

MEDICAL INTERPRETERS:
BRIDGING LANGUAGE BARRIERS AS CULTURAL ADVOCATES

By

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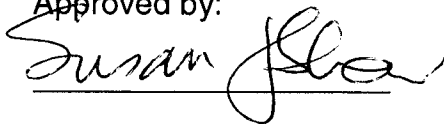
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Approved by:

A handwritten signature in black ink, appearing to read "Susan Shaw", written over a horizontal line.

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Bridging Language Barriers as Cultural Advocates

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Abstract: In this thesis I take an anthropological approach to examining the doctor-patient relationship and how barriers to this relationship, such as language or cultural differences, effect medical treatment. This literature review analyzes questions such as: What are the roles of medical interpreters, how can medical interpreters act as advocates for the patients, and how do they affect the trust in the doctor-patient relationship? I examine the impacts on trust of cultural differences, language barriers, and use of Medical Interpreters within the doctor-patient relationship. By better understanding the doctor-patient relationship from an anthropological perspective, I will answer questions that show how doctors and patients can establish trust, overcome language barriers, and have higher cultural competency. These answers will aid in closing the gaps between doctors and patients and renew a stronger- trusting relationship. The use of Medical Interpreters is the key to improving the relationship and overall health of limited English speaking patients.

Introduction

The relationship between a patient and doctor is perhaps one of the most important relationships an individual will establish in his or her lifetime. Patients see many different types of doctors under various circumstances. There are doctors a patient may see once in an emergency room, and then never again. There are doctors a patient sees only for special care, and then there are primary doctors that may establish life long relationships with the patient. In all these circumstances the relationship between the patient and the doctor share two vital aspects: communication and trust.

Looking at the doctor-patient relationship is vital in analyzing the future of America's health care. With the growing population and high immigration rates predicted in the future, the relationship between doctor-patients will be changed not only with cultural barriers, but also language differences as well. In 2009 over 40 languages were spoken at home other than English, including 36million Spanish speakers, 2million Chinese speakers, 1million French speakers.¹ In Ortman's study, "The projections we produced show that the use of LOTE (Language Other Than English) is projected to increase over the next ten years... The population speaking Spanish, as well as the population speaking Portuguese, Russian, Hindi, Chinese, Vietnamese, Tagalog, and Arabic are projected to increase. Spanish is projected to remain the most commonly spoken non-English language (Ortman 2011, 12). Combing these statistics with the continuous high levels of immigration, America's future in the health realm needs to transition to adapt. The medical field will be

¹ <http://www.census.gov/prod/2011pubs/12statab/pop.pdf>

² Listserv emails exchanged through CLASTalk.com with JS.

facing new challenges serving the increasingly diverse population. The key to facing these diverse languages and establishing a successful doctor-patient relationship lies with a medical interpreter.

Medical Interpreters (MIs) are the most important link in the medical field between doctors and patients who do not share a language. MIs are perhaps the most underutilized resource, but also the most important in these years of immigration change. They are particularly vital in the success for the patient's optimal health outcomes, and also vital for the doctor's accurate prognosis when the patient is Limited English Proficient (LEP). Studies have shown how infrequently MIs are used and how negatively the doctor-patient relationship can be affected when trying to overcome language barriers without the proper use of a MI (Rundle 2002, Garrett 2008, Seidelman 2010).

My personal experiences have led me to this research with much passion and determination to improve health access and feasibility for LEP patients. My family emigrated from Mexico, and I am the first-generation born here in America. I took on the role as primary care taker of my grandmother at a very young age. She was a monolingual Spanish speaker with a long list of medical problems. Together we faced many challenges throughout her medical occurrences and amongst several different doctors. Never did we use medical interpreting services because I always accompanied her. At times, I was the only way doctors could communicate with my grandmother, and being in my late teens and early twenties these were very life-changing experiences. I did not truly understand how much my personal life was impacted by these experiences, until further reflection upon my grandmother's

passing. Her life throughout the medical system may have been improved with proper medical interpreting services, rather than my untrained medical interpreting abilities.

My personal experiences inspired me to research the use of medical interpreters. This literature review along with my own experiences will explore many aspects of medical interpreters (MIs), such as how MIs can be used as accurate aids, how they aid in establishing trust within the doctor-patient relationship, and how they act as cultural advocates. Within the role of MIs there are different aspects to analyze. First, the role of the MI is shown to improve the communication within the doctor-patient relationship. There are several aspects to this; not only does the interpreter bridge the language gap, but many aspects of language, such as eye-contact, mannerisms, personal space, and voice over-lapping, are all cultural aspects of language that the interpreter can help bridge as well. With these aspects better improved because of the MI, the doctor-patient relationship will be able to communicate more efficiently which leads to a higher patient satisfaction.

The low use of MIs by doctors and the negative results will be examined. There are issues of doctors 'just getting by', using untrained medical staff as interpreters, and a major misuse of family members as interpreters. There are many negative implications of not using proper interpreting services, such as low patient satisfaction, misdiagnosis, miscommunication on prescriptions, and overall more emergency visits than preventative care visits. The drawback with medical staff is that they have not been properly trained to interpret and may use incorrect vocabulary, mannerisms, and lack proper professionalism.

The issue with using a family member as an interpreter is perhaps the most common alternative doctors practice when MIs are not used. This sets up difficult situations for the doctor, patient, and the family member. Although it may be comforting for the patient to have a family member present, other cases lead to confidentiality issues. There is also added pressure on the family member; he or she would not only be emotionally involved, but also responsible for all medical knowledge shared. This does not set up a proper situation for the doctor either because he or she would have no way of knowing whether or not interpretation was occurring honestly and accurately.

In discussing these different implications of lack of interpreting services, laws and standardization are analyzed as well. There are several different organizations striving for standardization within MI services, as well as the use of MI services by doctors. Policy barriers, civil rights, and usage of waivers are all factors pushing towards standardization of interpreting services within the medical community.

With higher usage of MI services in combination with more standardization, the increase in cultural competency is achievable. The Cultural Empowerment Model provided by Garrett et al. offers a holistic approach in bringing together MI services, cultural competency, and overall patient empowerment. Along with this, a study by Betancourt et al. shows how society can also improve the doctor-patient relationship, especially for LEP minorities. The study analyzes the health care workforce, the structural process of doctor-patient encounters, and how they believes society can reach cultural competency. Shaw's study is used to counter

Betancourt et al.'s idea of the importance of resemblance between doctor and patient, and shows how it would actually further racial gaps within minority groups. Braddock et al.'s study is also used to counter Betancourt et al.'s ideas of time within the structural process between doctor-patient encounters. Together these studies argue for a holistic approach to reaching cultural competency and improving the doctor-patient relationship.

This literature review strives to show how crucial medical interpreting services are within the doctor-patient relationship. MIs act as cultural advocates for the patients, and not only bridge language barriers, but also help direct patients to other medical services. MIs are the key to success in a time where language gaps are only increasing, and health access is only becoming more difficult. With an active role in the medical field medical interpreters will strengthen doctor-patient relationships, aid in great cultural competency, empower patients, and help LEP patients achieve ideal health access and success.

Looking At The Role

This section will discuss the several roles of the Medical Interpreter (MI), including their responsibilities, interactions, and importance in the medical field. The role of MI strengthens communication, bridges language barriers, and helps improve medical interactions and outcomes for the patients. It is important to use MIs as effectively and accurately as possible to ensure the best scenario for the patient and the doctor. The Massachusetts Medical Interpreters Association developed the first standards of medical interpreting. MMIA states that their interpreters receive on-going training in cross-cultural issues and learn how to meet

the needs of the patient population (Rundle et al.2002, 166). This shows that MIs are important for the ever-growing population of Limited English Proficient (LEP) patients. This section will discuss in detail the positive effects of using a MI, negative implication for the patient and doctor not using a MI, and how an MI is often substituted with family members.

Improving Communication To Improve Satisfaction And Outcomes

One of the vital roles of the MI is to improve communication between the doctor and the patient. However, before the communication even starts, the patient must understand the services of an MI. The patient needs to recognize that MIs are not only legally required, but that the doctors need them as much as the patient. Often patients feel that the language barrier is a burden, and perhaps that it is something the patient must just deal with. Explaining the purpose of the MI will help overcome the feeling of burden from the patient and allow for better communication with the doctor. Lakes et al. provides an example stating, “In previous LEP meetings, Mrs. Morales (An LEP patient from El Salvador) had not participated actively because an interpreter was not provided. Informing the parents that having an interpreter present was a right, not a favor, allowed them to advocate assertively for their needs” (Lakes et al. 2006, 388). Clarification and presentation of an MI is important so the patient understands and will trust in the MIs role. Reassuring the patients that the MI is present not only for him or her, but also for the doctor, will likely ease anxiety and lead to more open communication.

Graham et al.’s study found results that coincide with establishing strong communication using MIs. This study showed, “When language barriers are reduced

and health insurance coverage is the same, LEP patients show ambulatory health care utilization associated with lower cost and more access to preventive care through establishing a primary care home” (Graham et al. 2008, 207). Perhaps these patients had similar feelings as Mrs. Morales did in Lakes et al.’s study. Without the proper introduction or understanding of the role of MI, the patient is less likely to actively participate and be able to share his or her symptoms properly. This can lead to ineffective preventive care and ultimately lead to more emergency care as Graham et al.’s study showed.

Betancourt et al.’s study illustrates how communication can be linked to health outcomes. Betancourt et al.’s study found that, “Hispanic patients with language-discordant physicians are more likely to omit medication, miss office appointments, and visit the emergency room for care than those with Spanish-speaking physicians” (Betancourt et al. 2003, 297). With better communication the patient has higher satisfaction. With more satisfaction the patient is more willing to adhere to medical instruction. By better adherence the overall health outcome of the patient is highly improved (Betancourt et al. 2003, 297). To go hand in hand with this finding, Betancourt et al. also note, “Physicians who have access to trained interpreters report a significantly higher quality of patient-physician communication than physicians who use other methods, such as untrained staff or family members (Betancourt et al. 2003, 297). In this illustration, the links to the most optimal health outcome start directly with communication. This is where the MI role’s is most vital.

These two main points restate the importance of the first step of communication. The most optimal solution would be to use a trained MI to ensure strong and accurate communication between the doctor and patient. Important communication between the two is key to a strong beginning, but also creates a trusting bond between the patient and the MI. The MI can go beyond just interpreting, and aid the patient in other directions where language barriers exist. The MI can advocate for patients in situations where interpreting is key in familiarizing the patient to other services (Lakes et al. 2006, Garrett et al. 2008)

Interpreters As Advocates

Once communication is well established, the interpreter is now able to advocate for the patient and lead them towards more health care options. Some MIs would disagree with this, arguing instead that their role is to only facilitating communication. However, in Graham et al.'s study the interpreter was also able to further advise the patient to primary health care, financial help, and other services that would be offered, but otherwise unknown because of the language barriers. For example Graham et al.'s study showed,

In our system, interpreters act as advocates for patients, help clarify management and follow-up plans, notify patients of appointments, and assist patients to obtain financial counseling and social work services. Other studies also suggest that LEP patients with medically trained interpreters have improved outcomes consistent with less hospitalization, lower costs, and better chronic disease outcomes (Graham et al. 2008, 215).

This example shows that because the services of medical interpreters are used, the

patient is able to understand the health management system better. The patient may feel empowered by being able to plan and reach out to other services that will help with preventative care. This is a step in the right direction, because LEP patients often avoid medical services until emergency care, more costly situations, are unavoidable (Graham et al. 2008, 215).

Although there are many ways interpreters act as advocates, some argue that family members act as advocates as well. It is not accurate to assume that advocacy and interpreting are interchangeable. A family member may be better able to advocate for a patient because of close family ties, family history, and knowledge of medical ideals than a MI new to the patient's situation. However, the family member is most often not a medically trained interpreter where they are qualified to advocate and interpret in ways a professional MI could. Garrett et al. states, "Family and relatives facilitated engagement with the healthcare providers, advocated for patients, provided love, practical support and care. Many patients and staff elected to use relatives as the language facilitators rather than attempting to access the interpreter service" (Garrett et al. 2008, 486). Although this statement may be true, the importance of language translation is overlooked. The family member can still be present with the patient and act as an advocate, but a MI would only improve the situation. The MI would not only give proper interpreting services, but also act as another advocate for the patient. The more people involved, keeping the needs of the patient as the primary goal, will result in positive outcomes for all.

MIs Directing Communication And Roles

Rundle et al. explain that another important aspect of using MIs effectively is to distribute the power equally. The MI needs to respect the doctor's expertise by allowing him/her to direct the consultation. There is a fine line where the MI must learn to keep his/her personal beliefs to themselves, but also know when to aid in providing cultural insight. This is where the role of MI as 'Listener' and as 'Speaker' comes into play. Angelelli gives many examples of different scenarios where it is vital the MI understands their role. For example:

The doctor and the non-English speaking patient may not share the same sense of appropriateness of ways of speaking. If the patient is from a Spanish-speaking country, where total overlapping is the sociolinguistic rule during a conversation, and doctor is expecting turn taking, some tension may arise based on misunderstandings or misconceptions. MI as a third participant may sometimes try to be in control of the conversational traffic, adding an extra component to the tension. MI may also decide to educate the parties on this difference and another component is thus added (Angelelli 2004, 38-39).

This scenario shows many important factors. There are tension, cultural differences, language barriers, three parties, misunderstandings, and different power roles. The MI should take a role in educating the parties about cultural differences to avoid any misunderstandings, but also step back and allow for the doctor to perform his or her duties. It is also important that neither of them undermines the voice of the patient and that both respect his or her opinions. This

is a perfect example of how the MI may not only translate languages but also mediate cultural boundaries.

Doctors' Use Of Interpreters And Overcoming Barriers

To start, the training should begin during the first year in medical school, so that medical students better attain the skills and competency of using interpreters with limited English proficient (LEP) patients. Berekyei et al. performed a study following medical students starting in their first year and presented an experiential curriculum for them to follow teaching them skills and knowledge towards linguistic competency. This study showed that students who had completed the curriculum had increased confidence using MI services; they also become more comfortable with LEP patients. Berekyei et al. state, "With more students trained in linguistic competency, we can be more optimistic about meeting the demands of a growing LEP population" (Berekyei et al. 2010, s158).

The demands of the LEP population are indeed growing, and so are doctors' concerns regarding the availability of interpreters. Hornberger et al.'s survey of physicians showed that 52% gave negative feedback on availability of MIs. One physician stated, "Trained interpreters are excellent, helpful, and I enjoy working with them. However, they are slow to respond; they are overworked, and the interpreters services is understaffed" (Hornberger et al. 1997, 414). Others physicians stated that they used nursing staff, housekeepers or family members, as interpreters, or just made do without MI services. This studied showed how infrequently MI services are actually used. Approximately 21% of visits were with LEP patients. In these visits 20% of the interpreting was done by untrained staff,

36% by a family member, and 6% interpreting services were used either in person or by phone. The remaining percent the doctor spoke the patient's native language. Some physicians felt it was not the responsibility of the provider and would sometimes deliberately avoid situations with LEP patients (Hornberger et al. 1997, 415).

In other feedback from Hornberger et al.'s study, physicians noted that the cost of MI services was very expensive and that the government does not give them for free. This example shows how funding is another barrier doctors must overcome. Ponce et al. makes a very valid point stating:

Federal civil rights policy requires that most health care providers make interpretation services available to LEP patients. But the lack of reimbursement for language services has been a stumbling block, perhaps in private physicians offices particularly. The American Medical Association has strongly opposed allowing the burden of funding written and oral interpretation services for LEP patients to fall on physicians (Ponce et al. 2006, 74).

It seems that because of the high costs of MI services, doctors are avoiding seeing patients who would need these services, or if they do encounter a LEP patient they seek out untrained nursing staff, housekeepers, or family members when available. Physicians avoiding treatment of patients because of their LEP can be seen as discrimination. Even when they do see LEP patients, not providing them with proper interpreting services is a major cause for concern. This is where proper

funding and cultural competency create crucial steps toward closing the gap of language barriers.

Just as the MI has required guidelines to follow, the doctor is another important factor in this trio. The doctor must ensure the MI is used successfully. The doctor should not belittle the interpreter, but rather treat the MI as a part of the health care team. The doctor must trust the MI by respecting his/her expertise and allowing the MI to mediate the flow of the consultation. After all, the goal is to discuss the best possible health outcome for the patient and deliver the best possible care ensuring a strong and trusting doctor-patient relationship. Having the doctor, MI, and patient all involved is key to assuring the patient's full comprehension of his/her medical encounter (Rundle et al. 2002, 167).

There are many factors involving a successful consultation using MIs, but there is always room for improvement. MMIA shows continuous improvements and additions to their program to better meet the needs of the patient. Seidelman and Bachner state that the practice of medical interpreting is not without its flaws, but of all existing options it is the one consistently referred to as superior (Seidelman and Bachner 2010, 392). So with positive efforts and continuous improvements using a MI should always be considered the most successful option, especially in comparison to the common use of family members as interpreters.

Family Members Used As Interpreters

It is common for individuals to have fear or express anxiety when they must seek medical attention. There are fears of the unknown, preference of not knowing, or even the unfamiliarity of medical science. Many face intimidation and fear of

making life decisions, or making life changes. To experience this in a common spoken language is one scenario, however, it is further exacerbated for non-English speakers. Most often a non-English speaker will have fears and anxiety similar to those mentioned above, but also about receiving medical attention and facing language barriers. Family members usually accompany patients to help ease any negative feelings they may have whether or not they are English speakers (Angelelli 2004, 23).

If both the family member and the patient speak English the doctor can directly speak to the patient, in comparison to the scenario when the family member is with a non-English speaking patient. Here the family member may also take on not only the role of a supportive family member, but also the role of interpreter. Many studies show that it is common practice to use family members as interpreter because they have already accompanied the patient (Hornberger et al. 1997, 415, Seidelman et al. 2010, 391, Betancourt et al. 2003, 297). By doing so, many negative implications can be seen for the family member, the patient, and the relationship between the doctor and patient.

Impacts For The Patient

First, there are negative implications for the patient. They are being deprived of a medical necessity and requirement of receiving a MI. The benefits of a MI ensure processes and accuracy that a family member cannot guarantee unless formally trained as a MI. The patient warrants a fully trained MI to be there on their behalf and explain everything clearly and accurately. The patient would be more likely to trust in their doctor by having the MI present and supported as a member

of the health care team (Seidelman et al. 2010, 390; Angelelli 2004, 23). The patients may not be completely honest if a family member is present. For example, if they are having more serious symptoms or pain but choose to hold back from expressing these symptoms in order to avoid worrying the family member present. The patient may also experience confidentiality issues because of having the family member present.

Impacts For The Doctor

Secondly, there are negative implications for the doctor. The doctor would be relying on the family member to give accurate translation. There should not be the need to use a family member when a MI is available. This resource should be used regardless of cost, time, or other excuses that will be discussed further on. An accurate MI should not be a negotiable. The doctor would have no ability to identify any mistake the family member is translating, giving leeway to misdiagnosis. The doctor is also putting trust in the family member to be completely honest with the patient. For example, perhaps the family members take it upon themselves to not share information with the patient. Their motives may be to protect and avoid anxiety for the patient, or in rare occasions, ulterior motives to harm the patient. In either case, the doctor is placing his/her self at high risk for future difficulties in diagnosis and giving proper treatment (Seidelman et al. 2010, 391). Ultimately this may hinder the process of establishing a trusting doctor-patient relationship.

Impacts For The Family Member

Lastly, there are negative implications for the family member. This is often overlooked and there are few studies that show any research on the consequences

for these family members. There is added pressure for the family member to not only be supportive for the patient, but also to understand, translate, and hold all responsibility of interpreting the information from doctor to patient (Seidelman et al. 2010, 390). Medical interpretation is a specialized field that requires years of training and continuous updating, which even a fluent speaker would not be prepared to handle. In any event it is stressful to see a family member in need of medical attention, and to add a stressful factor of being his or her sole interpreter is an unfair request of anyone to have to endure. There are also added pressures to the family member of always having to be there for the patient. This adds stress to their work schedule, other family members at home, and other commitments.

Seidelman gives an excellent example of her personal experience with being the sole interpreter for her parents when they had to visit the hospital. She writes about having to leave work because she knew her parents had language barriers and would not feel comfortable without her (Seidelman et al. 2010, 487). This is a common feeling with other family members used as interpreters. Garrett et al. notes that most of the family interpreters in his studies were women (2008, 487). These women noted that they felt a burden in being required to be in attendance to ensure language facilitation and the safety of their relative (Seidelman et al. 2010, 487). Seidelman describes her feelings of being tired, stressed, and the added pressure of interpreting. She states how different the hospital setting and translation was in comparison to grocery shopping or bank encounters where she had translated for her parents before. She felt that she was the only option for her parents in receiving medical treatment because she was their translator.

Personal Experience

I found myself asking this same question, when thinking in retrospect of times at the doctors visits or hospital settings where I served as the interpreter for my grandmother, a monolingual Spanish speaking patient. Why was I allowed to be the translator? Especially since I was only between the ages of 18-23 during most of the visits. At the time, I felt as Seidelman did in being the only option for my grandmother, since my mother lived out of state. I left school and work at the drop of a hat whenever my grandmother needed medical attention. All I knew was that she was uncomfortable not being able to speak English and would only go if I accompanied her for that reason. Now after much research I realize how negatively this affected my grandmother and myself.

It seems now a reoccurring scene, that the doctors would ask their questions towards me, and more often than not I would answer without having to ask my grandmother the question. This could have been easily avoided if we had a MI present because they would not have made assumptions the way I may have done because I was family and my grandmother's caretaker. Never were we asked or spoken to about any MI services available nor confidentiality issues. This was an assumption made on behalf of the medical staff that had great negative impacts.

Seidelman et al.'s article also makes note of a patient not being honest with the physician in order to not worry the family member, and vice versa the family member not wanting to share all information with the patient to avoid fear and anxiety. I believe this may have also been the case with my grandmother. Of all five doctors: kidneys, lungs, regular physician, diabetes specialist, and podiatrist, not one

ever spoke to my grandmother without my presence. Perhaps if they had, my grandmother could have better explained her symptoms with a MI. Her mother, my great grandmother, passed away from heart disease, which my grandmother feared as well. Looking back, I believe she avoided saying these symptoms in front of me because she did not want to scare me or was afraid of how I would react. Although in retrospect things seem clearer, it is hard not to question that perhaps between five different doctors we saw on a monthly basis, they could have foreseen her heart attack and avoid a quadruple by-pass surgery if they used a MI and not a young granddaughter.

A recent study by Reynolds and Orellana provides a slightly different perspective on using family members, particularly children, as interpreters for their monolingual parents. I found many personal experiences tied into her findings. This is one example,

This seems to be the case even in medical spheres where hospitals are required by law to provide interpreter services; children are still called to interpret when no one else can. In a live, audio-recorded encounter, Sammy provided a nurse receptionist with his family's proof of insurance, social security information, and informed consent. Sammy knew all of the information by heart, a reflection of his accumulated expertise in navigating these encounters. When it came time to sign the paperwork, the nurse receptionist told him, "No, you don't sign. You're not old enough to sign anything" (Reynolds and Orellana 2009, 216).

In reading this, I remember countless times I encountered the exact same situation. I was able to call and make appointments on behalf of my grandmother, fill out all the paper work, but yet when it came to signing documentation, the medical staff needed to see my grandmother personally sign. I find this rather senseless because they are entrusting in a 'child' or 'young adult' to give them all the information such as insurance, address, medical history, etc, yet there was more importance placed on having a valid signature. We were never offered assistance in translating forms nor interpreting services. It is unfortunate that medical staffs would put more attention to ensuring the patient personally signed rather than ensuring the 'child' or 'young adult' provided valid medical information in the first place.

However, a main point Reynolds and Orellana make is that situations like this actually empower the child. Even at times when the child is left with no other option but to translate in the given situation, they learn from the experience and are further enabled because of it. They state, "They [young people] also enable things to happen in the world more than is often possible, given that young people are usually not authorized to participate in these activities because of their social status as children. Thus, Latino/a and Mexican immigrant child interpreters experienced the liberatory potential of borderland experiences as they forged new roles and identities for themselves" (Reynolds and Orellana 2009, 220). This statement is like a breath of fresh air. Always had I looked upon my experiences on behalf of my grandmother, but never understood how it was shaping me as a young adult. It is inspiring to think that my experiences as my grandmother's untrained interpreter would have such positive lasting affects on my life. I carry more confidence and

ever-lasting motivation to continue in aiding the situations surrounding the use of medical interpreters.

Because of this, it is important to continue this research for all LEP patients. This can start with setting standardization and implementing better policy to avoid situations where young people have no other option but to be the interpreter. It is important to understand the laws protecting minorities and LEP patients. Standardization within the interpreting services is a continuing work in progress. Each of these will be discussed further below.

Laws And Standardization

The lack of standardization within the interpreting services is a serious problem, but there is more involved when understanding the overall lack of medical interpreting being used for LEP patients. In 1964 Congress passed Title VI of the civil rights law that prohibits discrimination based on race, color, or national origin. This is meant to protect those who may be excluded from participation in activities receiving Federal financial assistance (National Health Law Program 2004, 7). These laws remain important with the ever-growing LEP population. Not only does Title VI protect people based on race and color, but language is apart of it as well. New immigrants are not required by law to speak English, nor does the United States have an official national language. Although some states may have English-Only laws, these do not over power the protection of federal law Title VI. Because of this, all are protected against language, race, color, and national origin discrimination.

With these laws enacted and the growing number of LEP speakers, medical

interpreting is becoming a necessity for all health care providers. A main concern for doctors is the financial burdens of using interpreting services. According to FamiliesUSA.org's information packet from the National Health Law Program, only 14 states receive federal funding for interpreting services. It further explains the problem by stating that, "Federal funding is only available for language services for Medicaid and CHIP enrollees (or to parents of Medicaid/CHIP enrolled children). It is also available for patients who receive Medicaid-covered emergency services. Health care providers who receive federal funds, however, must ensure language access for *all* of their patients, not just Medicaid and CHIP enrollees" (NHLP 2010, 7). This means that there is a distinction in existing federal funding and the need for services based on the patients enrollment insurance other than Medicaid. NHLP suggests that states could use funding to provide language services for other individuals. For example, once a state has established a language assistance program for its Medicaid and CHIP beneficiaries and invested the initial resources necessary to implement it (federal funding), the additional costs to expand the program to other LEP patients (non-Medicaid/Chip enrollees) would most likely be minimal (NHLP 2010, 7).

Funding is only given to the state if it is appropriated into the state agenda and expenditures. By doing so, the state enters into "federal matching funds" (NHLP 2010, 3). If the state can prepare itself by covering most of the costs for the patients on Medicaid and CHIP, then the expense of MI services for the patient not enrolled in Medicaid/CHIP would not be such a burden. Since many LEP patients are enrolled in Medicaid or CHIP already, this would further exemplify the importance, at the

state level, of asking for federal funding for these language services. Policy at the state level and asking for federal funding is more beneficial than focusing the responsibility on the doctor to require the interpreting service at his/her own cost, especially because their patients are insured in other ways than just Medicaid and CHIP (NHLP 2010, 7).

Aside from the problems with laws and policy, there is a more recent problem in standardization within medical interpreting itself. The Massachusetts Medical Interpreters Association (MMIA) is setting the stage in creating a standardization of practice for MIs. Angelelli states, "The MMIA has established standards of practice for medical interpreters to help decrease interpreting errors and to diminish behaviors that adversely affect the patient-provider relationship" (Angelelli 2004, 23). However she also states, " Even when interpreters are available, there is often little or no standardization in interpreter training, assessment of competence, or instruction of healthcare providers in how to use an interpreter (Angelelli 2004, 23). This coincides with the finding from Hornberger's research where many doctors seemed uninformed on how to attain interpreters, as well as believing untrained interpreters were adequate.

In the absence of national standards for MIs, states are on their own in addressing patients who decline MI services. The use of waivers has increased as quickly as the LEP population. The use of waivers is discussed here along with policy and standardization, because their use can have negative implications on the patient and overall communication between the doctor and patient can be weakened. The standardization is needed to prevent such from occurring. Here are

a few different scenarios taken from real situations throughout the US:

1. A Director for Diversity and Language Services from South Carolina states, “We do not offer waivers to our LEP patients... It is our position that effective, accurate two-way communication is our responsibility and in the best interest of both the caregiver and patient” (CLASTalk.comJS).²
2. An Interpreting Service Manager from California states, “Our Waivers are allowing family members to be the main interpreter by having the patient sign, but still allowing an interpreter on behalf of the doctor” (CLASTalk.comGG).³
3. A Director of Patient Relations in Connecticut states, “We do not use waivers - our staff document in the patient's medical record about the patient wanting to use their family member and our staff honor that but also inform the patient that we are going to use an interpreter for us. We utilize video interpretation as our primary interpretation method as we do not have paid interpreters” (CLASTalk.comLC).⁴
4. A Regional Manager from Ohio states, “A wide trend that I see is to discourage the use of waivers whenever possible as there is no way of evaluating the friend or family member level of proficiency, terminology or motives, but when a waiver is signed the provider and institution still has the right to keep an interpreter for them” (CLASTalk.comCB).⁵

² Listserv emails exchanged through CLASTalk.com with JS.

³ Listserv emails exchanged through CLASTalk.com with GG.

⁴ Listserv emails exchanged through CLASTalk.com with LC.

⁵ Listserv emails exchanged through CLASTalk.com with CB.

These four different examples show the wide variety and differences throughout the waiver dilemma. Accurate interpreting is a common goal between all examples, because it not only implies what is best for the patient, but also how doctors need the MI as much as the patient. The need for an MI is from both parties, and there seems to be few negative implications when both family member and a MI are present.

These examples are provided to show how wide spread the issue is, but also how individualized the issue can be made. Example 1 shows that the medical staff takes on the responsibility of accurate communication and does not allow for waivers at all. Examples 2 and 3 might seem as a compromise by allowing a family members to be the interpreter on behalf of the patient, but the waiver places the medical staff in a grey area because they have no way of measuring or insuring proper interpreting. Even though they 'may' use interpreters for their own doctors and benefits of communication, it involves more people than necessary and more interpreting that could take up valuable time. There may be more time spent just interpreting with two different interpreters, rather than information actually being shared amongst doctor and patient. By doctors caring and showing genuine interest in being able to best service their LEP patients, they would be more culturally competent and also realize the importance of MIs.

Increasing Cultural Competency To Improve Doctor-Patient Relationships

The quality of health care for minorities and the effects of low cultural competency within doctor-patient relationships go hand in hand. Oftentimes, language barriers also mean cultural barriers that can affect the overall relationship.

“Even when health care providers and patients share the same language, the differences in their cultural norms can lead to miscommunications and misunderstandings” (Angelelli 2004, 19). Cultural barriers include but are not limited to, tone of voice, mannerisms, position in speaking to one another, and eye contact.

Poorer quality of health care for minorities

In examining the use of medical interpreters, the quality of health care of minorities and affects of low cultural competency within doctor-patient relationships is perceived. Angelelli states, “Although physicians of today are better educated and more scientific than ever before, they sometimes do not communicate effectively with their patients. This is particularly true in cases where health care provider and patients do not share the same cultural background.” This is an important aspect of lower quality of health care for minorities. Physicians need to recognize that cultural differences can result in a variety of unintended negative clinical consequences. For example, health status, access to health services, and overall health outcomes can be adversely affected (Angelelli 2004, 15-19).

An important method for overcoming these cultural barriers is for the patient to be fully involved in explaining his or her needs and symptoms, while the doctor is listening carefully using elicitation skills and trying to understand the patient’s perspective. When a doctor uses these methods, the overall satisfaction of the patient tends to be higher. The patient thereby gains trust and is more likely to comply with diagnosis and medications. Angelelli reports studies done by Ferguson and Candib (2002) and Flores (2000) showing that minority patients, especially

those who are not English proficient, have a lower likelihood of establishing rapport with doctors, receiving enough information, receiving a sympathetic response from doctors, and are less likely to be encouraged in decision-making (Angelelli 2004, 19-21).

Cultural competency can be a large topic and cover several different factors in hundreds of different cultures. A criticism of cultural competency was found in Garrett et al.'s studying, noting that some believed that cultural competency may over-emphasize ethnicity and trait-based factors, thus leading to stereotyping and racism (Garrett et al. 2009, 480). However, it is not the duty of the doctor to assume or make visual assumptions of his or her patients. The doctor is providing a service and should listen to the patient and have them inform the discussion rather than the doctor making any assumptions.

Cultural Empowerment Model

In order to better understand and address the issue of poorer health care Garrett et al.'s study provide the Cultural Empowerment Model. The most common negative feedback from the minority and Limited English Proficient (LEP) patients was their feeling of powerlessness. Oftentimes the patients felt ignored. They felt they could not communicate their needs, and that they had no control over their own situations. To overcome these negative experiences Garrett et al. creates the Cultural Empowerment Model (2009, 490)

The cultural empowerment model was created to help doctors empower their patients to feel in control of their health problems. There are six main factors:

1. Facilitating language

2. Negotiating family involvement
3. Understanding patient beliefs, experiences, and constructions
4. Compassionately respecting patient and human rights
5. Negotiating the care partnership
6. Providing systems so providers can be competent

Facilitating language highly encouraged the use of medical interpreters. It does consider using family members and bilingual nurses and doctors to aid in language barriers. Negotiating family involvement allowed the family member to act in a variety of roles such as, supporter, mediator and information shaper, interpreter, and advocate. In some cultures the patient may want the family at the bedside at all times, and rely on them at decision-making times. However, other cultures may differ and this is why it is important for the negotiating of family involvement be explicitly discussed (Garrett et al. 2009).

Understanding patient beliefs, experiences, and constructions may be one of the most important factors in assisting a patient. A doctor would be better able to provide treatment if he or she had a strong understanding of what the patient believed in with regard to medicine, surgeries, etc. The manner in which the patient experiences moments of diagnosis is also very culturally sensitive and may have further implications of how the patient reacts to treatment. Compassionately respecting patient and human rights might prove challenging to doctors who are often overworked and in a time crunch. Often the amount of time spent with a patient is limited and sometimes a speedy appointment may make the patient believe that the doctor is disrespectful and acting uncompassionate.

Negotiating the care partnership is really where the doctor and patient must come together in developing a shared understanding of the prognosis and plan of treatment. This requires cooperation from both the patient and the doctor. The patient must be open to listening to the doctor and understanding the medical approach he or she suggests, while the doctor must also be willing to listen to the patient's wishes on culturally acceptable treatment.

The last factor is to provide systems so providers can be competent. This includes, but is not limited to, using medical interpreting services, multilingual signage, food accommodations, familiarity with local religious leaders, and an on-going cultural competency between the staff, doctors, and nurses to better understand the multi-cultural community they serve (Garrett et al. 2009). By following and insuring these 6 steps are completed with the utmost cultural competency, the health care for minorities and LEP patients can be greatly improved. Better communication will be established, along with a more open and understanding relationship between the doctor and patient. The patient will feel more empowered in their options in their own health choices and with all combined lead to better health outcomes.

Betancourt et al.'s Study:

Society's Role in Cultural Competent Health Care and Organizational- Leadership and Workforce

Garrett et al.'s cultural empowerment model focuses on direct factors within the doctor, patient, interpreter, and office/hospital setting. While this is most certainly the place to start to focus on culturally competent services, Betancourt et

al. provide a larger framework in preparing health services for the future. The sociocultural barriers are broken down into three parts: organizational-leadership/workforce, structural- process of care, and clinical- doctor-patient encounters (Betancourt et al. 2003, 293). The organizational-leadership and workforce section addresses how the doctor's own culture relates to his or her interactions with the patient. It examines how shared racial, and/or ethnic identity may help bridge cultural barriers between doctors and patients. The structural-process of care section focuses on challenges of obtaining health care and the process of navigating through underfunded and bureaucratic barriers. The last section on clinical encounters between doctors and patients focuses on interaction, communication, and negotiating. Each of these will be discussed further below.

A common circumstance throughout the studies reviewed here is a monolingual English-speaking doctor with a minority and/or Limited English Proficient (LEP) patient. Drawing the attention away from just creating better accessibility in this doctor-patient relationship, Betancourt et al. analyze the ethnicity of doctors to show how different ethnic groups are represented in the medical field. This study showed that African American, Latinos, and Native American make up only 3% of medical school faculty, fewer than 16% of public health school faculty, and only 17% of all city and county health offices. Furthermore, fewer than 2% of individuals with senior leadership roles in health care management are non-white (Betancourt et al. 2003, 295-295). These findings prove why it is often the case of a white English-only doctor with a LEP patient.

These numbers show that minorities are under represented in the medical field, and their societies are being treated through the eyes of white leadership. Betancourt et al.'s study further shows that minority medical leadership would be more likely and suited to meet the needs of a diverse community than the fellow white leadership. They would be more understanding in delivering more community friendly office hours, take patient wait time into more consideration, and work with different intake processes to eliminate fear of undocumented and deportation issues (Betancourt et al. 2003, 296).

An important reason to increase minority representation in the medical field is because several studies (Bereknyei et al. 2010, Braddock et al. 2004, Carpenter-Song et al. 2007) have shown how shared cultures and languages between doctor and patients improve the overall relationship. The more trusting relationship leads to overall better health outcomes and more preventative measures that the patient is willing to commit to and follow through with. Betancourt et al.'s study showed that beyond shared language, patients of different races preferred a doctor of their own race; this was common throughout several minorities.

Shaw points out in her study that patients seeking out doctors, or vice versa, of the same race/ethnicity would only further the racial gaps and disparities. While the overall goal in cultural competency is to create an environment suitable for all races and provide the best possible medical experiences for all cultures, it certainly does not suggest that races segregate and stay within their own. Rather, the perspective should be to eliminate the racial discrimination in the medical field. Shaw argues,

That many resemblance and cultural competency programs assume authentic ethnic identities that are constructed as 'mere particularity', a collection of ethnically specific characteristics and traits disconnected from the relations of power and inequality that are the ground for these differences. In failing to specify the socioeconomic contexts in which such identities are elaborated, resemblance programs fall prey to the same naturalizing and segregating tendencies that have plagued US social history and produced, in many cases, the very health disparities that physician-patient resemblance is meant to address (Shaw 2010, 537).

Nonetheless, minority doctors are more willing to take Medicaid and minority patients than their white counterparts. Approximately 45% of African American doctors and 24% of Hispanic doctors in California cared for patients with Medicaid, whereas only 18% of white doctors did (Betancourt et al. 2003, 296). Furthermore, 25% of African Americans and 23% Hispanic respondents were cared for by either an African American doctor or a Hispanic doctor making up only 9% of the nations doctor pool (Betancourt et al. 2003, 296). This shows how important it is for society to take an active role in increasing the minority representation in the medical field, but also for society to take an active role. Cultural competency and socioeconomic disparities will be of the utmost importance for society to have a strong future.

The second part of Betancourt et al.'s study focuses on the structural process of care. An important finding in this study is the positive effect of using medical interpreters (MI) to overcome patient dissatisfaction and aid the doctor-patient

communication. Language barriers have a severe impact on how effective health care delivery can be.

In addition, Betancourt et al. state, wait time is a major setback in the structural-process of care for all patients across races and ethnicities. But, waiting times for minorities were disproportionately long, exacerbating barriers to health care access. The wait time for patients also added to their dissatisfaction with the overall quality of health care (Betancourt et al. 2003, 297). However, many factors go into what could be causing the wait time. Are doctors spending too much or not enough time with their patients? Or are certain doctors overbooked because certain races/ethnicities are seeking only their services?

These questions are not answered in Betancourt et al.'s study, but do bring to light many different factors and structural barriers that are caused. Braddock et al. conducted a study on the significance of time and its impact on the doctor-patient relationship. These findings show that what is more important than looking at wait time, is looking at how the time is spent with the patient. The variable factor is that each person may perceive time differently and this proves difficult in finding a median. What was common is that the patients wanted to feel that the doctor was advocating and aiding in decision-making and spent enough time to build a trusting relationship (Braddock et al. 2005, 1061).

The findings in Braddock et al. can be used in relation to the findings in Betancourt et al.'s study. Betancourt et al. argued that doctors and patients with similar race/ethnicity would provide better medical care, but by analyzing time in the doctor-patient relationship resemblance did not seem to make a difference.

Overall the findings in Braddock et al. proved it difficult to generalize such a personal experience such as a doctor-patient relationship. Betancourt et al.'s study showed how flooded minority doctors were because most of their patients were minorities on Medicaid, so it does not seem to be a good suggestion in reaching cultural competency that the doctor and patients should have similar races/ethnicities. Rather, Braddock et al.'s study proves that what is at the root of a successful doctor-patient relationship is trust, respect, and well-spent time.

Betancourt et al.'s last section in reaching cultural competency is about understanding the clinical encounters between doctors and patients. What makes this type of relationship successful is accurate information. It is important that cultural and language barriers are addressed by interpreters and for both to keep a positive outlook avoiding stereotypes. The most important aspect of this relationship is communication.

Hispanics with LEP showed that they were more likely to miss appointments, skip medications, and visit the emergency room than those who visited with Spanish-speaking doctors (Betancourt et al. 2003, 296). This may seem like it reinforces patient and doctor sharing races/ethnicity, but any situation similar to this would be more successful by the use of a MI. Discussed further, I argue that the use of MIs would also allow for the patient to be better guided in using more preventative care to avoid the costly expensive of emergency facilities. I will take Betancourt et al.'s framework in combination with MIs acting as advocates to show how cultural competency, doctor's, patients, and MIs can all be successful.

Conclusion

In this anthropological literature review, the role of medical interpreters (MI), use of, and benefits has been discussed. In the beginning the details and breakdown of the roles of interpreters show the details and advantages of using them to benefit the doctor and patient relationship. MIs are used to improve communication between doctors and their patients. The communication is not only verbal with language, but with cultural differences being communicated as well.

These differences are bridged with MIs because they act as cultural advocates and cultural brokers as well. Most often interpreters share the cultural customs, or are familiar with the customs associated with the language they are translating. Body language, eye contact, and voice overlapping all have different connotations within different cultures. Besides communication, cultures also share in different views of medicine and remedies. A MI can help bridge the cultural gap here as well. MIs as cultural brokers improve the communication, which leads to improved patient satisfaction. Not only are they helping the doctor and patient communicate, but also are able to direct patients to other medical resources where language barriers may occur.

The limited use of MIs amongst doctors is cause for concern. The negative implications were shown and affects on the doctor, as well as the patient and/or family member involved. With the growing population of LEP patients, this needs to be improved. Better availability, funding, and understanding on how to properly use MIs are the major factors in improving this issue. MIs need to be available and not overworked. Funding between states and government needs policy reform, as well as improvements with private doctor offices. The needs of LEP patients

outnumber the availability of funding and resources that are provided to doctors. Schooling and proper training on how to use a MI should be implemented early on in training with medical students.

Most importantly, cultural competency must be promoted throughout the medical field. Minorities not only need to be represented in larger numbers within the medical field, but the doctors currently in the field need continuous involvement with cultural competency. A more common practice with MIs would help improve the minority health and lessen the use of family members as interpreters. MIs would also aid in the empowering of the patient as Garrett et al.'s model of Cultural Empowerment showed.

With LEP patients better empowered, informed, and able to take better control of their transitions through the medical field, their overall health would also improve. My personal experience with my grandmother has inspired this research, and lead to the belief that minority health can and will be improved in the future. As immigration is high and the diversity of America is growing, this needs to be a priority for all of society. Together with the use of MIs, higher cultural competency, and empowered minorities, the racial gaps and disparities can be improved.

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