

Un Poquito

The benefits and perils of knowing “a little bit” of Spanish when communicating with Spanish-speaking patients.

BY WARREN J. FERGUSON

PREFACE: Language is the currency of health care. Exchanging information, expressing emotion, instructing patients, and providing health education all occur through the medium of language. In the United States, traditionally this perspective was clear but of little importance: everybody spoke English. Today that circumstance is rapidly changing, with high levels of immigration into this country from all quarters of the world. Although English remains the principal language of the givers of care, it is not the language of many recipients of care. Now issues of linguistic ability, appropriate interpretation, telephonic “language lines,” and patient privacy are all in play in ways they never were before. Physician Warren Ferguson, speaking for legions of well-intentioned caregivers, sets the stage in his essay by reprising his career-long effort to learn Spanish well enough to make his Spanish-speaking patients and himself comfortable in exam-room dialogue. Then Nataly Kelly, a veteran Spanish-English interpreter, shares her experiences about provider sensitivity, patient vulnerability, and telephone interpreting. She is an active eavesdropper—and involved participant—in the practice of bilingual medicine, and her insights are many.

A YOUNG, PETITE Honduran woman was seated next to the small desk in the exam room. Her name, according to the chart, was Sonia Aponte, and she appeared nervous. I smiled while making eye contact and introduced myself, “Buenos días, Señora Aponte. Me llamo Dr. Ferguson.” Within a fraction of a second she responded, “I no speak English.” I repeated my introduction and the anxiety eased from her face. “Oh, doctor, *habla usted Español?*” My response was qualified: “Sí, yo hablo un poquito de Español pero a veces, necesito ayuda.” (“Yes, I speak a little bit of Spanish, but at times, I need help.”)

Señora Aponte told me she had arrived here to Worcester, Massachusetts, two years ago. Now she had come to our community health center because she was pregnant; she and her boyfriend were excited about having a baby. I gathered her clinical information without difficulty and then turned to her social history, asking her, still in Spanish, about her emigration to the United States. Tears glistened in her eyes, and she began to speak solemnly. It was clear that her journey had been difficult—but I didn’t understand much of what she was saying. The question that had haunted me for years asserted itself anew: When am I going to make it a priority to become more proficient in Spanish?

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On The Professional To-Do List

DEVELOPING PROFICIENCY IN SPANISH had been on my professional to-do list for almost twenty-five years, along with all of sorts of other tasks I never seemed to get to. It first went on the list near the end of my residency, when I was offered a position at a family health center in my home state of Massachusetts. On learning that 80 percent of my patients would speak Spanish, I bought a medical Spanish audiocassette course and studied off and on during the rest of my residency. Unfortunately, I finished only about half the course.

Even though it happened decades ago, I vividly remember my first night on call in my new position. That evening the phone rang at home—my first patient call there. The caller was a Spanish-speaking woman who, as far as I was concerned, might have been speaking ancient Greek. With three dictionaries open in front of me, I worked frantically to understand what she was telling me about her young child. My wife watched from the living room, laughing at my ineptitude. Eventually, I determined that the woman's eight-month-old daughter had had a high fever for three days; when the fever broke, the little girl had developed *una erupción* (a rash). She was otherwise well—eating, drinking, and playing. Roseola, I decided, and reassured the mother as best I could.

During the next five years, I completed a few more medical Spanish tapes and thought about taking Spanish courses, but I could never seem to find the time. I was working even harder than I had as a resident, on call every third night, and delivering eighty babies a year in addition to caring for adults and children at the local community hospital where there were no residents to assist us. Then, probably for want of someone more experienced, the board of the health center decided to make me the medical director. In my new role, it became easier to rationalize my lack of expertise. Even as I became a bit more proficient in Spanish, I was spending more time on administrative responsibilities and less time caring for patients. And the health center had medical assistants who were bilingual and bicultural, who I presumed were competent. Yet even with my limited knowledge of medical Spanish, I sometimes caught errors in the medical assistants' interpretations. For example, I would instruct a mother to give her baby "one *teaspoon* of amoxicillin three times a day," and the medical assistant would convey "one *tablespoon* three times a day." Relieved to catch the errors, at the time I didn't consider that such mistakes were a systemic safety concern. After all, we're doing the best we can, I thought.

Eventually, here at UMass Memorial Medical Center, where I now lead community health efforts, we realized that what we and many others were doing wasn't good enough, and several of us began working with the hospital's medical executive committee on improving language services. We applied for a grant, and along with nine other hospitals, UMass became part of Speaking Together (<http://www.speakingtogether.org>), a Robert Wood Johnson Foundation (RWJF) quality im-

provement collaborative. We then began developing new strategies for more effective and efficient language services programs, and, with support from the RWJF, health policy experts from the George Washington University designed a program for us to systematically address language services access and quality.

Getting The Message

IT WAS PATIENTS SUCH AS SEÑORA APONTE—and another young woman, Connie Camelo—who sparked my until then meager efforts to begin improving language services for our patients. In my role as a faculty member at the University of Massachusetts Medical School, I teach a workshop for students, staff, and faculty on cultural competence (which involves far more than language skills). In one of these workshops, Connie told the group her story of emigrating from Colombia to the United States. She spoke about the stages of acculturation, changes in her social status, loss of her culture, and loss of family, as well as her immediate need for shelter, food, transportation, and health care. In the process, she provided a poignant explanation of why many immigrants, struggling to survive here, have little time and energy for learning English.

While Connie spoke, the silence was palpable. Many listeners wiped away tears. Everyone had heard similar stories from and about patients, but Connie wasn't a patient. She was the director of interpreter services at UMass. Somehow it was different to hear the message from a professional colleague. Hearing the story told by "one of us" made such situations extremely real. None of us could say, "Things like that don't happen to people like her." Demonstrably they did.

Connie and I put in many hours working on the Speaking Together program. She was frustrated at the way health care professionals occasionally responded to patients who spoke limited English, noting a lack of empathy toward those who supposedly "should speak English now that they are in the U.S." At times patients were humiliated or treated with a dismissive detachment. Fortunately, these attitudinal issues weren't common. But they were part of the catalysis for Connie, me, and others at UMass to create and continue on a shared mission to improve access and quality for our patients who lack English proficiency. Through the process, I've come to see that the need for more and better medical interpretation isn't just my problem. It's a much, much bigger problem.

A Dangerous Medical Practice

DATA TELL US THAT MEDICAL INTERPRETATION, in fact, is a large and very real problem for all of us in the U.S. health care system. A pilot study by the Joint Commission, published in 2007, found that when people with limited English proficiency experience an adverse medical event, they are three times more likely than English speakers are to have a serious outcome. A sizable

literature documents the poor experiences of U.S. patients who don't speak English: they have less access to care, fewer preventive services, lower patient satisfaction, longer hospital stays, and more unnecessary testing.

Most physicians and other clinical staff are acutely aware when there is a need for interpreting and use “just-in-time” interpreter services. When those services aren't available in a timely fashion, though, clinicians cut corners to keep pace with their schedules and competing demands. They rely on patients' knowledge of some English. They ask family members and friends, as well as untrained bilingual staff, to interpret. Yet the literature also shows that these kinds of ad hoc interpreters can create significant, unintended communication errors.

Alternatively, as I had been doing, with a well-meaning apology, they rely on their own language skills—even when those skills might not be sufficient to communicate accurately with patients—also risking misunderstandings and medical error. Patients, often grateful to receive care and embarrassed about their lack of English, acquiesce to a lower quality of care and risk misunderstanding their diagnoses and treatment. It's said that a medical history accounts for 70 percent of the data used to make a diagnosis. If so, taking dangerous language risks is akin to operating with a rusty scalpel.

Learning What It Feels Like

AFTER TAKING IN THESE FACTS—and hearing numerous stories from around the country about physicians making poor attempts to speak a hospitalized patient's language without using an interpreter—those of us in Speaking Together at UMass set about developing systems to qualify physicians who are able to (sufficiently) speak another language with patients. I offered to be the guinea pig and scheduled an oral test with a language assessment company.

On the morning of my test, I was more than a little anxious, becoming even more so as I dialed the testing center's number. *Perhaps*, I thought, *this is how Señora Aponte felt at the outset of our visit*. The plan was for at least half of the questions to focus on medical subject matter, but all of them turned out to be about current events, hobbies, the weather, and things like that. I was befuddled, had no command of this conversational vocabulary, and failed miserably. I felt embarrassed and humiliated. *Perhaps this is how Señora Aponte felt when she sought medical care even though she knew enough English to communicate at the factory where she worked*, I thought.

My second oral language test was content specific, with 70 percent of the questions pertaining to health and medicine. This time I felt more confident, but still there were significant misunderstandings. My grade: “Intermediate Plus.” With this slightly encouraging appraisal of my skills, I felt confident continuing my usual office practices. Until, that is, I read the details of the evaluation: “A candidate at this level will cause misunderstandings between himself and the listener based on lack of ability to convey clearly his message.” Ouch. Guilty as charged.

Do these results mean that I should never speak with a patient in Spanish and lose my language “privileges”? Probably not. After all, I do understand quite a bit of Spanish, and I can communicate some medical information accurately. What the testing did was to raise my awareness of my limitations. Rather than winging it when I get stuck, I now request assistance from a professional interpreter.

What’s Needed Next

AN OUTCOME OF THE SPEAKING TOGETHER COLLABORATIVE is the newfound clarity that this nation is long overdue for robust policy changes to meet the linguistic demands of our increasingly diverse patient population. In looking at results of Speaking Together—and my experiences in it—I believe that several national policy approaches would be steps in the right direction.

First, we need more clinicians with specific language proficiencies to care directly for America’s limited-English-proficiency population. Pipeline policies should aim to increase the number of bilingual and bicultural clinicians in the physician workforce. Health profession schools need to offer—perhaps even require—language courses to increase the number of language-proficient clinicians.

Second, we need to ensure that excellent, trained medical interpreters are always available. More institutions of higher learning should develop credentialed degree programs and certifications that require the high level of skill and professionalism needed for effective medical interpreting and translating. Currently there is tremendous variation in the length and intensity of training for interpreters and translators. Moreover, there are a variety of interpretation techniques, including telephonic interpretation, videoconferencing, and simultaneous interpretation using headsets, and each method requires a different skill set.

Third, public and private insurers need to improve and extend reimbursements to cover the full, real cost of what have become essential interpreting services. Otherwise, the supply of professional interpreters and translators will never meet the demand. Even among the ten high-performing hospitals participating in Speaking Together, slightly fewer than half of the patients who asked for health care in a language other than English were provided with a professional interpreter or a qualified bilingual clinician. The Centers for Medicare and Medicaid Services has created mechanisms for reimbursing interpreting services through the Medicaid system, yet few states use them to provide funds for medical interpreting. It’s unclear why.

Fourth, health care institutions must extend their programs in patient safety and quality to include language services. If we consider medical interpreting to be a necessary tool for accurate diagnosis, treatment, and patient education, how can we, in this era of patient safety, continue to tolerate the well-documented language errors and omissions that exist?

What I Learned From Señora Aponte

NOW BACK TO THE REMAINDER of Señora Aponte’s office visit. Knowing that I was out of my linguistic depth, I asked one of our bilingual, bicultural medical assistants to interpret. I soon discovered why tears had come to her eyes when I asked about how she came to the United States.

Flooding in Honduras from Hurricane Mitch had drowned her brother and left her family with practically nothing, she told us. In desperation, she and a friend had decided to use their limited funds to travel to Guatemala, and from there to hop the “Train of Death” (*Tren de la Muerte*) to the United States. Central Americans hoping for a better life in the United States often use this method of stalking and hopping freight trains in the night along the Guatemala-Mexico border, bound for the United States. It’s incredibly dangerous, as the name implies. People risk robbery, rape, and murder by gangs who troll the wooded areas where the illegal travelers hide out along the tracks. They also risk accidental injury or death while hopping on or off moving trains and attempting to cling to their tops and sides. Train hopping-related accidents occur frequently enough that a program in Guatemala was created specifically to rehabilitate amputees. In fact, Señora Aponte and her friend felt blessed, she said, to have completed the journey safely.

After arriving in the United States, Señora Aponte told us, she had worked in California for three years as a migrant farm worker. Eventually she came to Massachusetts to live with a cousin. She had taken English classes in California and learned enough to apply for and obtain a job here in a textile factory. There she met and fell in love with her boyfriend. Between their two jobs, she and her boyfriend managed to live modestly, although they both lacked health insurance. Señora Aponte had come to the health center because she’d heard that the care was free and that the staff could communicate in Spanish.

Señora Aponte went on to have a normal pregnancy and an intense but uneventful delivery. She had a professional interpreter by her side during her labor and delivery. By hearing her life history, I learned a great deal about her; I know much about the source of her continued anxiety and insomnia.

Statistics show that Señora Aponte had an equal chance of experiencing the fear and confusion faced by patients who don’t have a bilingual clinician or an interpreter. She was one of the lucky ones—even though it took me *and* an interpreter. I am a better doctor to her and her child because I heard her story.

Ours is a health care system that has witnessed many impressive technological advances during the years, and all of us involved in it yearn to improve quality and patient safety. For us to get beyond yearning, accurate medical interpreting is basic. The United States must address this *ahora*—and that means now.

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