

Health Affairs

At the Intersection of Health, Health Care and Policy

Cite this article as:
Alice Chen
Doctoring Across The Language Divide
Health Affairs, 25, no.3 (2006):808-813

doi: 10.1377/hlthaff.25.3.808

The online version of this article, along with updated information and services, is available at:

<http://content.healthaffairs.org/content/25/3/808.full.html>

For Reprints, Links & Permissions:

http://healthaffairs.org/1340_reprints.php

E-mail Alerts : <http://content.healthaffairs.org/subscriptions/etoc.dtl>

To Subscribe: <http://content.healthaffairs.org/subscriptions/online.shtml>

Health Affairs is published monthly by Project HOPE at 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133. Copyright © 2006 by Project HOPE - The People-to-People Health Foundation. As provided by United States copyright law (Title 17, U.S. Code), no part of *Health Affairs* may be reproduced, displayed, or transmitted in any form or by any means, electronic or mechanical, including photocopying or by information storage or retrieval systems, without prior written permission from the Publisher. All rights reserved.

Not for commercial use or unauthorized distribution

Doctoring Across The Language Divide

Trained medical interpreters can be the key to communication between physicians and patients.

BY ALICE CHEN

PREFACE: It's fortuitous that "patients" and "patience" are pronounced the same. Their link as homophones continually reminds us that physicians' communicating with their patients—and the patience it involves—is essential to good doctoring. When one factors in different languages and different cultures, communicating becomes an even more layered process requiring additional patience—and perseverance. California physician Alice Chen speaks three languages; nonetheless, she found herself one language short with a patient who spoke only Arabic. As Chen details in her essay, the only communication with her patient that she could trust was provided by a trained medical interpreter; she finds it inexplicable that despite the growing need for this important specialized service and its proven effectiveness, the need for trained medical interpreters is often swept under the carpet by policymakers. Then, too, although people from two different cultures ostensibly speak the same language, it doesn't mean that they truly understand one another. In his essay, physician-professor Jack Coulehan looks back on a summer almost forty years ago when he and his wife worked on a public health project in Jamaica—and realizes that with time and patience, he has finally understood what was said to him.

THE FIRST TIME I MET Mrs. Haddad, I was running late. She was sitting on the exam room's metal folding chair, covered head to toe in the black hijab worn by some Muslim women. Her face was exposed but expressionless and didn't change when I walked into the room. A man seated beside her stood up immediately.

Because most of my patients don't speak much English, my usual routine is to walk into the room, introduce myself, and ask what language the patient speaks. In addition to English, I speak Mandarin and Spanish, but as often as not, I leave to find an interpreter. Fortunately, this community health center has professional interpreters who speak Cantonese, Korean, Toisanese, and Vietnamese, as well as bilingual staff members who have been trained to serve as medical interpreters for Cambodian, Lao, Mien, and Tagalog.

"Hi, I'm Dr. Chen. I'm sorry to have kept you waiting. What language do you speak?" Mrs. Haddad said nothing. The man—her husband, as it turned out—answered instead, "She speaks Arabic. But I speak English." Mr. Haddad was slender with an open, animated face, wearing a dark blue T-shirt and dark pants and holding a cell phone.

Alice Chen (Achen@medsfgh.ucsf.edu) is the medical director of the General Medical Clinic at San Francisco General Hospital in San Francisco, California, and an assistant clinical professor of medicine at the University of California, San Francisco. She was at Asian Health Services, a community health center in Oakland, California, when these events took place. The names of the patient and her husband have been changed, as have some details.

I looked at Mrs. Haddad. She looked at me, silent. I looked back at her husband. He launched into the reasons his wife was here to see me: “She has leg pains and stomach problems. She recently had breast surgery.” She was still looking at me, without expectation. None of the clinic staff spoke Arabic. With no other interpreter available, I sat down reluctantly, pen in hand.

“How long have you had these symptoms?” I glanced at Mrs. Haddad. She looked down, and Mr. Haddad began to describe his wife’s aches and pains. I tried to multitask: noting her birth date (she was forty-nine); listening to her husband and nodding; thumbing through her chart for something that could anchor the litany of problems swirling around me; and, out of the corner of my eye, keeping an eye on my patient. She watched us stoically. This went on for a few minutes. I began to feel inundated as I registered lab results (normal blood counts, normal chemistries, normal thyroid) and x-ray reports (all normal) while trying to focus on what Mr. Haddad was saying.

Then I stopped. I didn’t have any sense of who Mrs. Haddad was; I wasn’t able to hear her intonation, watch her facial expressions, or read her body language. All I had so far was a long list of symptoms filtered through her husband.

I turned to him and asked, “Can we start over?” He looked surprised. I took a deep breath. “Because I can’t speak Arabic, I need you to be my voice and my ears. I need you to say everything I say, exactly the way I say it. I need you to tell me exactly what your wife says, exactly as she says it. If you want to add something, or have an opinion, that’s great, but I need you to let me know that it’s your opinion, not your wife’s. OK?” He looked dubious. “Sure.”

Mr. Haddad proved to be a fair interpreter. I spoke in short, simple sentences, and, generally, he interpreted rather than answered for his wife. I was able to begin focusing more on my patient, and I soon realized she seemed unhappy. We discussed her symptoms, when they started, what made them better, what made them worse, and what treatments she had received before. We talked about her surgeries and her medications. I commented, “You seem sad.” Her husband responded, “She has a lot of stress.” I asked him to interpret my words to her. Mrs. Haddad nodded slightly, then tears started rolling down her face. Her husband explained tersely that their whole family was under a lot of stress because their son was being harassed by U.S. authorities. I handed her a tissue.

She wiped away her tears, and we moved on to other subjects. I recommended some changes in her diet and sent her for some blood tests. After she left, I felt uneasy, wondering if I had missed something important because I wasn’t comfortable asking sensitive questions with her husband serving as our interpreter. What if she was crying because her husband or someone else was abusing her, or what if she was feeling suicidal?

A month later, when Mrs. Haddad came for follow-up, her husband again served as our interpreter. With some prompting and occasional redirecting, we again fell into a rhythm: talk, pause, interpret, pause. He stopped me once to ask,

“What does ‘irritated’ mean?” I had thought I was doing a good job by avoiding specialized medical terminology but had forgotten that English was his second language. “It means upset, feels bad.”

While examining her, I looked carefully for signs of bruises, asked casually about any episodes of trauma. I found out that she was from Yemen; had been in the United States for about six years; spoke and understood almost no English; had four children and five grandchildren; lived in a household of fourteen people; and spent her days cooking, cleaning, and looking after her extended family. With these facts I felt I had a quick sketch of Mrs. Haddad, but no real understanding of her as a person or how her neck, shoulder, back, hip, and knee pain related to her activities or stressors or her expectations of medical care. Her interaction with her husband seemed reasonable, and her labs were reassuring except for a mild anemia, but I still felt troubled. I sent her for more blood tests and some x-rays.

I also looked into how we could get a trained medical interpreter for our visits. Mrs. Haddad was insured through a Medicaid health plan that has a simple process to request and obtain an in-person interpreter for medical visits. This was, indeed, fortunate. Although all Medicaid managed care plans across the country are required by federal regulation to provide language-assistance services for enrollees who speak limited English, many have not yet developed this service. Some have created daunting administrative hurdles to accessing interpreters, while others provide only telephone interpreters, which requires a clinician to have a telephone—and, ideally, a high-quality speakerphone—in the exam room.

Suddenly, Seamless Communication

AT MRS. HADDAD’S NEXT APPOINTMENT we had a professional female interpreter with us. One of Mrs. Haddad’s sons had brought her to the appointment, but once he found out we had an interpreter, he was happy to stay in the waiting room. I started off by reviewing Mrs. Haddad’s symptoms, then gingerly edged toward asking about the source of her stress and about her relationship with her husband. Thanks to our interpreter, our exchanges were quick and seamless. Her spontaneous smile—the first I had seen—and immediate shake of her head when asked about problems with her husband were all the answer I needed. Although I still had all her aches and pains to deal with, I didn’t have to worry about domestic violence, too.

From there I developed a fuller understanding of my patient. She made a face as she related why she hadn’t gotten the hip x-ray I had ordered to assess for arthritis: The x-ray technician was a man, and he had wanted to lift up her hijab so that he could properly position the equipment. (I referred her to a different facility with a notation that she needed a female technician.) In discussing her anemia and recommendations for further evaluation, I discovered that she was still having heavy monthly periods. Although she didn’t know her exact age, working backward

from the age of her oldest child, we calculated that she was roughly thirty-nine years old, not forty-nine as her official birth date suggested. I relaxed a bit; at her age, a mild iron-deficiency anemia was likely due to heavy periods and less likely due to colon cancer.

She told me about how several months before, the police had broken down her door. One of them had thrown her to the ground and held her down with his foot on her back; she had experienced nagging back pain ever since. She said that a policeman had put a gun to her son's head and that the family van had been impounded. She cried about how her son had been accused of financing terrorism because he owned a currency exchange, a common business practice in immigrant communities. Her exam unremarkable, I was able to reassure her that she didn't have any permanent physical damage from her encounter with the police.

At the end of that visit, along with a prescription for iron supplements, I gave her the telephone number of a legal advocacy organization. She clasped my hands in thanks. I, in turn, thanked our interpreter, who had helped us connect, at least for now, across the no-man's land between English and Arabic. And I silently thanked Mrs. Haddad's health plan.

Needed: Trained Medical Interpreters

ACCORDING TO THE MOST RECENT U.S. CENSUS, the number of limited-English speakers in the country increased by 50 percent during the past decade, with one in five residents in my home state of California considered limited-English speakers. This burgeoning linguistic diversity has been accompanied by a number of policy initiatives addressing language barriers in health care settings. For example, in 2001 the federal government issued national standards for Culturally and Linguistically Appropriate Services in health care (CLAS standards), which served as a catalyst for many organizations to develop or refine their interpreter services. Unfortunately, for the most part, these national standards have been treated as voluntary guidelines without the force of law.

Depending on a facility's number of limited-English-speaking patients and organizational resources, it might not be feasible—or necessary—to hire trained medical interpreters for a given language. At the same time, too many hospitals, clinics, and health plans leave it to the individual clinician and patient to muddle through with an untrained interpreter or to try to make do with English. Neither of these options should be acceptable to clinicians or their patients.

Communication between a clinician and a patient is always a delicate transaction. Even in the best of circumstances, with both being native English speakers and with a well-educated, well-informed patient, the opportunities for miscommunication are plentiful—and the consequences potentially profound. Add in differences in language and culture, lack of acculturation, and sometimes low literacy, and it's a wonder that we connect at all.

In the ideal world, we would have bilingual, bicultural clinicians who could communicate with their patients directly without the assistance of a third party. But truly bilingual clinicians who understand the nuances of more than one culture are few and far between. No one can speak all the languages needed in our increasingly polyglot society; my clinic, for instance, had professional interpreters and bilingual staff members for ten languages—not one of which was the right one for Mrs. Haddad. Even if we began to require second-language fluency as a prerequisite to medical school admission, it would take years for this to affect clinical care, and we would still be lacking numerous languages. So we are left with relying on a third person to help us communicate: an interpreter.

Trying to communicate through an untrained interpreter is like playing the children's game of telephone: Start with a sentence, pass it along a chain of people, and laugh when it emerges altered and garbled at the end of the chain. Except in a clinic situation with an untrained interpreter, you are left wondering whether what you asked was what the patient heard. And that's not funny.

Study after study has shown that untrained interpreters in medical settings—such as husbands, friends, secretaries, and janitors who have some bilingual skills and happen to be available—are reliably unreliable. They typically lack fluency in English, the linguistic skills to convert from one language into the other, and knowledge of the medical terminology that's needed to provide an accurate and complete interpretation. They might have their own agendas or opinions and, in the worst cases, might intentionally cover up their own abuse of the patient.

Children used as interpreters are a special problem. Although their English might be accentless, their command of their parents' native language is often shaky, their vocabulary is usually sparse, and their understanding of medical concepts tends to be simplistic at best. They often feel a tremendous burden of responsibility, even guilt, for the information they convey, and just as often parents

“Our professional interpreter was arguably a better diagnostic test than all the labs and x-rays I had ordered.”

can be embarrassed or reluctant to disclose important symptoms and details to their child. And there can be far-reaching consequences. One of my patients never finished high school because, as a child, when her baby sister was chronically ill, her parents routinely pulled her out of school to interpret for them.

..... Bilingual medical staff members, such as medical assistants, are a better alternative; however, few organizations actually test their staff members' bilingual fluency in medical terminology, let alone their interpreting skills. Anyone who can speak a second language knows that it is one thing to be able to speak in the second language, another to be able to interpret into that language, and yet still another to be able to interpret from that language into English. In addition to quality assurance, asking bilingual staff members to serve as interpreters requires that organizations

explicitly acknowledge and structure this responsibility. Otherwise, such staff members are likely to resent and avoid interpreting as a burden that distracts from their primary obligations.

Clearly there are many challenges. There are an estimated 311 languages spoken in the United States. The health care workforce is diversifying, but at a glacial pace. Few clinicians have training or experience working with trained medical interpreters. Telephone interpreter services, such as the prototypical AT&T Language Line, are increasing, but they can be prohibitively costly depending on how often they are used and the languages involved, and they are frustratingly inadequate when difficult cultural or interpersonal issues arise.

The U.S. Department of Health and Human Services' Office for Civil Rights has the authority to enforce federal requirements mandating medical interpreter services. However, it suffers from chronic underfunding and understaffing and, in recent years, has been additionally tasked with the enormous responsibility of enforcing the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

On the policy front, there have been legislative attempts to ban the use of children as medical interpreters, as well as laws passed in New Jersey and California mandating that cultural competency (including issues of language access) be part of continuing medical education for physicians. Although important, these efforts sidestep the central question: Who pays for trained medical interpreters? The federal government has indicated that medical interpreters are an allowable covered service under fee-for-service Medicaid, but each state has to decide whether to pay for this service; so far, only eight states exercise this option. Outside the Medicaid arena, the issue has been a hot potato, with insurers, health plans, hospitals, and physicians each looking to the others to devise a solution.

We need increased support for using trained medical interpreters, through either centralized, direct reimbursement for medical interpretation (similar to how our federal judiciary pays for qualified courtroom interpreters) or increased payment to providers that care for patients with language barriers. Another model would be to establish a national system of telephone interpreters, similar to the one operated by the Australian government, which provides interpreting services for medical practitioners throughout the country—twenty-four hours a day, seven days a week, in one hundred languages—for the cost of a local phone call.

For Mrs. Haddad, just as the legal advocacy organization's telephone number might have been more therapeutic than all the various antidepressants and pain medications we had tried, our professional interpreter was arguably a better diagnostic test than all the labs and x-rays I had ordered during the preceding months. Caring for patients who speak limited English can be a challenge for both linguistic and cultural reasons; using a trained medical interpreter is the right medicine.

.....
A portion of this essay was written with support from the Medicine as a Profession initiative at the Open Society Institute.