Journal of Patient Experience
2020, Vol. 7(6) 830-832

DOI: 10.1177/2374373520942398
journals.sagepub.com/home/jpx
SAGE

Language and Cultural Discordance: Barriers to Improved Patient Care and Understanding

Derek Soled, MSc[1]

Abstract

Providing optimal health care to patients whose first language is not English remains a major challenge. Medical students, residents, and attendings receive limited cultural competency training, but these short sporadic training courses are not nearly enough to give physicians the proper resources or preparation to understand all their patients' beliefs. Medical interpreters can fill this gap and strengthen health care for these already marginalized communities. It is important to reconceptualize medical interpreters as true collaborators in medicine who can provide valuable insights that extend beyond language interpretation at the bedside. Physicians would benefit from the insights of these professionals who can function as both language and cultural interpreters who know these patient communities well. Improved communication between physicians and interpreters would not violate traditional physician–patient boundaries but would instead strengthen this relationship to provide the best possible care.

Keywords

clinician–patient relationship, communication, culture/diversity, interprofessional communication, relationships in health care, team communication, caregiving, community engagement

As a first-year medical student, we experience immersion sessions, one of which is shadowing a language interpreter. Mine, a middle-aged fellow named Roy*, was a Haitian immigrant, fluent in Haitian Creole and English, who resided in the Boston suburb Roxbury—home to one of the largest number of Haitian immigrants. The following encounter was one of my earliest exposures to the challenges that physicians and patients may face when a language barrier exists, even in the presence of a medical interpreter.

"Doulé," the patient muttered, her shaky and fragile finger pointing to her lumbar region. While the words were directed toward the primary care physician seated in front of her, they were intended for the gentleman sitting beside her.

"Pain," the Haitian Creole interpreter uttered, "All throughout her back and legs."

The patient never removed her solemn and fearful eyes—underlined by dark bags—from the physician 40 years her junior. And her lips, laced with pink lipstick protruding from her near black skin, quivered uncontrollably. The physician, at a loss of words and unable to make sense of the pain after inconclusive lab tests and scans, continued to stare blankly at her notes. Ultimately, the physician raised the patient's daily ibuprofen dosage and instructed the patient to follow-up next month.

After our patient meeting, I asked Roy what he made of the patient's back pain. Nonchalantly, Roy proclaimed, "The hysterectomy." It is true that the patient had a hysterectomy several years ago, but there was no reason that it should be related to the back pain. Roy continued to explain that the patient apparently thought her hysterectomy was unnatural, and the pain she was now experiencing was God's retribution. He said this was a common phenomenon in his immigrant community, in which hysterectomies are viewed as unnatural and subsequent nonlocalized pain is generally cast as an act of God.

I was shocked: Roy had just presented a compelling explanation for the patient's behavior. As defined by medical anthropologist Arthur Kleinman, a patient's explanatory model reveals how people make sense of their illness (1). Not everyone subscribes to Western biomedicine. By eliciting the patient's explanatory model, the physician learns more about

[1] Harvard Medical School, Boston, MA, USA

Corresponding Author:
Derek Soled, Harvard Medical School, 25 Shattuck St, Boston, MA 02115, USA.
Email: derek_soled@hms.harvard.edu

the patient's beliefs about his or her illness, accompanying personal and social attachments to the disease, expectations about care and treatment, and goals for future therapy. Comparing the models of both physician and patient allow for identification of major differences that may lead to challenges in clinical management, as well as appropriate patient education and clarification.

"Why didn't you tell the physician about this?" I asked, as it is imperative to make explicit both the physician and patient explanatory models and negotiate any discrepancies. He said that in his role, he is not supposed to propose ideas related to the medical diagnosis, nor is he allowed to serve as an advocate for the patient or his/her beliefs.

I continued to ask Roy more about his immigrant community in Roxbury and what physicians might not know about the Haitian community. He told me that Haitians are reluctant to use social services available to them compared to Latinos and other Caribbean Islanders. He based this observation on his own experiences and those of his neighbor, who serves as a social worker in a different Boston hospital. Shame and history were major preventive factors: In the 1980s, the Centers for Disease Control and Prevention listed Haitians as a primary group as risk for AIDS, and when Congress passed an immigration law that permitted many Central Americans to obtain legal immigration status, Haitians were excluded (2). While this is no longer the case, this history—along with the November 2017 decision to end a program that granted almost 60,000 temporary visas to Haitian immigrants after the 2010 earthquake (3)—has led to a deep fear of deportation as well as dissuaded many Haitian immigrants from seeking and receiving health services.

Roy also informed me that immigrants from different regions in Haiti have different levels of trust in the medical profession. While Haitians of all education levels feel that religion plays a large role in their health ("God's way of paying back"), regional differences trigger some to harbor greater wariness of a doctor's guidance. Moreover, Roy explained how particular medical tests simply do not work with Haitian immigrants. For instance, there are cognitive neurology tests that use animal images to assess mental ability. Since the wildlife is different on the island of Hispaniola, and since Haiti is one of the most poorly educated nations in the world, it is common for immigrant children to not know what a rhinoceros or ape is. These individuals might be inappropriately labeled as cognitively impaired or slow.

An example of how culture might influence health-care delivery in the Haitian immigrant community is in regard to pap smears. Currently, there are many older Haitian female immigrants who have never had a pap smear. Past research has indicated this is because of a lack of access (4). However, Roy explained how in all the major Haitian immigrant communities around Boston (including Roxbury, Dorchester, and Cambridge), there are multiple free clinics that give pap smears, suggesting that it is not an access or structural problem. Rather, the problem stems from the failure of many Haitians to utilize social and medical services, possibly because of fear of deportation, shame, or distrust of the medical community.

Currently, medical students receive limited "cultural competency" training. At the most basic level, they learn that cultural factors can influence behavior and decision-making (5). As their education progresses, hospitals often require training in cultural competency for all staff, including physicians, who deal with patients. But can someone truly become culturally competent after one or more sporadic and short training courses? It would be as though learning Le Chatelier's principle is enough to understand all of chemistry. Providing additional cultural competency training may also push physicians to succumb to stereotypes and make assumptions about patient beliefs based on their backgrounds and nationalities. More training is therefore not necessarily the answer.

Even when language is not a barrier, patients and physicians may have different cultures and backgrounds that may prevent mutual understanding. Patients often choose which information to disclosure to physicians, which can limit optimal medical care. Nonetheless, there is evidence that these issues are more pronounced in ethnic minority patient populations who face language barriers, discrimination, differing values, and acculturation (6).

My conversation with Roy proved to be an eye-opening wakeup call. "Pure" language interpretation omits salient cultural aspects that may be important for physicians to know in order to provide the best care to the patient. Language interpretation is not a proxy for cultural understanding; there might be improved physician–patient communication, but not necessarily a better connection. If physicians do not understand their patient's culture—which often times they do not, especially if the patients are first-generation immigrants, regardless of whether they are fluent in English—then the scope of the interpreter should be augmented and he or she should be able to serve as a cultural broker as well. Ideally, the interpreters should be people who live with the given population, enabling them to provide a deeper and more nuanced perspective regarding patients and their beliefs and concerns.

The idea of interpreters as cultural insiders is not new, as other have proposed increased roles for interpreters to augment patient care and experiences (7). Even so, medical interpreters continue to be scarce, so additional requirements for cultural immersion could pose further obstacles to access and utilization (8,9). Further, interpreters can sometimes be too overbearing and function as co-diagnosticians and history-takers (10,11). This begs the question, what is their proper role?

Some researchers have suggested creating different categories of interpreters with different levels and types of training (12,13). In reality, such a drastic measure might be unnecessary and impractical. What may be described as an interpreter being too dominating in one patient encounter may be perfectly involved in another. Indeed, the "ideal" role will vary, and interpreters must be flexible. Moving forward, it is important to reconceptualize interpreters as collaborators in medicine and be treated as such. After all, physicians and

interpreters have the same ultimate end goal: to provide the best patient care. Just as there has been an increased push toward increasing physician and nurse communication (14), there should be a similar movement for improving communication between physicians and interpreters. Examples of what this may look like include encouraging physicians to join interpreter-specific lectures and classes and including interpreters on medical rounds and asking, when appropriate, for their input. Increased dialogue outside of single-patient encounters will improve future collaboration and dialogue.

Improving health-care delivery to immigrant groups remains a major challenge. To do so, health professionals must better understand each group's unique culture. This should not be the job of physicians alone, however, as it is impossible to be omniscient with respect to every culture. Rather, physicians would benefit from the insights of interpreters like Roy who, with their familiarity and sensitivities, know these communities best. Such increased responsibility would not violate traditional physician–patient boundaries; if anything, it would help strengthen this bond. This is a small step forwards to delivering stronger health care to one of the most marginalized populations.

Authors' Note

* = The language interpreter's real name has been changed to preserve anonymity.

Acknowledgments

The author would like to thank Dr. David S. Jones, the A. Bernard Ackerman Professor of the Culture of Medicine at Harvard Medical School, for his mentorship and guidance.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

ORCID iD

Derek Soled, MSc https://orcid.org/0000-0002-2714-2581

References

1. Kleinman A. Concepts and a model for the comparison of medical systems as cultural systems. Soc Sci Med. 1978;12:85-95.
2. Farmer P. "Aids and Accusation: Haiti and the Geography of Blame." [PhD Dissertation.] Harvard University; 1990.
3. Trotta D. Haitians in US malign Trump decision to send them back home. Reuters. 2017. https://www.reuters.com/article/us-usa-immigration-haiti/haitians-in-u-s-malign-trump-decision-to-send-them-back-home-idUSKBN1DM0AR.
4. Green EH, Freund KM, Posner MA, David MM. Pap smear rates among Haitian immigrant women in eastern Massachusetts. Public Health Rep. 2005;120:133-9.
5. Association of American Medical Colleges. Cultural Competence Education. Association of American Medical Colleges; 2005. https://www.aamc.org/download/54344/data/tacct_pdf.pdf.
6. Rocque R, Leanza Y. A systematic review of patients' experiences in communicating with primary care physicians: intercultural encounters and a balance between vulnerability and integrity. PLoS One. 2015;10:e0139577.
7. Hsieh E, Kramer EM. Medical interpreters as tools: dangers and challenges in the utilitarian approach to interpreters' roles and functions. Patient Educ Counsel. 2012;89:158-62.
8. Schwei RJ, Edl Pozo S, Agger-Gupta N, Alvarado-Little W, Ann B, Alice HC, et al. Changes in research on language barriers in health care since 2003: a cross-sectional review study. Int J Nurs Stud. 2016;54:36-44.
9. Ahmed S, Lee S, Shommu NS, Rumana N, Turin TC. Experiences of communication barriers between physicians and immigrant patients: a systematic review and thematic synthesis. Patient Exp J. 2017;4:122-140.
10. Hsieh E. Interpreters as co-diagnosticians: overlapping roles and services between providers and interpreters. Soc Sci Med. 2007;64:924-37.
11. Bolden GA. Toward understanding practices of medical interpreting: interpreters' involvement in history taking. Discourse Studies. 2000;2:387-419.
12. Hsieh E. Understanding medical interpreters: reconceptualizing bilingual health communication. Health Comm. 2009;20:177-86.
13. Dysart-Gale D. Clinicians and medical interpreters: negotiating culturally appropriate care for patients with limited English ability. Family Community Health. 2007;30:237-46.
14. Tan TC, Zhou H, Kelly M. Nurse–physician communication—an integrated review. J Clin Nurs. 2017;26:3974-89.

Author Biography

Derek Soled is a third-year MD/MBA candidate at Harvard Medical School and Harvard Business School. He has a Master of Science in medical anthropology. As a future clinician, Derek is interested in designing innovative ways to optimize healthcare delivery within marginalized communities.