

Virtual Mentor

American Medical Association Journal of Ethics
August 2007, Volume 9, Number 8: 566-571.

Medicine and Society

Language Barriers and the Patient Encounter

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If they haven't already, many young physicians are likely to confront a reality that their mentors and teachers have not prepared them for: patients who cannot understand them. Research tells us that communication failures between patients and their caregivers contribute to adverse events and medical errors. Linguistic diversity within the United States today is far greater than in the whole of Europe [1]. Rapid growth of the population with limited English proficiency (LEP) is emerging as a new risk that few doctors are prepared to handle.

Communication challenges when patients and doctors do not speak the same language is not surprising, but, according to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the skills required to comprehend typical health information exceed the abilities of the average American [2]. Like the canary in the coal shaft warning miners of impending danger, patients with limited English proficiency may be the harbinger of challenges that go beyond language differences. This article takes the perspective that learning how to effectively communicate with patients when there are language differences may offer insights and skills transferable to communicating with English-speaking patients.

Speaking to patients through interpreters while actively considering inherent cultural factors offers a model to increase awareness of potential communication breakdowns with all patients. This is one of the essential lessons we've learned at *Hablamos Juntos* (Spanish for "We Speak Together"), the Robert Wood Johnson Foundation (RWJF)-funded initiative to develop affordable solutions for eliminating language barriers in health care. Since 2001 the national program office of *Hablamos Juntos* has tracked the literature on interpretation and translation and created an open dialogue with national experts, practicing interpreters, and translators with a shared interest in developing best practices.

Ten demonstration projects funded under *Hablamos Juntos* gave us an opportunity to explore solutions and gain an understanding of the challenges health care professionals face in providing high-quality, safe care to patients with limited English proficiency [3]. While focused on Spanish speakers with limited English, we came to the same conclusion as the JCAHO report—communication breakdowns occur even when patients and doctors speak the same language. The RWJF project has come to view every health care encounter as a cross-cultural encounter; the

culture and language gap between patients and their doctors is growing wider with every innovation in medical care and health reimbursement policy.

Language Barriers Influence Every Patient-Physician Encounter

As we listened to how the role of the interpreter was conceptualized, observed interpreter-mediated speech, and, in particular, studied translated text from English into Spanish we identified three factors inherent in language-discordant communication: (1) language and culture are inextricably linked; (2) relationship building is hindered with interpreter-mediated communication; and (3) cultural competency and effective communication are interdependent. Understanding how these factors affect communication with patients whose proficiency in English is limited can raise awareness of potential failures in communication with all patients.

Ninety million English-speaking Americans have trouble understanding complex texts common in health care [3]. Among those unable to comprehend typical health information were college graduates and professionals such as teachers and engineers. Beyond reading and writing skills, health literacy includes listening, speaking, and conceptual knowledge that make it possible to understand health interactions, forms, and instructions. In essence, health care environments have cultures of their own, ways of doing things, and uses of language that are different than what average persons experience in their day to day lives.

Rarely are physicians asked to think about how patients discern meaning from the information they receive during a visit. Language professionals tell us that words have no meaning until meaning is assigned; that is, as we learn new words we associate them with concepts that give them meaning. Comprehension, then, is based on our ability to link experience and knowledge of the world to the words we hear.

Scenes-and-Frames Semantics

Scenes-and-frames semantics is a theoretical model for understanding how we comprehend written words. In this model, words are “frames” that activate mental pictures or “scenes” related to past experiences and knowledge of the world. In order for comprehension to take place “frames” must activate proper “scenes.” In essence, words acquire meaning through context activation associated with particular “scenes.”

Generally, the mental maps we form of frames and scenes (words and associated concepts and meaning) are culturally determined—acquired formally through education, dictionaries, and thesauruses and informally through our lived experiences with family, friends and coworkers, and other socializing events such as movies, news reports, etc. Common experiences lead to common “frames of reference.” Speaking a language other than English in the U.S. obviously means that one’s lived experiences are likely to be quite different than those of English speakers. The greater the difference between our lived experiences and those of others, the more likely our frames of reference will be different. Therein lies the potential for misunderstanding.

In daily communication, minor misunderstandings are common. A simple command “Put it down” can be laced with ambiguity. Place it down on the table or drop it on the floor? Next to the phone or near the window? Our mental maps of word-concept associations help us draw conclusions about what is meant. The context in which the command is heard, the speaker, and our previous experience all help inform what is meant in a specific time and place. What is the likelihood that the scenes and frames used by American doctors are the same as the average English-speaking person’s? For example, the newly diagnosed diabetes patient may encounter familiar words such as blood, sugar, diet, and exercise but in a context that may be unfamiliar and possibly confusing. Not surprisingly, the idea that one can catch diabetes from someone else or that people with diabetes can’t eat sweets or chocolate are common myths.

If simple explanations can cause doubt, imagine what can happen when we consider that a typical health dictionary contains about 40,000-45,000 entries. Moreover, completely unrelated confounders such as reimbursement practices, local and national policies, economic trends, and technology—all of which influence how health care is organized and how medical care is delivered from city to city and state to state—can infuse unintended meaning. The nature of local institutions and relationships plays a pivotal role in determining the character of each community’s health care system. Without intending to do so, the cultures or referral patterns concerning who can be seen by which doctors also create a web of context that patients experience and must navigate. We have found that patients who have limited English proficiency are often victims of confusion introduced by local referral patterns. Being told they cannot be seen can lead to poor compliance or a belief that nothing can be done. In the end, language discordance is but one of many obstacles to good communication with patients.

Relationship-Building via Interpreters

Clear communication between caregivers and patients is essential to safe, high quality health care services. Developing rapport and gaining patient trust relies on understanding. When patient and doctor do not speak the same language, there is less opportunity to develop rapport or use “small talk” to obtain a comprehensive patient history, learn relevant clinical information, or increase emotional engagement in treatment. Rather than solving these problems the introduction of an interpreter may raise another set of questions.

Unfortunately, most interpreters learn their trade through on-the-job training. Their language proficiency and how accurately intended meaning is conveyed from one party to the other is often not known. Using untrained interpreters or family members who are less skilled in being transparent and impartial can result in incomplete patient assessments. How are subtle nonverbal communication cues (e.g., emphasis, alarm, urgency, or emotions such as empathy or concern) conveyed from one speaker to the other? The skills of an interpreter are critical—they are the sender and receiver of our message and the patient’s. Interpreter-mediated communication

brings attention to how normal communication is altered and how the connection and trust important to an effective patient-physician relationship may be more difficult to develop.

How then can we know when an interpreter-mediated communication has been effective? Training in working with interpreters and experience using interpreters can help. Speaking indirectly to patients requires active listening and engagement. Intermittent pauses, necessary to allow the interpreter to convey our message, can be opportunities to pay attention to facial expressions, gestures, or body language of the patient and to create new ways to maintain a connection and cultivate a relationship with the patient.

Uncertainty about what is being said or whether two-way understanding is taking place provide opportunities to explore doubts. Considering these obstacles can increase awareness of how we are connecting or not connecting with a patient, whether we are developing trust or not. Active engagement can make interpreter-mediated encounters more productive, while humanizing our ability to communicate with all patients, irrespective of language.

Cultural Competency and Communication Go Hand-in-Hand

Graduate medical education now includes content on culturally determined aspects of patient care—different disease explanatory models, ways of interacting with health care professionals, communication style, whether patients make eye contact or not, and differences in decision-making styles and in understanding of disease and health. Moreover, beliefs, attitudes, intentions, and behaviors toward health care—all derived from a patient's culture—factor into the patient-physician relationship. Modesty, refusal to eat certain foods, and observance of religious rituals are examples of cultural factors that must be negotiated in clinical encounters. At the same time, variability from one group to another and within groups can be stunning, particularly as we consider acculturation, education, and other factors that serve to broaden a person's world view.

Less attention has been paid to how the clinician's background influences the way he or she diagnoses disease and treats the patient [4]. And even less recognition has been given to how the culture of medicine determines interactions or how the culture of health care organizations influences what patients understand and how they experience care.

Too often we learn of life-and-death dramas in local newspapers—reminders of the potential affects of communication failure on patients with limited English proficiency: the young Savannah mother of two, unable to speak English, who died after being treated for a possible stomach infection in the emergency department and told to leave [5]; or the 41-year-old native of Haiti who died of tuberculosis after giving birth to a son, [6] never mentioning her coughing fits during regular visits to her obstetrician during pregnancy. These cases bring attention to the extreme outcomes, but, while language and cultural differences are markers for variability

that require attention, they can serve as reminders of the importance of effective communication in all clinical encounters. And the lessons should not stop there.

When 90 million American have trouble understanding and acting on health information, effective communication between patients and their doctors is a problem even when language is not a barrier [7]. Physicians need to understand that the health world is a foreign country to many Americans and pay closer attention to understanding the language patients use and how they draw meaning from what they hear. Interpreter-mediated encounters, as difficult as these may be, offer lessons for active listening and culturally aware communication—not just listening to what patients are saying but looking for what they may mean. In cross-cultural communication words alone are often insufficient. Looking and listening, making a human connection, even when the languages we speak are different, will go along way to understanding what patients need to comprehend the important advice physicians have to offer.

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