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Doctor and Patient

When the Patient Gets Lost in Translation

By PAULINE W. CHEN, M.D.

Every morning after his liver transplant, and often in the afternoons as well, I visited Armando (not his real name) as part of my daily rounds. In his 50s, with still dark hair and even darker eyes, Armando had developed liver failure from hepatitis C, contracted from a blood transfusion when he was a young man in Mexico. I was the surgeon on call the night a liver became available for him.

Despite his wiry build, there was plenty of room in Armando for a good-sized new liver. And a pair of gloved surgeon's hands. While some bodies seem tightly packed from within, as if organs might spring loose at any moment, Armando's abdominal cavity, broad and flat, possessed a luxurious sense of space. His intestines fell away from the walls, allowing me to see, without craning my neck, the gossamer lining of the abdominal cavity and the outlines of the last ribs curving down below his chest.

After five hours in the operating room, I knew one part of Armando probably better than any other person ever would. Yet despite this encounter with his innermost parts and the lifesaving exchange of organs, I would never learn as much about him as I had about his abdomen. Armando did not speak English, and I could only feebly stumble through three, maybe four, words of Spanish.

Pressed for time and acutely aware that a couple dozen more patients were always waiting, I never called an interpreter to Armando's room during my daily rounds after his operation. Although interpreters were available at all times, it would take time, I thought, for one to arrive, and then the translation itself could slow things down. While I always asked for interpreters to help with discussions about potential complications, worrisome lab results, or the complex immunosuppressive medication regimen, I tried to get by on my own during what I thought were more routine checks.

So morning conversations between Armando and me were always the same. After my exam, I would smile, point to his belly and give him a thumbs-up sign. "Dolor?" I would ask.

"Un poquito," he would reply.

For over a decade now, researchers have documented the effects of language barriers on health care. Patients who speak English poorly or not at all face longer hospital stays, an increased risk of misdiagnoses and medical errors, and decreased access to acute and preventive care services, often regardless of socioeconomic or insurance status. These disparities exist, in part, because of a lack of access to trained medical interpreters and translation services.

But according to a new study published in The Journal of General Internal Medicine, doctors' assumptions about communication — what they deem important in a conversation — may also have a role.

Dr. Alicia Fernandez and colleagues at the University of California, San Francisco, and at Yale University examined language barriers between patients and doctors at two teaching hospitals with excellent interpreter services. The investigators interviewed 20 residents, young doctors recently graduated from medical school who make up the clinical frontline at these two urban medical centers.

A complex picture emerged from the interviews. While the doctors acknowledged that they were underutilizing professional interpreters, many made the decision not to call an interpreter consciously, weighing the perceived value of patient information against their own time constraints. Moreover, despite their personal misgivings, the doctors often felt that this kind of shortcut was acceptable and well within the norms of their professional environment.

I called Dr. Alicia Fernandez, the senior author on the paper, to discuss her findings. I also found myself confessing that like the study doctors, I had more than once just "gotten by."

"People have discussed the findings," Dr. Fernandez said, "and they've recognized themselves. I recognized myself. If I'm rounding late at night, I might just decide not to use an interpreter. It has become an acceptable shortcut in care. But the truth is that the patient deserves to speak to the doctor as well."

Doctors will triage their conversations with patients, categorizing discussions about advanced directives or risky medications as "high stakes," and those that occur during routine rounding on a stable patient as "low stakes." Doctors will then tend to use interpreters in "high stakes" conversations but will muddle through "low stakes" topics themselves, resorting to gestures, mimicry or bilingual family members in order to communicate.

"To a certain extent," Dr. Fernandez said, "physician-patient communication is driven by the physician's need for patient input rather than by the patient's need to communicate. Communication is viewed as something that is supposed to change decisions that the doctor can foresee. So the use of interpreters may have more to do with how we think about communication with our patients and less to do with our views on interpreters, limited English proficiency patients or even time pressures."

She then added, "Of course, from the perspective of a hospitalized patient, the stakes are never so low that they would not wish to speak with the doctor caring for them."

Technology can help facilitate translation services. In one hospital where Dr. Fernandez sees patients, interpreters are centrally located in one room but provide their services throughout the hospital by video. While the video faces the patient and doctor during the initial part of the visit, the video is turned away during the physical examination. "You can actually do a pelvic exam in Cambodian," she said, "but at the same time not violate the patient's privacy."

But Dr. Fernandez was quick to acknowledge that at present, many doctors simply do not have access to basic interpreter services. "Time and cost are very real issues," she said. "If we could tackle language barriers in health care on a statewide or regional level so not every physician had to reinvent the wheel — if there were, let's say, 'central banks' of interpreters on video — it would be much easier for each physician." She pointed out that California recently passed an

unprecedented law mandating that health and dental plans supply interpreters and translated material to H.M.O. and P.P.O. patients .

Given that 43 percent of people in California do not speak English at home , this law appears to be an important first step toward increasing the availability of translation services for all doctors and patients. But that still leaves a growing segment of the population — more than 20 million people in the United States — with inadequate care .

“Although immigrants want to learn and are learning English,” Dr. Fernandez said, “our health care system has to come halfway through offering interpreter services and training doctors to use them. There has to be a minimum standard. I personally believe that a hospitalized patient should be able to talk to his or her doctor once a day.”

“This is where humility and compassion and professionalism all come together,” she continued. “Right now, they are the only things that keep us from cutting corners. We need to shore those qualities up, but at the same time we need the right structures and the reimbursement that will allow all of us to do the right thing more easily.”