



ASHT DEI Virtual Training Toolkit

Case Simulation Curriculum

Developed by Valerie Aziegbe, OTR/L, CHT, COEE
In Partnership with the American Society of Hand Therapists (ASHT)

8 Case-Based Modules | Branching Decision Scenarios | Research Insights | Guided Reflection

MODULE 1

Cultural Humility at the Evaluation Table

QUESTIONS

ASHT DEI VIRTUAL TRAINING TOOLKIT

Cultural Humility at the Evaluation Table

Theme: Cultural Communication, Patient Autonomy, and Interpreter Use



SCENARIO

Case: Yuki's Dupuytren's Evaluation

Patient: Yuki, a 62-year-old Japanese immigrant presenting for evaluation of Dupuytren's contracture.

Situation: Yuki's adult daughter attends and begins speaking for her mother from the moment they enter the room. The therapist, pressed for time, finds it easier to direct all clinical questions to the daughter, including pain scale ratings, functional limitations, and home environment details.

Context: Yuki nods politely throughout and does not interrupt. The therapist documents the evaluation without noting that all information was obtained via a third-party family member.

Stakes: Key clinical data (Yuki's own pain perception, ADL priorities, and occupational goals) may be inaccurate or filtered through the daughter's lens.



LEARNING OBJECTIVES

- Distinguish between culturally informed deference and patient autonomy violations.
- Identify when interpreter services or structured communication strategies are clinically indicated.
- Apply cultural humility principles to redirect clinical interactions without causing offense.

DECISION POINT 1: BEGINNING THE EVALUATION

The daughter immediately begins answering all your intake questions on Yuki's behalf. You are 10 minutes behind schedule. What do you do?

- A. Continue directing questions to the daughter, she clearly knows her mother well and this is faster.
- B. Warmly acknowledge the daughter's presence, then gently redirect: 'Thank you for being here. I'd like to ask your mother directly first, please feel free to add anything afterward.'
- C. Ask the daughter to step out of the room entirely so you can complete the evaluation privately.
- D. Request a professional interpreter before proceeding, even though the daughter speaks fluent English.

DECISION POINT 2: OBTAINING PAIN AND FUNCTIONAL DATA

Using Option B, you've redirected to Yuki. When you ask about her pain level, she looks at her daughter before answering. Her daughter says '3 out of 10' before Yuki can respond. How do you handle this?

- A. Accept the daughter's answer and move on, the number is probably accurate.
- B. Pause, smile at Yuki, and gently say: 'I'd love to hear from you directly, Yuki, there's no right or wrong answer, and even a gesture or pointing to the scale works perfectly.'
- C. Document '3/10 per family report' and continue, noting the proxy dynamic in your clinical notes.
- D. Ask the daughter to translate for Yuki and accept her report.

DECISION POINT 3: OBTAINING PAIN AND FUNCTIONAL DATA

By the end of the evaluation, you've gathered data primarily from the daughter. When you ask Yuki what her main goal is, the daughter answers: 'She just wants to be able to cook again.' You are unsure if this is Yuki's goal or her daughter's assumption. What do you do?

- A. Document 'Patient goal: return to cooking' and build the HEP around this.
- B. Show Yuki a simple visual goal-setting tool or picture board and ask her to point to her priorities.
- C. Ask the daughter to ask Yuki in Japanese what her goals are and report back.
- D. Schedule a follow-up appointment with a trained interpreter present before finalizing goals.



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ANSWER SHEET

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DECISION POINT 1: BEGINNING THE EVALUATION

The daughter immediately begins answering all your intake questions on Yuki's behalf. You are 10 minutes behind schedule. What do you do?

A	Continue directing questions to the daughter, she clearly knows her mother well and this is faster.	✗ INCORRECT Efficiency cannot override patient autonomy. Relying solely on a family proxy undermines Yuki's right to self-report and introduces the risk of filtered or inaccurate clinical data. This approach fails to establish a therapeutic relationship with the patient herself. (Serrano-Diaz et al., 2025)
B	Warmly acknowledge the daughter's presence, then gently redirect: 'Thank you for being here. I'd like to ask your mother directly first, please feel free to add anything afterward.'	✓ BEST CHOICE This approach honors both the cultural value of family involvement and Yuki's right as the patient to be the primary informant. It sets a respectful tone without dismissing the daughter's role. Cultural humility means engaging with what the patient values while ensuring their voice is centered. (Serrano-Diaz et al. 2025; Stanford, 2020)
C	Ask the daughter to step out of the room entirely so you can complete the evaluation privately.	⚠ PARTIAL CREDIT While having one-on-one time with the patient has clinical value, removing the daughter entirely without explanation may feel abrupt or disrespectful in cultural contexts where family is integral to healthcare decisions. A better first step is to invite Yuki's voice while keeping the daughter present. (Stanford, 2020)
D	Request a professional interpreter before proceeding, even though the daughter speaks fluent English.	⚠ PARTIAL CREDIT Requesting an interpreter is appropriate when there is a genuine language barrier, but in this scenario the primary issue is proxy communication, not language access. If Yuki does have limited English proficiency, a professional interpreter would be strongly indicated, but this alone does not address the dynamic of the daughter speaking for her. (Serrano-Diaz et al., 2025)

DECISION POINT 2: OBTAINING PAIN AND FUNCTIONAL DATA

Using Option B, you've redirected to Yuki. When you ask about her pain level, she looks at her daughter before answering. Her daughter says '3 out of 10' before Yuki can respond. How do you handle this?

- | | |
|---|--|
| A Accept the daughter's answer and move on, the number is probably accurate. | ✗ INCORRECT
Accepting proxy-reported pain scores as clinically valid undermines evidence-based practice. Self-reported pain is the gold standard in rehabilitation. Deferring to a family member's interpretation of another person's pain introduces bias and can affect clinical decision-making. (Serrano-Diaz et al., 2025) |
| B Pause, smile at Yuki, and gently say: 'I'd love to hear from you directly, Yuki, there's no right or wrong answer, and even a gesture or pointing to the scale works perfectly.' | ✓ BEST CHOICE
This response is patient-centered and culturally sensitive. It normalizes non-verbal communication options, reduces performance pressure, and reinforces that Yuki's perception matters independently. It also models inclusive communication for the daughter without being dismissive of her. (Downey et al., 2014; Stanford, 2020) |
| C Document '3/10 per family report' and continue, noting the proxy dynamic in your clinical notes. | ⚠ PARTIAL CREDIT
Documenting the proxy dynamic is good clinical practice and shows self-awareness. However, stopping at documentation without attempting to obtain Yuki's self-report first is a missed opportunity for patient-centered care. Documentation of a proxy response is a last resort, not a first response. (Serrano-Diaz et al., 2025) |
| D Ask the daughter to translate for Yuki and accept her report. | ✗ INCORRECT
Using a family member as an interpreter introduces significant risk of information filtering, bias, and role confusion. Professional interpreter services should be used whenever a language barrier is present. Family members should not serve as medical interpreters. (Barylski et al., 2023; Serrano-Diaz et al., 2025;) |

DECISION POINT 3: OBTAINING PAIN AND FUNCTIONAL DATA

By the end of the evaluation, you've gathered data primarily from the daughter. When you ask Yuki what her main goal is, the daughter answers: 'She just wants to be able to cook again.' You are unsure if this is Yuki's goal or her daughter's assumption. What do you do?

- | | |
|---|---|
| A Document 'Patient goal: return to cooking' and build the HEP around this. | ✗ INCORRECT
Treating a family-reported goal as the patient's own documented goal is a clinical and ethical error. Goals must be patient-identified or explicitly confirmed by the patient to be valid for a client-centered treatment plan. (Stanford, 2020) |
| B Show Yuki a simple visual goal-setting tool or picture board and ask her to point to her priorities. | ✓ BEST CHOICE
This is an excellent example of adaptive, inclusive clinical practice. Visual tools and functional demonstration overcome language or communication barriers and give Yuki agency in establishing her own goals. It demonstrates clinical humility by meeting the patient where they are. (Downey et al., 2014; Serrano-Diaz et al., 2025) |
| C Ask the daughter to ask Yuki in Japanese what her goals are and report back. | ⚠ PARTIAL CREDIT
While this acknowledges the need to obtain Yuki's own perspective, using a family member as a medical interpreter is not best practice and creates the risk of filtered or summarized responses. A professional interpreter service should be used for clinical goal-setting conversations when a language barrier is present. (Serrano-Diaz et al., 2025) |
| D Schedule a follow-up appointment with a trained interpreter present before finalizing goals. | ✓ BEST CHOICE
This is a strong, patient-centered decision that prioritizes accuracy and equity over efficiency. Scheduling interpreter-assisted goal-setting ensures Yuki's voice is genuinely heard and documented. This is particularly important for long-term treatment planning. (Serrano-Diaz et al., 2025; Stanford, 2020) |



WHAT DOES THE RESEARCH SAY?

Schouten et al. (2020) Mitigating Language and Cultural Barriers in Healthcare Communication: Toward a Holistic Approach. *Patient Education and Counseling*, 103, 2604–2608.

Patients who receive language-discordant care ask fewer questions, demonstrate lower understanding of their illness, are less adherent to treatment, report lower satisfaction with their providers, and are more likely to miss appointments compared to patients who receive language-concordant care.

Although professional interpreters are widely regarded as the gold standard, the use of informal interpreters, such as family members, is common practice worldwide. The quality of the communication process is often compromised when mediated by informal interpreters; however, patients frequently prefer family members because they place greater trust in them than in professional counterparts.

In complex clinical situations, having both a professional interpreter and a family member present simultaneously may be optimal: the family member can emotionally support the patient and provide culturally relevant context, while the professional interpreter ensures accuracy and communication coordination.

Some patients from collectivistic cultures prefer family-centered over individually-centered decision-making, which requires a flexible, patient-informed approach rather than a fixed protocol.



SELF-REFLECTION CHECK-IN

Reflection Prompt 1:

Think about a clinical encounter where a patient's family member played a significant role in communication. In retrospect, do you feel you adequately centered the patient's own voice? What might you do differently now?

Reflection Prompt 2:

How comfortable are you requesting professional interpreter services in your current clinical setting? What systemic or logistical barriers, if any, make this difficult and who in your organization has the power to address them?