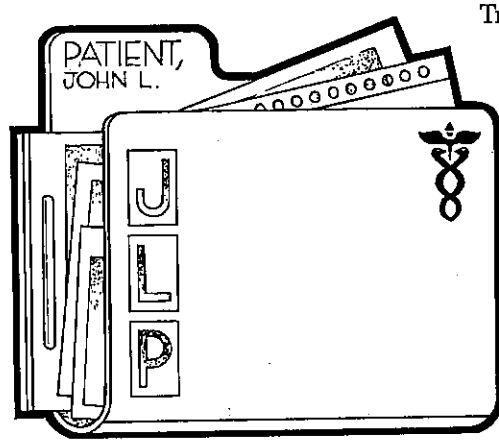
North DeKalb (GA) Health Centers

The changing demographics of our communities are significantly affecting the provision of health care services. For example, in DeKalb County, Georgia, the total population grew 13% from 1980 to 1990; however, the refugee and immigrant population more than tripled during that same period and actually accounted for 40% of the county's growth (Georgia Department of Human Resources, 1994). Since 1990 the influx of new residents has continued to radically change the mix of cultures, races and ethnic groups in DeKalb. The most striking example is the Doraville-Buford Highway Corridor area where as many as 105 different cultural and linguistic groups may be represented.

With so many cultures, languages, and dialects, how can health care be provided effectively? Most institutions and agencies are ill-equipped to respond effectively to the growing need for medical interpretation services. Furthermore, the question must be asked, what is considered adequate and appropriate medical interpretation in the clinical setting?



Being unfamiliar with the nuances of language and culture, one may naively assume that interpretation is simply the "swapping" of a word in one language for the same word in the other language. Anyone who has taken just one high school-level course in any foreign language knows that it is not that simple. Language is the manifestation of people's expression of the richness and variety of their culture.

Each individual's language is influenced by a multitude of cultural factors including educational level, belief systems, laws, values, scientific assumptions, and socio-economic class. What would be your personal comfort level in telling a non-English speaking health care provider your symptoms utilizing an interpreter? That interpreter becomes not just a language translator but a personal culture broker for you during the encounter. Isn't it the responsibility of the interpreter to not only convey the correct meaning of what you say to the provider, but also to ensure that the provider understands your beliefs about your illness?

Individuals and cultures have many unique terms for describing illness and hold many different perspectives regarding the cause of illness (Kleinman, 1980). Consider the Hmong refugee who presents in the clinical interview with what he calls "a difficult liver." A literal interpretation may lead the health care provider to suspect cirrhosis. Further questioning and description of the cultural context of this perspective would reveal that the patient is probably experiencing loss of sleep, poor appetite, perhaps excessive worrying, crying or confusion. This may be due to loss of family or status, or may be symptomatic of his being dislocated from his homeland. Nothing about his particular illness has to do with the bio-medical concept of liver functioning, yet the patient's description of his illness is based on cultural references that connect social disruptions to "the liver" (Walker, Hall, & Hurst, 1990, pp 1056-1065).

Western bio-medicine tends to negate the importance of other life factors or the diverse psychological, social and interpersonal components of illness that are recognized and treated in other cultures (Walker, et al., 1990).

Traditional home healing practices that have been utilized by some cultures for hundreds or thousands of years are still employed today. A high percentage of refugee and immigrant patients seen in public health facilities have already tried some home healing method(s) before coming to the clinic.

The Khmer peoples of Cambodia often attribute sickness to a "bad wind" which implies an internal bodily shift to an imbalanced state. Traditional home healing practices may prescribe the consumption of "hot" or "cold" foods to restore balance. These foods themselves generally are not hot or cold in temperature, but rather have been assigned energizing (hot) or calming (cold) attributes. Other healing practices may dictate such behaviors as providing food to Buddhist monks or performing acts of kindness to elders (Frye, 1995). Prior to visiting a clinic, most Khmer peoples will have performed some home healing behavior.

The medical interpreter must provide culturally appropriate explanations of the patient's beliefs and practices in order to bridge the cultural gap for the provider. Yet, this too is controversial in the medical setting. Like the patient and the provider, medical interpreters bring to the encounter their own set of values, beliefs, biases and cultural norms. Additionally, interpreters usually live within the community in which they work and often may know the patient or his/her family. The patient may be reluctant to reveal certain information with the interpreter present. Likewise, the interpreter may know information that the patient has not volunteered that could dramatically affect diagnosis and treatment (Putsch, 1985).

Issues of trust cannot be over-emphasized. In most encounters where an interpreter is needed, neither the patient nor the provider is aware of exactly what has been said by the other. Only the interpreter holds the knowledge of what both parties have attempted to communicate. This places the interpreter in a position of considerable power. As the sole possessor of both the patient's and the provider's words, feelings, etc., the interpreter is in a position to manipulate not only the information, but also the clinical situation (Putsch, 1985).

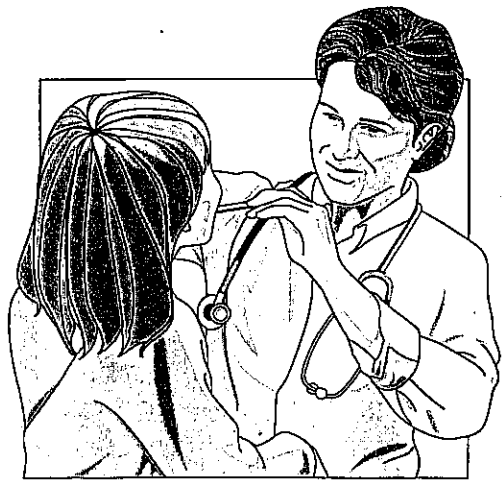
Dr. Robert W. Putsch, III, M.D., the national guru for medical interpretation, notes that emotions behind a statement often can completely alter basic meaning or intent. The actual meaning of words account for a small portion of the message that is communicated. Nonverbal messages including body language, voice inflection, facial expressions and cadence convey far greater meaning than the words themselves.

Try the phrase, "You don't understand." How many ways can you say it? Say it as though you're angry, or sad, or joking. Doesn't your facial expression or posture convey a lot of meaning? Could you trust someone from another culture to interpret the message you wish to convey with this phrase through simply repeating the words?

Historical experiences can also affect the level of trust patients ascribe to the clinic situation. Many immigrants and refugees have little experience with seeking Western bio-medical care. In some Southeast Asian cultures, one only goes to a clinic as a last resort, often only when the patient is close to death. Naturally the historical experience of the culture in trusting health care providers is diminished when patients have seldom regained their health from these services.

Unreported experience can also impinge upon the medical encounter. Often times only through working very closely with the interpreter can the provider salvage a medical encounter that is going awry. A Russian refugee had a history of testing positive on PPD skin tests for tuberculosis. The health care provider suggested that she schedule the patient and other family members who also had a history of positive tests for chest x-rays. The patient adamantly refused and was about the leave the clinic frustrated and angry. Only through quick intervention by the interpreter was it determined that the patient was fearful of having x-rays performed. This was due to his belief that he and his family had been exposed to excessive radiation. Further questioning revealed that their home in Russia had been located approximately 50 miles from Chernobyl. Working with the interpreter, the provider was able to further evaluate the patients for active tuberculosis and determine that the x-rays were not necessary at that time.

Providing preventive health care presents other unique challenges in that many cultures have no historical experience in seeking health care prior to illness. For example, in attempting to explain to a Vietnamese mother that a nurse would come to her home to provide a well-baby check on her newborn, it became apparent that there was no literal Vietnamese translation for "outreach worker." Furthermore, the mother could not understand why a health care provider would need to examine her baby who she perceived as perfectly healthy. The medical interpreter functioning as a cultural broker was able to help the mother begin to understand Western bio-medical preventive health care practices.



Since many societies and cultures around the globe do not subscribe to Western bio-medicine, there often does not exist a literal word-for-word translation of a specific medical term. Just as our Vietnamese mother didn't have a vocabulary equivalent for "outreach worker," many more technical English terms either have no equivalent or are terms unfamiliar to the patient. Even in mainstream U.S. culture patients are frequently confronted with explanations of illness in "doctorese," a slang term for medical terminology not familiar to the general public. Now, complicate this situation by introducing an interpreter whose command of the English language may be limited as well.

Obviously, misinterpretation or misrepresentation of information could be harmful to patients. When the traditional patient-provider relationship is built on communication, understanding and trust, how can a provider be assured that the interpreter is communicating the interaction effectively (Woloshin, Bickell, Schwartz, Gany & Welch, 1995)?

In Georgia, no governmental body has set standards or policy for medical interpretation. Training in medical interpreter services is difficult to procure. Historically the Georgia State Division of Public Health, Office of Rural Health and Primary Care has offered episodic medical interpreter training. This training was provided through a contractual arrangement with the Cross Cultural Health Care Program of Pacific Medical Center in Seattle, Washington.

Cynthia E. Roat is the editor of the training manual entitled, Bridging the Gap: A Basic Training for Medical Interpreter for Multilingual Groups which has been used by trainers in Georgia. In the manual she proposes a code of ethics for interpreters of health care. This code encompasses 12 basic tenets of professional behavior for interpreters. These include confidentiality of all information exchanged in the medical encounter; accuracy in conveying the content and spirit of the communication; completeness in conveying everything that is said; conveying cultural frameworks appropriately; presenting a non-judgmental attitude; allowing for the self-determination of patients; conveying an impartial and respectful attitude towards patients and providers; acceptance of interpreter assignments only when no perceived

conflict of interest exists; and accepting compensation for services only from the employing agency. Additionally, interpreters are charged to represent their training and experience accurately; always withdraw from an encounter when they perceive a violation of ethics; and always present themselves in appropriate manner and dress for the situation (Roat, 1996, pp. 30-31).

The process of attempting to establish official codes of practice, policies, and laws for medical interpretation plays a significant part in defining the relationship between patients, providers and interpreters (Kaufert & Putsch, 1997). Currently many health care institutions are seeking to standardize or centralize interpreter services, develop agency-wide guidelines, and upgrade or expand services. Inevitably these decisions will also determine how agencies and institutions are perceived by the community. Customer service and being customer friendly take on new and exciting dimensions in multicultural settings.

Interpreter services are no longer just options in health care; they are necessities. Recent rulings by the U.S. Department of Health and Human Services Office for Civil Rights on the Civil Rights Act of 1964 require that Federally funded programs provide all patients with equal access to services. This includes language access. The responsibility for providing access is on the provider or agency, not the recipient of service (Rockwell, 1993).

A great many health care professionals are monolingual and therefore must depend upon others to facilitate the medical encounter with their linguistically diverse patients. This fairly pervasive monolingualism presents a significant challenge. Using family and friends to provide interpreter services is inefficient and often inappropriate. Even those staff with bilingual skills seldom have a complete bi-cultural perspective and rarely have specialized training in interpreting. Medical interpreter services are a rapidly growing need with few formal training programs. The opportunity for institutions of TESOL programs to take the lead in this area is obvious. In the meantime, health care providers are challenged to provide quality services with limited medical interpretation resources.

References

Frye, B.A. (1995). Use of cultural themes in promoting health among Southeast Asian refugees. *American Journal of Health Promotion,* 9;4, 269-280.

Georgia Department of Human Resources, Division of Public Health (1994). *Access to health care by limited English proficient populations in Georgia.* ATLANTA: author

Kaufert, J.M., & Putsch, R.W. (1997) Communication through interpreters in health care: Ethical dilemmas arising from differences in class, culture, language and power. *Journal of Clinical Ethics*, 8, 71-87.

Kleinman A. (1980). *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine and psychiatry.* Berkley: University of California Press.

Putsch, R.W. (1985). Cross-cultural communication: The special case of interpreters in health care. *Journal of the American Medical Association*, 254, 3345.

Roat, C.E. (Ed.) (1996). *Bridging the gap: A basic training for medical interpreters for multilingual groups.* (Ver. 2). Seattle: Cross Cultural Health Care Program. [Originally published by the U.S. Public Health Service, Region 10, Seattle, 1995.]

Rockwell, C.P. (1993). *Letter of information.* Seattle: The Office for Civil Rights, Region 10, U.S. Department of Health and Human Services.

Walker, H.K., Hall, W.D., & Hurst, J.W. (Eds.) (1990). *Clinical methods* (3rd Ed.) Boston: Butterworths, 1056-1065.

Woloshin, S., Bickell, N.A., Schwartz, L.M., Gany, F., & Welch, H.G. (1995). Language barriers in medicine in the United States. *Journal of the American Medical Association*, 273, 724- 728.