**2019 Online KT Conference:**

**Innovative KT Strategies That Work**

*Misinterpretation, Misunderstanding, Misdiagnosis*

Seeta Ramdass

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>> ANN OUTLAW: Our next presentation will be given by Seeta Ramdass. She has a solid understanding of health care systems and working with university teaching hospitals as well as the needs of patients and their families. Thanks to a career spanning more than 25 years. And the health care public relations and communications field. Most recently, she was the director of public relations for Saint Mary's Hospital center, a spokesperson for the McGill center and helped patients in the Montreal community. She encourages cultural sensitivity with respect to race, religion, language, disability, gender, sexual orientation and socioeconomic factors by serving on the taskforces for the McGill University faculty of medicine and for other local and international hospital and University networks.

 Ms. Ramdass is involved with many task forces in health and education organizations dedicated to socio-cultural, safe and sensitive healthcare including Community Health Montreal, a patient-centric initiative that is working with marginalized communities to tailor the delivery of health care services to the needs of each community. Her presentation today is entitled: Misinterpretation, Misunderstanding and Misdiagnosis. If you have any questions, address them in the chat box and we will address them in the Q & A session. Seeta, I understand you have a colleague joining you. Would you mind introducing him before you begin?

 >> SEETA RAMDASS: Yes, absolutely. My colleague is Mr. Ronnie Santos and Ronnie will be helping me by portraying the voice that is very rarely heard about patients, so he will be representing the patient's voice. Ronnie works me with the Canadian project to develop a network for those from different organizations who helped nah gave newcomers throughout the country of Canada both with respect to healthcare and Social Services needs we talk about navigating refugees, asylum seekers, people who have been displaced involuntarily from their countries of origin and he will accompany me today in the reading.

 >> SEETA RAMDASS: So just to tell you a bit more about myself, I'm a patient advocate -- as was mentioned -- and co-chair of the patient's committee which is based at the McGill University Health Center. I'm on the board of directors for the Council of the organization of the [Indiscernible]. A pediatric hospital -- I'm on the patient's committee for over 20 years now. This hospital serves a very large culturally diverse group of communities from indigenous peoples to refugees and asylum seekers, immigrants from other places. My work in health care revolves around establishing Social Services because there are so many barriers to getting the proper healthcare and Social Services in a cultural context. Language can be a barrier. Customs, religious beliefs, age, gender identity. The list goes on. My presentation is based on excerpts from clinical did he brief -- different cultural background from those who are involved. Among the excerpts, there are characters who act directly on the patient and his family. And there are other actors or influencers on the patient and on the patient's outcome who are personified or portrayed through characters such as time, innovation, logic and the healthcare system itself. Although these characters may be abstract, they have an impact on the patient and family and on all patients in the community, particularly in this context as you will soon understand when we read a little bit more about him. The patient is never in their own clinical [Indiscernible] nor is the patient's representative ever in their own clinical debrief. The one who knows most about the patient himself, you will hear what he could have said, that he didn't get a chance to say. You will hear from a family member who understood him who is voice wasn't considered, from the cultural broker who was an emerging profession, who is still not recognized among the clinical professions, but whose voice actually truly captures very important elements that are critical to providing this patient with a proper care. The patient himself is a 76-year-old male. He has a history of heart disease. He can walk maybe 2 or 3 steps and then he is out of breath. He is very easily fatigued. He speaks very little English and his dialogue is generally through a translator. Let me introduce you right now to Kalim.

 >> RONNIE SANTOS (KALIM): Hello. I am 76-year-old male patient named Kalim. I have a history of diabetes, hypertension. I immigrated here in my 20s so I have lived here and contributed to this society for 50 plus years. I come from a family of 10 children; we were poor, food was scarce, and medical care even more so. I am one of the first members of my community and the first member of my family to immigrate here from Andrha Pradesh. My mother tongue and customs are Telegu. ​

 When I got my first apartment here and found some steady employment, I was able to sponsor some family and friends. People from my village and area eventually moved here over several years. I put them up in my apartment until they could support themselves. They eventually rented in the same apartment building and sponsored some of their family and friends too. After just a few years, members of my community had moved into my building and other buildings next door. I eventually started a business here, a small grocery store that grew from selling local goods to foods and products from my culture as well. I was able to provide culturally familiar foods and products to my community and introduce new items to the locals. Everyone could shop in my store and find things of interest and need.

 I employed over 40 people full time, which meant all these people had an income and were able to sustain their families and their communities. My employees came from different backgrounds, but most were from my own culture. With the help of my community and the generosity of my customers, I raised money to buy and renovate an old dilapidated building into a small temple for our community to worship, to gather together to celebrate, to mourn, and to heal. The temple was not just a place where we worship; it was really our community centre, our school, and our clinic.

 I was no longer alone; my community was growing and evolving around me. I was at the centre of my community. They counted on me to help them get settled, learn their way around, and adapt to their new country while still maintaining our cultural values. I did what I could to preserve my own heritage while adapting to the wonders and privileges of my new home and living in harmony with my new neighbours in my new country.

 The people of my community view me as an elder and founder of our community here. They look up to me and expect me to lead them, advise them, and care for them. They depend on me, and I cannot let them down. I must be strong for my community as an elder. I practice and teach the ways of our customs, using the healing herbs and rituals of my ancestors, conducting the prayers and special religious life and death ceremonies of my heritage. As a leader in my community, I have many roles: father figure, advisor, teacher, and healer. I cannot be frail or weak or let my people down.

 I had a cardiac bypass procedure last year. I tried to hide this from my community, but they found out anyways since I was absent from my business, community events, and the temple. Since then, I have lost my wife suddenly and unexpectedly. She was a warm, caring person who helped me run my business from day 1. She helped me to care for our community and preserve our traditions. Her sudden loss has been difficult for me to deal with and has been hard on our community.

 Now I am too old and sick to run my business, so I retired. I lose my balance often, and I have joint pain, especially in my hips. I had hernia surgery a week ago. I was discharged from the hospital the next day despite the fact that I was feeling dizzy and in pain. They gave me pain medications and sent me home. One day after being discharged, I fell in my house and split my head open. There was a lot of blood. I don’t remember much after that. My younger daughter took me to the emergency room. They asked me if I had pain, and I shook my head from side to side. They said “good.” They asked me if I felt dizzy, and I shook my head from side to side; they seemed pleased.

 >> SEETA RAMDASS (CULTURAL BROKER): Hello. I am the Cultural Broker or Cultural Navigator. I just met this patient. He is of Telangana background. In this culture, shaking of the head from side to side means Yes—not No as in North American culture. He is from the Brahmin caste of his culture, which means that his people view him as a teacher, religious leader, and protector.

 >> SEETA RAMDASS (SHANTA): Hello, I am Shanta, the daughter and caregiver of the patient. I need help to take care of my father who is very frail; he has heart disease and diabetes. I have been trying to get this help since last year after he had heart surgery. I don’t really know how to take care of him, and I am scared to lose him. I did not learn to take care of the sick. My mother died suddenly so I never learned to take care of the sick. I need someone to check my father because he is getting old and I do not know how to take care of him, yet I have to take very good care of him because it is my duty as a daughter to him and a duty to my community because he is an elder and leader and of Brahmin caste.

 >> SEETA RAMDASS (CULTURAL BROKER): I am the cultural broker. The daughter, Shanta, has been trying to get a geriatric assessment for her father. Because she is the only daughter in the family, she is responsible for her parents. And because of her father’s prominent role in the community, she must devote herself to his needs. She only completed high school and then she had no choice but to help her parents by working in her father’s store. She has no personal health insurance coverage and is unaware of this need or her own personal needs other than she must care for her father.She is rather isolated because she is devoted to doing everything for her father: caring for him and coordinating his schedule for his important role in the community. She is not used to asking for or receiving help as she has fallen into the primary female nurturer role, especially since her mother died. Furthermore, in this culture there is a general reluctance to ask for help, especially for an elder who is a leader—for fear of appearing disrespectful.

 >> SEETA RAMDASS (SHANTA): Hello. I am Shanta again. I care for my dad full time. It is exhausting work, and I am close to burning out but there is no support for me. I have never told anyone before about how tired and stressed I am. I have no medical or nursing experience, but I have to push through and do what I can for him. I use our traditional spiritual and healing practices to help my dad, but this is not enough. His medications and cost of living is very expensive and impossible to be covered by his small pension and insurance. I am still waiting for someone to help us to get the materials he needs to navigate around the house (the shower and bath, etc.) because he has the tendency to fall. He needs a walker or a wheel chair because he cannot walk or stand for too long, but he does not want them.

 He had hernia surgery last week. He was discharged a day later despite my concerns to the medical staff that he is on blood thinners and is weak and wobbly. When we got home, he said some confusing things as though my mother was still alive. He called out for her. He also had an episode where he sat very still and speechless for close to an hour. He fell in the house while trying to get up to go to the bathroom and split his head open. I called an ambulance, and we went back to the hospital where he had his hernia surgery 2 days ago.

 He waited for 4 hours before having a CT scan. We were told he had a brain bleed, but since he could speak and confirm his name and that he had no dizziness or pain, they sent him home. I know my dad best, and I told the medical staff that some of his behaviours earlier were not normal and that he was confused. I called his family doctor and his cardiologist; they said he should be kept and monitored at the hospital because he is on blood thinners. I told them that the emergency room staff discharged him and simply told me to call 911 if he got worse.

 As his caregiver, I was not allowed to be in the room when he was being examined and questioned by the hospital staff. I know he is dizzy and has pain, but somehow the doctors think otherwise and sent him home. I do not understand why. I am worried about what could happen to him at home, and I am not qualified to care for him or know what to do if he got worse.

 >> SEETA RAMDASS (CULTURAL BROKER): The cultural broker or navigator. A social and clinical assessment of the patient and his family environment is urgently needed. It would be helpful to have some home care arranged as well as some financial assistance, especially since the daughter is the only full-time care giver that the father and the community trusts her with his care.

 The Telegu nonverbal way of communicating the word “yes” is to shake the head from side to side. Kalim, when asked if he was in pain and dizzy, shook his head side to side to confirm that he was in fact dizzy and in pain. However, this action was not interpreted in the context of his culture, but rather in the context of the clinician’s culture rendering it a gross misinterpretation of the actual response of the patient: The clinician thought that Kalim was not in pain and he was not dizzy.

 In this culture, it is very important for Kalim to show his community that he is still autonomous and strong, especially since he plays many roles: elder, leader, advisor, and healer. In his culture, it is inappropriate for any woman outside the family to care for him, and his community is not comfortable asking for help from those outside the community—especially for him—because in asking for help for him they may be appear to be disrespecting him, a very offensive thing to do to a Brahmin in the culture.

 >> SEETA RAMDASS (SHANTA): Hi. I am Shanta again. My father does not want to have anyone else care for him but me. The community does not want anyone else to care for him but me. He is not comfortable with strangers caring for him. He wants to show he is still able to take care of himself and the community and that he is still strong. ​In our culture, it is inappropriate for any woman outside the family to care for him. He does not want to get financial assistance because he must show he is independent; all this is necessary for his self-esteem and to fulfill his responsibility as an elder in our community. I would like to help maintain his dignity and preserve his status in the community. It is important to him, especially since my mother died. It is also very important to the entire community that he is kept close to them. ​As the only daughter in my family, it is my duty to support and care for my father. It is my honor and privilege to care for my father. Personal desires and wants are not important in my culture, only fulfilling my duties to a highly respected community leader who happens to be my fatherIt would be very helpful if I could be trained to be a professional caregiver so I do not have to ask for outside help to care for my father. I can do it all myself, which will make him happy, is better for his morale, and is expected of me by him and the community. I never had the chance to learn beyond high school, and I would like to learn to provide care to others in a professional way.

 >> SEETA RAMDASS (CULTURAL BROKER): I'm the cultural broker again. We have to help the patient with his disabilities, but we also have to help the caregiver. She needs support and training.

>> SEETA RAMDASS (UNION): Hi, I am the Union. I have another perspective: If we start compensating and training caregivers, then we will lose jobs in the health care network.

>> SEETA RAMDASS (LOGIC): Hello. I'm logic. We should have transition care units, rehabilitation units, step-down units, and more community-based long-term care places to help elderly patients get back their autonomy. These should be culturally safe and sensitive environments located within the patients’ communities to keep them in familiar neighbourhoods surrounded by community members who can play different care-giving roles and sustain this patient more efficiently. If we do this, then it may help prevent them from relapsing and ending up in the Emergency Department and occupying acute-care beds with their long-term needs. It will be good for their morale, and the assistance and participation of the community in the care of the patient may also save the health care system money.

>> SEETA RAMDASS (HOSPITAL ADMINSTRATION): Good afternoon, I am the hospital administration. Our Emergency Department is bursting at the seams. Wait times exceed 15 hours. We have many elderly patients who need complex care. Our acute-care beds are congested with many of these elderly patients because there are not enough beds in the community to take them. It is challenging to admit more complex acute-care patients if we cannot liberate our beds of long-term care patients. Having socioculturally safe and adapted environments is important but is not a priority right now—acute care is.

>> SEETA RAMDASS (HSSS): Good day. I am the Health and Social Services System. Creating culturally safe and sensitive transition care units, rehabilitation units, step-down units, and more community-based long-term care places for the elderly is a nice idea, but it is not a priority right now. That is a very resource-intensive and cost-prohibitive task! I will need human, material, and FINANCIAL resources to inject into this task! This will take time.

 >> SEETA RAMDASS (TIME): Hi. I am Time. I have been observing this phenomenon for over 30 years. This is an old and worn-out excuse that many previous bureaucracies have used. Over the past decades, I have seen numerous migrations of various cultural groups into our country. I have seen millions of patients and their families go through similar situations like this. It’s the same old story. We have become a more socioculturally diverse society with hybridized cultures among us. This trend will continue.

 >> SEETA RAMDASS (LOGIC AND INNOVATION): Logic and innovation. We are logic and innovation. The government, bureaucrats, etc. are complaining about resources. Well, why not recycle some of the abandoned health institutions you already have? Some of them are already adapted for patients with physical and mental challenges. Why not use medical, nursing, and allied health professionals-in-training to staff these facilities? Why not engage more cultural brokers or cultural navigators in the multidisciplinary teams who care for patients? It would save lives and improve the quality of life. Oh, and why not use technology such as digital games, videos, etc. to help treat and improve patients’ autonomy and functionality?

 >> SEETA RAMDASS (SOCIETY): Hello. I am society. There are more people in this country over the age of 55 than ever before. Data from the 2011 census showed for the first time that there were more people aged 55 to 64, typically the age group where people leave the labour force, than aged 15 to 24, typically the age group where people enter it. These older people contributed to building our great country. They served our communities. They want to continue to be active and involved as they age. Why are we not better prepared to help them have a healthy old age, instead of just letting them age? We can enable them instead of sustaining their disability or inability.

 >> SEETA RAMDASS (CORONER): I am the coroner. While all this has been going on, the patient and millions more have died. Miscommunication and misunderstanding played a role in his death. There is a need to implement socioculturally safe and sensitive measures to manage the socioculturally complex barriers to health care that exist in our very diverse society. We need support and action by those with the power to implement change and preserve the health, well-being, and dignity of all patients from all backgrounds.

 >> SEETA RAMDASS: So thank you so much for allowing me to share this excerpt about this patient -- just a disclaimer. Rest assured that the name of the patient was changed to protect privacy as was the name of the daughter to respect the confidentiality of the family although this scenario is real. What I wanted people to understand about this particular scenario is that something as simple as a cultural custom of how the worth "yes and no" expressed non-verbal communication played a huge role in the diagnosis -- or misdiagnosis of this particular patient. The role of cultural navigators -- they go by so many different diverse names because this is a profession that -- while it is very important, is still very unrecognized as part of the clinical team. It is so important because it was the cultural broker who was able to really confirm and clarify to the clinical staff that when a person from the culture shakes her head from side to side, they are not saying no, they are actually saying yes. In the case of an elderly gentleman with very low verbal communication skills English, the non-verbal cues we very important in expressing what he was going through.

 Another important element of this, the daughter. The daughter who -- herself may have only had high school education is an expert both in the patient -- her father -- and in his care with respect to the community, she herself is also an excellent cultural navigator. But during the evaluation with the clinicians in the ED, she was not allowed to be present when they asked the patient about what about after he struck his head. Because she was not there, she could not explain that her father was actually confirming that he was, in fact, feeling dizzy, that he was, in fact, having headaches. She was also not included in discussions about his well being because had she been included, they would have understood more about the fact that he was on blood thinners before he left the ED, and she would not have been put in a position where she had to try to fold and get the other doctors, the other specialists to find out more information that may have helped her father.

 The daughter herself, Shanta, is also not empowered as his caregiver by either the clinicians or the system itself. And again, we see it is the voice of the cultural broker who clarifies not only on behalf of the patient, but clarifies also on beLandau level of his primary caregiver, the daughter, to explain the presence of her role. She is not something as a passive caregiver. She is acting on behalf of her father and an entire community. In this community, there is not individual decision making that transpires, but rather collective and community decision making. The daughter tries to convey that through her own language and through the words that she uses that there is an importance of her father's role in the community and of her own role of supporting him for the community. She talks about what the community wants. Her father recognizing what the community wants and they are acting in a context that will be beneficial while at the same time preserving her father's leadership in the community. Individual decision making versus collective decision making. We also learn another important lesson through this dialogue. That is that there may be a willingness in caregivers to do more but if they themselves are not empowered, they don't have an interpreter or someone to act on their behalf, they recognize their own faults to providing home care. They have a symbiotic relationship that should be looked at as a whole not as two separate entities. They are connected. Another lesson, this focused not on the pure needs of the patient. 76-year-old patient with a history of heart disease who is easily fatigued -- no. This looked at the social and community elements of this patient so that you see the whole person. I think when you see the whole person, the language barrier -- the non-verbal challenges interpreting what he is trying to convey, you get a more comprehensive picture that allows both the clinicians and Social Services providers to adapt the care more to his needs so that the patient has a better or potentially better outcome.

 I think that the other issue that is important is that over all, we look at a story that reflects a phenomenon that is going on certainly in North American societies and developing countries. We are all receiving our fair share of newcomers. These are people who may be voluntarily immigrants. These are people who may be forcibly displaced from their homelands and environmental disasters. They are coming into our lands with no knowledge of our cultures and we also have very little -- or no knowledge of theirs. Navigating this will be challenging to them and continues to be challenging unless we really focus on adapting care and Social Services to the cultural context of newcomers. I will pause there at this point and I will be happy to take any questions or comments that you may have.

 >> ANN OUTLAW: Seeta, thank you so much for this presentation and for Ronnie for representing Kalim. I bet you haven't been able to see the Zoom webinar chat as you're presenting. I wanted to share, the method you have for sharing this presentation has received a lot of accolades. Amazing, creative, brilliant methods. Thank you so much for doing this today. At this time, I would like our reactors to turn on your webcam. Thank you so much. We've had a few questions coming in from the chat and I'll go ahead and start with these and we'll tune into the reactors. An amazing way to get all of the voices to the table. I'll withdraw on this as a KT strategy for my own work for those who don't get a seat at the table. Do you have any advice about how to go about doing that?

 >> SEETA RAMDASS: It's very challenging, but it starts with thinking beyond just the clinical teams that look after a patient. The receptionist who first greets the patient might be part of the discussion. The transport attendant. We know that with the recent influx of Syrian refugees, it was the emergency room clerk was the primary navigator for people who did not speak a word of English. The victims of horrors we couldn't possibly understand. So looking beyond just the clinical team at all the points of encounter of the patient, it is challenging, but it can be done. The best way to do it is to pretend that you're a patient or to get an authentic version, getting a patient with common language skills or maybe a patient who has freshly arrived. If you know anyone who came to the country or to the area and have basically the trajectory followed. So you literally pretend that you're the person, follow them as you come in. Look at how they're received from everyone -- the security guard when they enter, if they enter by the emergency room. The trajectory and every personal encounter of everyone working that has a hospital ID will help you. Bring them to the table. You'll of these people have a voice in attendance. Sometimes it's simple things like a woman from certain cultures feel uncomfortable being transported by male attendants. Male attendants have found ways to transport females from point A to point B. Engage these non-clinicians, bring them to the table.

>> ANN OUTLAW: Another comment that came in was misdiagnosis is certainly seen with misinterpretation. You mention the cultural difference between shaking the head and nodding to indicate agreement. Are there other examples or common gestures one culture that you're aware of that can mean something different in another or perhaps com on behaviors that can be misinterpreted?

 >> SEETA RAMDASS: Absolutely. We can look at the Greek culture, for example. So I can briefly tell you the story of a young nurse who worked in an elder care center. Her job -- she was assigned to an elderly Greek gentleman who refused to have interactions with other patients. He would not go into the social room or the movie room, nothing. Not the exercise room. He didn't want to talk to other staff at all. So this young nurse was assigned. She had this young, sun shining personality. She would go into the room where the gentleman would stay the whole day. He would give everyone a bit of a grumpy look and shoo them off.

 After about a week -- again, this is the clinical staff gathering around the table, she said, "I think I'm making progress with the patient" because now when I walk into the room, he gives a little wave of the hand. When he leaves, gives a little wave of the hand. She believed -- as did the rest of the clinical team -- that the introduction of the acknowledgement of that hand wave was a positive sign of the -- the little wave of the hand which I'm not doing accurately -- that little wave of the hand is an insult in the Greek language. It is the flipping of the finger is the best way to describe it. So he was not receptive. He did not want her there. The misinterpretation of that meant that people were barging into his room and try to go do more things with him, just agitating him even more.

 In fact, subsequent to that misinterpretation, people kept trying to go into the room and talk to him. There were more code whites brought to him. That is when a patient gets a little aggressive and agitated and has to be restrained because they were invading his privacy in large numbers when what he was trying to say is, "Please stay away from me."

 Another common encounter -- a gentleman from an African nation who was in our emergency room when I was at St. Mary's hospital. This gentleman came in. He not answer questions from the clinicians. He would not talk to them. No nurse. No doctor. He wouldn't look them in the eye. They called in psychology to give him an evaluation. Their belief was that this gentleman may have mental health issues and that is why he is not looking at them or focusing on them. He may have a personality disorder. The psychologists ruled that out and called an audiologist. Maybe he can't here.

 It turned out it was a lot simpler than that. A young medical student who happened to be in the ER that day was flipping through the patient's chart and looked at some social notes that were taken by one of the social workers. In reading through the notes, he discovered that the patient was a physician in his original country. So the young medical student went up to the student and referred to him by Dr. So-and-So. He said hello Dr. So-and-So. I see here you are a doctor in your own country. I'm just curious, what kind of medicine did you practice? Were you a pediatrician? And he engaged him based on the gentleman's profession. And the patient opened up right away. He spoke right away and he said, "Yes. I was this kind of doctor in my country and I managed a clinic," blah, blah, blah. And he goes into quite a bit of detail about himself. It turns out that the reason he did not speak or look at the other clinicians is because in his country, being a doctor is a very highly respected role and it is important in that culture to address people formally by Mr. or Mrs. and professionally it is important to address them as a doctor. He was offended by the fact that he was not addressed by Mr. or Dr. Once that gap was closed in terms of identifying who he was, he opened up and he was much more participatory in his own care. His outcome was favorable afterwards.

 >> ANN OUTLAW: Thank you so much for sharing that in those examples. Let me turn it over to Janet, one of our reactors today. Janet is from the Amputee Coalition. What social and cultural barriers have you encountered in your work? How have these barriers led to misinterpretation, misunderstanding or misdiagnosis?

 >> JANET PANOCH: Well, within the limb-loss community, we have a significant number of those who have limb loss as a result of diabetes and vascular issues who live in rural areas. So access to care is a big problem for people who live in rural areas as well as basic communication with their providers. They may not have good internet connections whereas people that have Wi-Fi, we can go to a patient portals to access our providers.

 Communication can be limited for many of our constituents prior to what my work at the Amputee Coalition, I did a lot of research involving misdiagnosis and misinterpretation. You know, just teaching basic inter-personal skills like active listening and waving the body language of a patient and so on can go so far to reduce that type of misinterpretation and asking patients deeper questions. We sometimes forget about -- we talked about medical decision making and shared decision making and eliciting the value of the patient. Asking them what is most important to you when you're making this decision or as you're engaging the health care professionals because sometimes what we assume as clinicians is in fact not at all the goal of the patient. Previous speakers spoke about that as well. The importance of asking them what their goals are as opposed to clinical goals. Going back to the limb loss population, I remember the case of a gentleman who had upper arm amputation and they had done all of this work to find him buy on I can arms and hands. Finally he spoke up and he said, "All I want is an elbow so I can hook it around, open doors" and so his goals were not at all the high-tech goals of his -- some of his medical team. Can be similar with lower limbs.

 We have all of these wonderful prosthetics. Their insurance coverage may not cover it, and so on. But frequently, if you engage directly with a patient and ask them, "What do you want?" Going back to values and what is important in your life, it might sometimes be, "I just want to be able to sit on the floor, play with my grandchildren, go to the mailbox and go to the grocery store" and that is a good quality of life for people. That is a long response. It is multi-faceted as you can imagine. First-year medical students a few years ago -- I would love to see more scripts like this and distribute this to the first-year medical students like right at the beginning as they're starting to think about interacting with the patient. Having them play out these different roles. Thank you very much.

 >> ANN OUTLAW: Excellent thoughts. Kate. Let's hear from you. Have you engaged with a cultural broker or navigator with your work at skipper?

 >> KATE DUNN: Thanks, Ann. Seeta that was a great presentation. I think it shed light on how our administration and processes are at the state right here. Have he engaged with cultural brokers and navigators my work? I've never -- they've never been titled cultural brokers or navigators but I have three examples that I wanted to share with you and in my role, I don't necessarily provide the implementation with KT myself but I am coaching researchers and teams on how best to do it. I have three examples. The first is a computer science professor and he is working to develop an app on how to navigate pockets on clinical guidelines in Saskatchewan. We have a computer scientist looking into how to create different avenues of our health care.

 The second example I have is about a month ago, Saskatchewan got their very first children's hospital. It's a big moment in our province. We've been fundraising and building for over 15 years. Really exciting to have that.

 What that means is that there's a bit of a shift in our practices in terms of giving birth in our province. So our province is huge. We have 1 million -- it's not huge, but we have 1 million people and the geographical distances are very long. We have people up in the very tip of the province. They have to travel 8-10 hours to give birth and we have a researcher right now involving patients with experience and elders and knowledge keepers -- huge multidisciplinary team. Are day 1, you can see that everyone is so invested and ready to make these changes as soon as the research has kind of identified them. Large focus groups with different decision makers and patients and women that have actually traveled down to give birth. We are excited to see what happens there.

 The third example, we are working with a group of physiotherapists would are working with another indigenous community. Key kept asking a population about their back pain. Even though they've had a lot of people coming to their clinic with back pain, everyone is saying they are not having back pain. Why are you coming to the clinic? They found out that in the Cree language, back pain -- the word doesn't exist. So they used things like "soreness" or "stiff." They just say "can't bend" or "can't tie my shoe." And they describe it as things they can't do. This was illuminating to the whole team and changing the terminology and how they disseminate their research findings and how physiotherapists care for that community. Thanks for listening.

 >> ANN OUTLAW: Thank you, Kate. Those are great examples. Thank you for sharing those. Jean, in your experience, what assumptions have led to misinterpretation or misunderstanding in your work? Do you have any advice for how to confront these assumptions?

 >> JEAN WINSOR: Yeah. I'm sad to say in the employment field for individuals with disabilities, we have similar issues an concerns and significant amount of research that documents that culturally and linguistically diverse families and familiar lids that come from a non-middle and upper class background have reduced access to services that lead to the community -- [Indiscernible] studies have non-white families have found negative experiences with service providers, limbed knowledge of the services that be available. There's challenges that we often find related to stereotypes. Insufficient language and interpretation. There's consideration about the impact on status, and how that impacts services supporting an individual to -- who may be a U.S. citizen or have the ability to work in the community -- to be able to pursue the supports they need to be successful. As we look at the literature, our training and case studies have not met the need to date. So how do you move this forward when it really is a need right now. That resonated with me because these are people who are living lives right in this moment. It's really challenging for us to say, "We are working on this."

 I try to think about examples of what we have done to really meet the needs at the moment and time that we can. One of the strategies I've seen be successful is considerations. One of the pieces that brings together -- I can see that it really hit on the fact that you can't do this without the community. You can't do this without all the individuals that touch people in that culture and in that community and you also can't do it without the members of the community there. Providing an opportunity and a safe space to have those difficult conversations with where there is misunderstanding and where there is misinterpretation because until folks have that opportunity to connect in that way and have conversations, it is difficult to move forward into those next steps saying, "What are the strategies we are going to work on together to really change this outcome?" And have an immediate impact because again time is really of the essence.

 >> ANN OUTLAW: Most definitely. Thank you, Jean, for sharing your perspective. I want to thank all of our reactors for the morning presentations and to Seeta. Thank you so much. That was a very enjoyable presentation.