The need for language and cultural awareness in clinical and public health care facilities

La nécessité pour la sensibilisation linguistique et culturelle dans les cliniques et les établissements médicaux

Necesitatea conştientizării lingvistice şi culturale în clinici şi instituţii medicale

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Abstract

In this study the author focuses on the cultural and linguistic barriers encountered by both physicians and patients in the medical process. In order to properly diagnose and treat multi-ethnic individuals, doctors must either have a powerful cross-cultural experience and certain linguistic skills, or benefit from the services provided by trained medical interpreters or by state-of-the-art-technologies that are meant to facilitate intercultural communication. The paper also underlines the dangers of using ad-hoc interpreters, who might put at risk the lives of many people as well as the carriers of health care practitioners.

Résumé

Dans cette étude, l'auteur se concentre sur les barrières culturelles et linguistiques rencontrés par les médecins et les patients dans le processus médical. Afin de bien diagnostiquer et traiter les personnes multi-ethniques, les médecins doivent avoir soit une expérience puissante interculturelle et certaines compétences linguistiques, soit de bénéficier des services offerts par les interprètes médicaux ou par les technologies state-of-the-art qui sont destinées à faciliter la communication interculturelle. Cet document souligne également les dangers de l'utilisation des 'interprètes ad hoc, qui pourrait mettre en péril la vie de nombreuses personnes.

Rezumat

În acest studiu autoarea analizează barierele culturale şi lingvistice care intervin în actul medical şi cu care se confruntă atât doctorii cât şi pacienţii. Pentru a diagnostica şi a trata indivizii multi-etnici într-un mod adecvat, medicii trebuie fie să posede o experienţă multiculturală bine înrădăcinată şi anumite abilităţi lingvistice, sau să beneficieze de serviciile furnizate de interpreţi medicali special instruiţi sau de tehnologii de ultimă oră menite să faciliteze comunicarea interculturală. Lucrarea de asemenea subliniază pericolele de a folosi interpreţi fără experienţă şi fără pregatire în domeniu, care ar putea periclita vieţile a multor oameni dar şi carierele medicilor.

Key words: *culture, linguistic barriers, training, communication, health care facilities.*
Mots clés: *culture, barrières linguistiques, formation, communication, établissements de soins de santé.*
Cuvinte cheie: *cultură, bariere lingvistice, instructaj, comunicare, instituţii medicale.*

"Translating" culture

People often tend to restrict their views on interculturality, considering that intercultural communication represents the same ideas and perspectives as international communication. Others believe that the international factor is just a subset of the intercultural elements. International communication occurs between individuals belonging to different nationalities. On the other hand, official speakers or the governmental representatives convey and receive messages from representatives of other nations. Therefore, the level of interculturalness that takes place here, is closely related to the speakers' previous personal experience in the countries involved in the communicational process. In the latest years, it has become easier and easier to identify national boundaries and that is why individuals find it difficult to cope with the cultural borders. As a consequence they began equating the intercultural with the international. But, undoubtedly, there are huge differences between the rural and the urban area of a region, between one nation and another, between one person and another. After a close and careful research in this field, scientists have reached the conclusion that heterogeneous participants must definitely be intercultural while the homogeneous participants are regarded as intracultural. The aspects of intercultural communication can be defined from several perspectives: the homogeneity-heterogenity, the male-female, the age distinction.

Researchers defined communication as a series of transactions that involve the three basic elements: participants, messages, codes. The behaviour of one individual influences the behaviour of others and therefore, besides speaking and listening I turns, the participants also use nonverbal codes that may occur simultaneously. For the communicative act to take place under optimum conditions, and for mutual responsiveness to occur, both parties have to know the verbal and nonverbal behaviour of each other. According to scientists, communication should always be initiated from experiences that are common to both parties: food, shelter, family, happiness, natural phenomena, even though, the way in which they experience such dimensions is really different, because no two persons can have identical experiences. "The Global Village", so frequently brought into discussion nowadays, is a concept based on intercultural communication as well. Obviously, mass-media accelerates the information exchange in real time, between opposed regions of the world and the economic, political, cultural ramifications of the globalization phenomena apparently favor this type of communication." [1] The first element to take into consideration when it comes to intercultural communication is language. And indeed, there is a necessity of using either a set of verbal or nonverbal methods, but however, sometimes this way of conveying the message fails.

An explanation would be that people often tend to overlook the culture in itself, and the powerful connection between the linguistics and cultural aspects. While some verbal or nonverbal codes are funny and interesting for one nation, they may be completely offensive or forbidden in other countries. When translating from one language to another, translators cannot consider a one-to-one translation because different cultures, assign different symbols to different elements. Miscommunication most often than not appears when telling jokes. Two people with different cultural backgrounds, may listen to the same joke in the same language (that is not their mother tongue) and understand the joke completely different, or not understand it at all.

Linguistic and cultural impact in the field of medicine

In medical settings things occur pretty much the same. Language must not overlook culture and the other way round. The first step when trying to understand an individual's perception of an illness is culture. There are many cultural barriers related to treatment plans. It is very difficult for health care providers to improve the health of displaced patients. The first thing they must resort to is culture. When establishing the patient-doctor relationship as well as the appropriate health care programmes, both parties should cooperate in order to understand each other's ideologies and beliefs. Doctors must intelligibly explain to patients the medical notions, as they often have different perceptions of illness, and many rely on traditional medicine (that is specific to their culture).

In order to obtain effective communication between the health care institution and the target community as well as successful disease prevention, messages should be modeled according to a culturally appropriate environment so as to meet the needs of the consumers. The disparities in the health care system may be reduced by the physicians improved cultural competency. To overcome cultural barriers, patients must be approached as part of a relevant cultural framework so that both them and physicians can better understand the process of diagnosis, symptomology and treatment. Science has proved that medical practitioners who obtain detailed information about patients' cultural background will have much better results. The patient's cultural framework must be taken into account in order to obtain a correct medical history of the patient. Differences in defining illness, reliance on false perceptions about medicine, or traditional medical methods – they all contribute to the emergence of misunderstandings between patient and doctor: "…health culture shapes the way in which sickness is defined and the interpretation of its severity, it also influences the actions necessary to treat it and the way in which it is described to others. Ideas concerning the source of sickness and disease, something many mistakenly believe are universally understood and accepted, are susceptible to varying explanations." [2] Translators working in the medical environment noticed that patients who do not speak the doctor's language are usually obedient and avoid asking too many questions in order to avoid shame - which increases the physicians' confusion. Because of their cultural norms and variations, patients make it difficult for the medical practitioner to win their confidence and even to give them suitable treatment plans. In a survey carried out by Margeaux Corby, a woman who was interviewed, said: "They ask you how many partners you have. We don't ask that back home or are you active and things like that, we don't ask those things. When they asked me for the first time I was like "What do you mean? I'm single." You didn't understand the question to be honest." Such misunderstandings of important medical questions have the potential to lead to inaccurate health histories, which may cause clinicians to order unnecessary, expensive and time-consuming diagnostic procedures or misdiagnose a patient." [3] For the medical system to work properly when dealing with foreign patients, the medical practitioners must, first of all, learn about their culture nuances and find adequate communicational techniques. They must also use simple words, convey simple messages avoid jargon and show an active interest in the patient's understanding of their explanations. A key component in this whole process is asking questions that require the patient's opinion, like *"What do you think has caused the pain?"* Besides a good knowledge of cultural frameworks doctors must be creative and flexible in order to remove health barriers in the relationship with multicultural patients and to make clinical decisions. Medical practitioners should participate to training programmes designed to improve their health communication skills. We all know that English is nowadays regarded as lingua franca – if we consider this aspect, we might refer to acquiring such communicational skills by role-playing, by watching or enacting specific case presentations, by giving opinions. There should be English courses based on culture and terminology, provided in medical schools and during residency. When researching the acceptance of medicine among refugees, Paez et al., observed: "If […] those working in a patient-care, health provider setting are able to move beyond their own personal perceptions of lack of care coordination, racial and ethnic prejudices and assumed patient ignorance, the cultural competency process can begin and the length and quality of refugee lives can be improved and brought up to par with majority members of the population." [4]

For the communication in medical settings to be efficient, diagnosis must be made according to a good history of the patient. However, misunderstandings and difficulties occur because medical interviews are complex and often unpredictable. Personality attributes also have a major importance. Philip D. Welsby identified five personality dimensions: extroverted-introverted; neurotic-stable; curious-incurious; agreeable-antagonistic; conscientious-non-conscientious. But, besides the cultural dimension, the other essential aspect in effective communication is language. And linguistic skills cannot be achieved over night, therefore, interpreters and translators often interfere with the medical profession. They represent the instruments used to bridge the language and cultural barriers. Trained medical interpreters often benefit from state-of-the-art technologies

meant to simplify the whole health providing system. In the article entitled *Bridging Language and Cultural Barriers between Physicians and Patients*, the authors identified such devices. The system is called "remote-simultaneous interpretation" and it requires the use of mobile phones in order to establish connections between interpreters and physicians, hospitals and even patients' homes. This method proved to be efficient as it helped the patients feel more confident in asking questions, and also, the number of mistakes on the interpreter's part was significantly reduced. When dealing with non-English speaking patients, researchers have identified other methods, too. The ideal case would be for the doctor to speak the patient's language; but when this does not occur, they resort to interpretation performed by a family member, which does not always represent the best solution. Such an interpreting dilemma caused by cultural factors, occurred in a situation studied by Helen Spencer-Oatey and Peter Franklin: "A 72-year-old Aboriginal man was admitted to hospital for diagnostic evaluation of urinary tract problems. He spoke only Ojibway, and on his admission, his son acted as interpreter. The next day, he was scheduled for a cytoscopic examination, and so arrangements were made for a male interpreter to come to help explain the procedure and get the patient's signature of consent. Unfortunately the male interpreter was called away, and the only interpreter available was a 28-year-old woman. The urologist started his explanation, but soon became frustrated because he felt the interpreter was hesitating too much and seemed unable to get his message across. After several unsatisfactory exchanges, he drew a sketch of the male urinary system, and eventually the patient agreed to the procedure, saying that although he didn't understand everything, he would sign because he trusted them to do the best for him. Why was the interpreter so hesitant and seemingly incompetent? Kaufert explains as follows: After the consent agreement was signed, the interpreter returned to her office and discussed the encounter with her supervisor. She explained how the direct translation of the physician's explanation of the procedure would have forced her to violate fundamental cultural prohibitions against references to urinary and reproductive anatomy in cross-gender communication. She added that her reluctance in this case was strongly influenced by the patient's age and by his status as a respected elder. The Director of the Aboriginal Services Program told her that professional medical interpreters must translate stigmatized concepts objectively and accurately. The interpreter agreed, but said that the elder would not have understood that her role as an interpreter had given her the privilege of using words which he saw as disrespectful in a conversation between a male elder and a young woman. The program Director conceded the validity of her point and agreed that the interview should have been delayed until a male interpreter was available." [5]

When interpreters deal with this process of converting messages, two major things are to be taken into consideration: first of all, the way in which the message is converted and secondly, whether the message is converted or not. The interpreter's decision of conveying a message has a huge impact on the actual utterance and on the interaction in itself. Just like in the situation above illustrated, the interpreter may often find oneself in a deadlock due to cultural impediments and conventions. Under such circumstances, researchers in the field advise to take the best possible professional decisions. An interpreter's ability to perform accurate renditions of the original utterance is not represented only by one's linguistic proficiency; this profession requires training and good cultural knowledge. Therefore, the communicational process, under such circumstances, is best improved by using trained interpreters. But unfortunately it does not occur very often due to the high costs involved – despite the fact that failing to hire a trained interpret compromises and puts at risk the patient's health. In some hospitals medical practitioners use commercial services to ensure suitable communication with the patients. Such a service is available by phone, offering 24-hour interpreters. When non-professional interpreters are used, the quality of the message is badly damaged and therefore, the patients might die, while the physicians may be accused of malpractice. Very much hype was created around the story of such a doctor in 2008. Doctor Daniel Ubani, of German origin, killed a patient by administering him 10 times the normal dose of diamorphine, while working for the British National Health System. When investigated, the doctor admitted that

he was confused because of the difference between the drugs used in Germany and the ones used in Great Britain.

Unfortunately, there is still a huge demand for trained medical interpreters, mostly because of the high costs involved and because of the fact that the Government cannot provide such services for free. Researchers claim that the visibility of the interpreter depends on the setting in which they act. And this visibility has an utmost importance because it has a certain role in the communicational process, in bridging the cultural gaps and language barriers that emerge, in building up confidence in the doctor-patient relationship. The use of untrained interpreters creates exactly the opposite effect: destroys mutual respect, impedes communication and monopolizes the dialogue. According to Angelelli, the visibility of the interpreter is given by the communicational style and by the cultural background he/she possesses. In some other situations, occasional interpreters just decide by themselves what is relevant and what is not; what to tell the doctor/patient and what not – attitude which may lead to serious medical mistakes. Doctors often use indirect clues, like the social factors, to draw some conclusions related to the patient' illness. Interpreters must not advocate for anyone; neither for the doctor nor for the patient; they must stay neutral. Many patients who needed the services of trained interpreters claimed that they acted more like mediators because they did not reproduce everything that was said. Even if the doctors' time is limited, they should not "help" them in this way. They must not reproduce summaries of the dialogue and should not have private conversations with the doctor, in front of the patient. Usually, even if a conversation begins between the doctor and the patient (the doctor using the first person when addressing the patient), it ends up as a discussion between the doctor and the interpreter (the doctor addresses to the interpreter and the patient becomes the third person), because the interpreter takes over by deciding which messages to convey. As Davidson pointed out: "The interpreter here evaluates the patient's response and dismisses it as irrelevant…The interpreter is acting as pre-filter for patients' utterances, screening them for relevance to the physician's questions…however, converting data by passing it through a grid of medical meanings is the central component of the process of diagnosis itself." [6] Therefore, untrained, and sometimes, even trained interpreters will act according to the situation, in the way that seems natural to them, will make choices and provide summaries of what they consider to be relevant, endangering thus, the whole medical process.

To sum up, in multi-ethnic societies there will always be a need for trained medical interpreters in order to face the challenges of the cultural and linguistic barriers. Because culture is a dynamic concept, physicians should be as familiar as possible with anything arising from it: religious beliefs, values and traditions. On the other hand, linguistic competence in clinical communication increases patient satisfaction and improves medical services. The latest technologies used for interpreting also have their significance because they protect the patient's privacy and provide more accurate messages for the doctor. Even though little research has been carried out in this field, nowadays, more and more interest and concern is shown for the issues related to cultural diversity in medical settings. And in order to overcome these obstacles health practitioners must learn to eliminate ethnic and racial barriers.

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