounded if there is no shared language between the clinician and the patient. What might be thought as ethically “right” by the clinician is not necessarily agreed with by the patient. It is not possible to provide good care to a patient with a serious condition without being able to communicate with them. In this setting a professional interpreter is essential. The greater the cultural distance between the clinician and the patient, the more likely that any assumptions made will be inaccurate, even if based on other knowledge about the culture of the patient. The patient is the best source of information about his own values and beliefs. For a broader discussion I would recommend Cherney's paper [7] for those grappling with these issues.

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Conflict of interest

There is no actual or potential conflict of interest including any financial, personal or other relationships with other people or organizations within three years of beginning the submitted work that could inappropriately influence, or be perceived to influence, my work.

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