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Lost in Translation: Exploring the Impact of Language Barriers on Healthcare

Dania Saltagi

Abstract: As the United States becomes more diverse in its immigrant population, it is also increasing in the number of people with limited English proficiency. Many of these individuals seek medical care, but are often met with challenges due to linguistic discrepancies. I use my experience as an Arabic interpreter, as well as my grandmother's experience as a nonfluent patient in America's healthcare system, to discuss the importance of evaluating how language barriers can have an effect on the quality of healthcare for these patients.

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When I signed up to volunteer at a local health clinic as a clinical assistant, I did not anticipate that my bilingualism in Arabic and English would be of any use. Up until that point, I had not contemplated the experience that non-English speakers go through while navigating the healthcare system in the United States. America's cultural and linguistic diversity is increasing parallel to the number of immigrants entering the United States. With this influx of immigrants comes a growing number of limited English-proficient (LEP) patients, who are establishing care within the current healthcare system. According to the United States Census Bureau, about 21% of those residing in America 5 years of age and older speak a language other than English at home.¹ These LEP patients are in need of translators to help maneuver the complex nature of the United States' healthcare system. As an Arabic speaker, my role at the clinic quickly transitioned to an Arabic interpreter as the number of Arabic-speaking LEP patients progressively increased. The number of people with limited English proficiency continues to increase in the United States, and there is a need to address the extent of care these patients receive. Language barriers provide a unique, and often overlooked, challenge to provider-patient relationships. Addressing issues regarding interpretation services is essential to improving care among this growing patient population.

The appropriate use of professional interpreters is essential to ensuring exceptional patient communication with a healthcare provider. Trained interpreters help limit the number of interpretation errors and reduce the risk of medical complications. Therefore, properly trained interpreters are preferred over untrained, or ad hoc, interpreters. Ad hoc interpreters include "bilingual employees, patients' relatives or friends, and untrained volunteer interpreters."² Use of ad hoc interpreters has been shown to often compromise patient safety due to interpretation errors. Among these errors are "omissions, embellishments, false fluency, use of false cognates, paraphrasing, and giving opinions."³ As a volunteer at the clinic who had not been officially trained in translation services, I would be considered an ad hoc interpreter. Speaking from my own experience, it was

challenging to avoid paraphrasing while interpreting for patients, posing a risk of misinformation. I tried to avoid interpretation mistakes by downloading an Arabic medical dictionary app that provided me with direct translations, and by encouraging patients to speak as much English as possible to the provider and address me only when needed. In contrast to my experience as an ad hoc interpreter, a professional interpreter will have the skill set to avoid these errors, improving the quality of care for LEP patients.

Although providing interpretation services is an essential component to ensure LEP patients receive adequate care, several limitations exist. Diagnostic errors due to loss of information is one of the more severe consequences. In order to accurately diagnose a patient's symptoms, a provider needs to gather information for a complete patient history. However, the accuracy and thoroughness of the patient history is compromised when the patient cannot directly speak to the provider. This is especially detrimental when paraphrasing is used, since a precise description may be needed to aid in a correct diagnosis. Furthermore, many of the same symptoms can be attributed to multiple health conditions. For example, the description of the type of chest pain a patient is experiencing is often what helps the provider make the correct diagnosis. Tearing chest pain may be associated with a thoracic aortic dissection; sharp stabbing chest pain may be associated with acute pericarditis or a musculoskeletal abnormality; and burning chest pain may be associated with gastroesophageal reflux disease.⁴ Frighteningly, a heart attack could potentially manifest with any of these types of chest pain,⁴ further exemplifying why an accurate diagnosis is essential. These conditions are managed very differently; therefore, it is extremely important that a healthcare provider be able to take an accurate patient history in order to facilitate the development of an appropriate treatment plan. In addition, there are often words and phrases that are specific to certain languages. As someone who is fluent in Arabic, I have found that there are phrases and words in Arabic that have no English equivalent. A study that looked specifically at Arabic speakers' perspectives of interpreters found that having an interpreter

who spoke a different dialect of Arabic or had different political views compromised the interpreter's ability to properly translate.⁵ Therefore, even though access to adequate professional interpreters is imperative, they can still pose threats to the care of LEP patients.

Similarly, a provider and patient communicating via an interpreter lose an important part of the interaction: non-verbal communication. Non-verbal communication, such as gestures and body language, is important for diagnosing certain medical conditions as well as building a relationship with the patient. Furthermore, there are certain body cues exhibited by patients that can help a provider discern what the problem is. For example, a patient presenting with a rash around the mouth has many potential causes of the perioral rash, but "constant lip licking by the patient" can be helpful in diagnosing perioral dermatitis.⁶ Likewise, a patient presenting with chief complaint of a chronic cough can be more easily diagnosed with chronic obstructive pulmonary disease, especially emphysema, if the provider notices pursed lips due to difficulty breathing.⁴ With an interpreter in the room, the provider and patient may put their attention more on the interpreter than on each other, leading to missed body signs.⁴ Additionally, the provider may not be able to connect with the patient as easily due to decreased opportunities to use friendly or comforting gestures.

Likewise, language barriers between the provider and the patient result in reduced initial and follow up office visits, underuse of medical services, and lower adherence to medications.⁷ Moreover, LEP patients often delay in seeking care, as well as seek care less often than their English proficient counterparts. For example, a systemic review was performed examining whether a correlation existed between utilization of psychiatric care and limited language proficiency. Of the eighteen studies evaluated in this literature search, fifteen reported that language barriers led to decreased use of psychiatric services.⁷ In addition, a survey conducted in California evaluating medical comprehension found that limited English proficient respondents were more likely than their English-proficient counterparts to "report problems understanding a medical situation, trouble understanding labels, and bad medication reactions."⁸ My grandmother, who is fluent in Arabic and speaks little English, recently underwent two surgeries in the United States. The first was a coronary angioplasty in her heart with an Arabic-speaking physician, and the second was an eye surgery correcting her cataracts with a non-Arabic speaking ophthalmologist. I asked whether she felt there was a difference in her experience as a patient due to language barriers acting as an obstacle. She replied,

With my stent with the cardiology doctor who spoke Arabic, I felt that I was more comfortable despite it being an invasive procedure because I felt that I was able to understand the physician completely. In contrast, the eye doctor did not speak Arabic so I felt less clear

about the procedure, although I did trust he would do a good job because he was friendly. However, not speaking the same language led me to ask fewer questions...I had less comprehension of what he would do and the risks and benefits of the surgery (N. Saltagi, oral communication, October 2016).

This encounter demonstrates that underutilization of care and compromised patient education can lead to increased adverse outcomes for an LEP patient.

In addition to language disparities, it is important that cultural differences be addressed for LEP patients. Providing professional interpretation services is not enough when considering cross-cultural medical care. Improved patient satisfaction and care result from providers who are culturally competent. Cultural competence is defined as "having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities."⁹ By improving cultural understanding, risk of misdiagnosis and medical errors are decreased. It is therefore important that providers have an open mind and take into account the ethnic disparities in health and wellness. Depending on ethnic background, patients have differences in how they interpret symptoms, when they choose to visit a provider about these symptoms, and how they deal with illness. This is especially true in the context of pain. The perception of pain varies from culture to culture.⁴ In addition, different ethnic groups deal with illness in different ways. Traditional Asian medicine is an example of this. The belief in Yin and Yang is an important part of clinical medicine in Asian culture, and is often viewed as the forces of hot and cold in the body maintaining internal balance. Furthermore, Asian Americans often utilize the practices of coining and cupping at home. These techniques are similar to acupuncture and result in skin changes that resemble bruises,¹⁰ which can be mistaken as abuse. It is essential that providers are trained to understand the cultures of the patients they serve to avoid misjudgments.

In conclusion, the expansion of LEP patients necessitates evaluation of the access and quality of care provided to these patients. Ensuring access to professional interpretation services, as well as recognizing the consequences language barriers have on the quality of care for LEP patients is instrumental in increasing the quality of their healthcare. By acknowledging that LEP patients are often disadvantaged in healthcare, perhaps solutions and recommendations can be made to decrease the prevalence of negative outcomes, leading to a healthier America.

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References

1. Bureau USC. Language use in the United States. <https://www.census.gov/prod/2010pubs/acs-12.pdf>. Published 2010. Accessed September 20, 2016.
2. Bischoff A, Hudelson P. Access to healthcare interpreter services: where are we and where do we need to go? *Int J Environ Res Public Health*. 2010;7(7):2838-2844. doi:10.3390/ijerph7072838.
3. VanderWielen LM, Enurah AS, Rho HY, et al. Medical interpreters. *Acad Med*. 2014;89(10):1324-1327. doi:10.1097/ACM.0000000000000296.
4. Papadakis MA, McPhee J. S, Rabow W. M. Current Medical Diagnosis & Treatment 2016. Lange; 2016.
5. Hadziabdic E, Hjelm K. Arabic-speaking migrants' experiences of the use of interpreters in healthcare: a qualitative explorative study. *Int J Equity Health*. 2014;13(1):49. doi:10.1186/1475-9276-13-49.
6. Wolz MM. Language barriers: challenges to quality healthcare. *Int J Dermatol*. 2015;54(2):248-250. doi:10.1111/ijd.12663.
7. Ohtani A, Suzuki T, Takeuchi H, Uchida H. Language barriers and access to psychiatric care: a systematic review. *Psychiatr Serv*. 2015;(July 2014):1-8. doi:10.1176/appi.ps.201400351.
8. Wilson E, Chen AH, Grumbach K, Wang F, Fernandez A. Effects of limited English proficiency and physician language on health care comprehension. *J Gen Intern Med*. 2005;20(9):800-806. doi:10.1111/j.1525-1497.2005.0174.x.
9. Kalichman SC1, Kelly JA, Hunter TL, Murphy DA TR. Culturally tailored HIV-AIDS risk-reduction messages targeted to African-American urban women: impact on risk sensitization and risk reduction. *J Consult Clin Psychol*. 1993;2:291-295.
10. Ngo-Metzger Q, Massagli MP, Clarridge BR, et al. Linguistic and cultural barriers to care. *J Gen Intern Med*. 2003;18(1):44-52. doi:10.1046/j.1525-1497.2003.20205.x.