

Engaging Differences in Healthcare

Sandra Smith

October 2006

Abstract

In this paper, I explore the effects of difference on access to healthcare, delivery of services, and quality of care. I focus on differences in healthcare providers' and consumers' logic, language and experience. In this wide communication gap lie endless opportunities for misunderstandings, misdiagnoses, unnecessary or inaccurate testing, breaches of confidence, unreliable research data and other errors that impede access, confound equity, increase costs and reduce quality of care. Finally, I review social policies intended to motivate healthcare services providers to engage differences in a timely manner and thereby improve access and quality of services to diverse populations.

Engaging Differences in Healthcare

Note: the stories and examples presented here are taken from my personal experience as a healthcare administrator. They are based on actual events. The characters are fictional. The information on Harborview Medical Center also is taken from my hospital experience. Harborview and the International Primary Care Clinics are real places. I have actually observed those operations. Details may be out of date.

Introduction

I am visiting Harborview Medical Center, the King County hospital, in Seattle. I am in the combined waiting room of the International Primary Care Clinics, which serve all County residents regardless of immigration status or ability to pay. The long open room looks like a busy international airport with people of all ages, shapes and colors, all manner of clothing, and a cacophony of speech. Most common among the 160 foreign languages on record here are Somali, Russian, Vietnamese and Spanish. The people waiting to be seen have complex medical histories shaped by war, poverty, tragedy, and varied beliefs about health, illness and treatment, bodies and social proprieties that clash with the culture of this efficient Western medical center.

I am observing in the Maternity Health Clinic. Batula, a Somali woman in her early twenties, is standing outside the exam room with two female relatives and two wide-eyed toddlers. They are ready to go home, but wait patiently for the doctor who said she would be right back. (Batula sees only women physicians since, in the Islamic tradition, men and women do not touch each other.) Batula looks calm and radiant in her flowing orange and blue skirts and scarves. Under her hejab, her hands cradle her belly, huge with her third child. She is 17 days past due. The doctor returns with a senior consulting physician; both of them look worried. They want to induce Batula's labor. Working through an interpreter, they explain carefully the risks of continuing the

pregnancy. The Somali mother still looks calm and maybe a little amused. She is shaking her head slowly, no. The doctors explain again in a different way. Still she shakes her head. "It is not time," she says finally, and moves toward the exit. Now the doctors are shaking their heads.

In the next wing, 18-year old Maria, a Latina patient of the Maternity Health Clinic is being rushed into the Emergency Room. Her medication label reads, "Take one tablet once a day." She told the pharmacist that she understood the instruction. But *once* in her language means 11. She took the medication 11 times in a day. She died.

Up on the fifth floor, George is being re-admitted to the Heart Center. A native-born English speaker, George is a wiry 50-year old firefighter who runs to keep fit. In medical staff parlance, he is a CABG (say *cabbage*). He had a coronary artery bypass graft here a few weeks ago after he had a heart attack at a fire. His doctor told him to take it easy, so yesterday George ran three miles instead of his usual five.

Jack, a 47-year old salesman who has not exercised since he graduated from Garfield High School near here, also is being readmitted to the Heart Center. Jack had a heart attack and surgery about the same time as George. The surgeon told him to take it easy, too. He has not been out of bed for three weeks and now his systems are shutting down.

Communication errors like these happen every day in medical offices, clinics, ERs and hospital rooms across the country. They lead to unnecessary suffering, delayed treatment, reduced quality of care, repeat testing, hospital readmissions, poor outcomes, lost productivity, law suits, spiraling healthcare costs, and disparities in access and outcomes (Mateo, Gallardo, Huang and Niski 2004)

Mismatches in Logic, Language & Experience

Doak, Doak and Root (1996) suggest that most communication errors in healthcare settings result from mismatches between providers' and patients' logic, language and experience. The greatest among these is language. Logic and language refer to the way a person thinks and talks about health, illness and treatment. They are inseparable from each other and from culture. Mismatches in logic and language are evident and expected when provider and patient are of different nationalities, ethnicities, races, genders, ages, classes, and religions; and they cannot speak to each other, as in Batula's and Maria's stories. However, as seen in George and Jack's experiences in the Heart Center, communication errors with negative health consequences are common between doctors and patients who speak the same language and share the same macro cultures (national, ethnic, racial) and micro cultures (gender, age, religion, city) (Diversity RX).

Differences in logic and language affect health services delivery

Linguistic and cultural diversity is an inescapable and growing challenge to health and healthcare in America. Healthcare facilities in almost every large American city and many suburban and rural areas are serving diverse populations (Hasnain-Wynia, Yonek, Pierce, Kang, Greising 2006). According to the 2005 American Community Survey, 19.4% of the US population over age 5, approximately 52 million people are *heritage speakers* – they speak a language other than English at home. In 1975, only a few languages were heard in the US (Census Bureau 1975). Now, the Census Bureau (2000) reports US residents speak 380 single languages or language families (Census

Bureau 2000). Harborview Medical Center is located in Washington State, where 84% of the population are native English speakers, yet the managers of these clinics do their best to maintain interpreter services in 160 languages. In some states, the proportion of the population that does not speak English at home far exceeds the national average. States with the highest proportion of heritage speakers in their state populations are California (42.3%, up from 31% in 1990), New Mexico (36%) and Texas (33.6%). (Census Bureau, American Community Survey, 2005)

In healthcare, the term *limited English proficiency/proficient –LEP* typically describes heritage speakers or anyone whose first language is not English (Mateo et al 2004). Although most healthcare workers want to provide equitable services, when provider and patient do not speak the same language, communication problems can overwhelm to the system as well as the person. Accommodating LEP patients is possible (and legally mandated) as illustrated daily here at Harborview. Still, it is a constant challenge and expense. Even here where healthcare professionals and workers are trained to approach cross-cultural encounters as opportunities for learning and growth, persons with LEP encounter difficulties at every level, which limit their access, quality of care, effectiveness of treatments. For example, the extra difficulty of communicating on the telephone can make a basic task overwhelming, like making an appointment or obtaining test results, so persons with LEP often delay treatment. Delayed treatment leads to treating problems in advanced stages with greater expense and less effectiveness. Confusion over appointment time, date, location and preparation can make a person with LEP chronically late. Completing the routine registration forms may be an arduous task requiring an interpreter and other assistance. The medical

interview and examination present unlimited possibilities for miscommunication such as inaccurate or incomplete medical history, inadequate preparation for tests, inaccurate test results, inadequate instruction to follow medication or treatment regimens (Diversity RX)

The healthcare professionals and managers at Harborview Medical Center have a basic understanding of the impact of language and culture on health services delivery. The International Clinics are models for efficient organization of health services to meet the needs of a diverse patient population and the institution. This institution is the exception. A national survey of hospitals (Hasnian-Wynia, Yonek, Pierce, Kang, Greising 2006) found that 80% of hospitals encounter persons with LEP frequently; 32% are engaged in efforts to address LEP; and only 3% receive direct reimbursement for providing language services. Funding for language services is a major challenge. Washington is one of three states (with UT and MN) that reimburses healthcare language services (Mateo et al 2004).

Major and subtle cultural differences in thinking continue to complicate health services delivery. At Harborview Medical Center, the Western emphasis on the individual pervades culture, policy, language and architecture, although health and healthcare are family affairs for Batula and many of those in the Clinics today. The doctors here view illness in strictly scientific, biological terms, while for many patients cultural beliefs influence the way they describe symptoms, respond to diagnoses and interpret instructions. For example, in her book, *A Spirit Catches You and You Fall Down*, Ann Fadiman writes of the conflicts between a Hmong family whose daughter has epilepsy and her American doctors. The book title is the parents' description of the

cause of epilepsy and seizures – the Spirit catches you and you fall down. To them, the disease is a blessing. It means their daughter is special; she may be a shaman someday. The doctors are frustrated by the parents' apparent non-compliance and lack of caring.

Similarly, Batula, the Somali Mother, and Maria, who died in the ER, show how cultural beliefs complicate the delivery of healthcare. Batula's concept of time is very different from the pressure cooker mentality of the medical staff in the Clinics who are scheduled to see 30 patients a day and who are problem focused. In their thinking, a "post-dates baby" is a problem. Batula is not in a hurry to leave the clinic, and she will not hurry her baby. In her logic and language, there is no such thing as a post-dates baby. While the doctors worry about her *failure to progress*, she sees their treatment plan as *failure to wait*. In her culture and experience, babies are born when they are ready. While she understands what the doctors said to her through the interpreter, she and her family perceive elevated risk from the treatment rather than from her "condition", which she considers a healthy state.

Maria did understand the dosage instruction for her medication; and the pharmacist made sure to confirm that. But her understanding did not match the pharmacist's understanding. Eleven doses per day may have sounded excessive to Maria, but in her culture, a woman does not question authority.

Patients are not the only ones here at the Medical Center who speak a foreign language. Medicine, as a profession, has its own language and culture. Every medical specialty and every hospital has its own vocabulary and micro-culture. The culture, logic and language of Nursing and that of Medicine are often at odds. Communication

among physicians, nurses, and “the allied professions” is peppered with acronyms representing Latinized terms so that “CABGs are on IV and EKGs in the ICU until stabilized.” Negative test results are positive. Common terms, such as “stool”, “cap” and “screen” take on special meaning in a healthcare context.

Add to this alphabet stew plenty of legalese. Since life and death is the daily fare in medical institutions, patients sign long complex documents to give so-called informed consent for treatment. These consent documents are written by lawyers to protect the professionals and institutions. Readability testing shows that most are virtually unreadable by many patients (Passche-Orlow, Taylor, Brancati 2003, Young 1990). A review of 76 consent forms found 96% exceeded an eighth grade reading level (Philipson, Doyle, Gabram, Nightengale, Philipson (1995), the average capacity for American adults (Doak et al 1996). Patients sign the document or forgo treatment; few are truly informed.

Mismatches in Experience affect health and healthcare

Language barriers explain only a portion of communication errors in healthcare. As we have seen, native-born English speakers like George and Jack also face a communication gap between themselves and their doctors, even when doctors speak “plain English”. George and Jack both grew up in the neighborhoods surrounding Harborview. They are high school graduates with responsible jobs. Both understood the surgeons’ plain language instruction to “take it easy”. Yet, due to differences in logic, language and experience, neither interpreted the instruction the way the doctor meant it. In addition, when George’s wife overheard two nurses preparing for shift-change refer to

her husband as "the CABG (*cabbage*) in 515", she took it as an insult, rather than medical shorthand.

Because of their unique training, the nature of their daily work and their position of power, physicians' experience of health, illness and healthcare are unlike that of any of their patients. For both Maria and Batula, their initial prenatal care visit to the Maternity Health Clinic at Harborview was their first encounter with an institution of any kind. Neither George nor Jack had spent any time in a hospital before their heart surgeries. For the two men and their families, their stay in ICU – the intensive care unit – was a major life experience marked by loss of control, anxiety, vulnerability, confusion, uncertainty, fear and pain. On the other side of the gap, to the physicians who spend everyday in the hospital George and Jack were two cases– business as usual. This is not to imply that the physicians are uncaring, but rather that they are comfortable, powerful and in control. Their language is spoken here. The system is organized for their convenience and efficiency. In addition, these physicians do not experience poverty, low literacy, poor education, or discrimination, facts of many patients' lives.

Racial discrimination is an undeniable factor in disparities in access to care and outcomes. A growing number of researchers argue that racism should be considered a public health issue. (McKenzie 2003). They cite studies that report associations between perceived racial discrimination and birth weight (Collins, David, Symons, Handler, Wall, Dwyer 2000), hypertension, self-reported health status and days off sick (Krieger 2000). In a recent study from the UK (Karlsen, Nazroo 2002), victims of discrimination were more likely to have respiratory illness, hypertension, a long term limiting illness, anxiety, depression and psychosis. Stress is being investigated as a mechanism by which

racism affects health. Racist acts may be acute stressors; effects of racism on self-perception may be a chronic stressor (King, Williams 1995). This investigation shifts the discussion of health disparities away from recruitment of workers and access to healthcare services and toward prevention and deeper understanding of possible links between racism and health.

Social Policy Solutions

Social policies enacted in the 1990s intend to motivate healthcare providers and health services delivery systems to engage differences in a timely manner and thereby improve access and quality for diverse populations. Federal and state laws, Medicaid regulations, and accreditation standards hold healthcare professionals legally responsible to bridge the gaps between themselves and their patients.

Title VI of the 1964 Civil Rights Act states:

No person in the United States shall, on the grounds of race, color or national origin, be excluded from participation in, be denied benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

The Office of Civil Rights has consistently taken the position that Title VI places the burden of ensuring effective communication with patients and their families on the recipient of Federal funds – healthcare providers and organizations. Since federal funding of medical care is so pervasive, Title VI binds nearly every healthcare provider (Perkins and Vera 1998). Similar non-discrimination language in the Hill-Burton Act and in Medicaid laws is further basis for requiring clinicians and healthcare organizations to overcome language barriers. In addition, HCFA (say hick-fuh) – Health Care Finance

Administration – the agency in charge of Medicaid at the federal level, specifically requires states to communicate orally and in writing in a language understood by the beneficiary.

JCAHO (say jay-coh) –Joint Committee on Accreditation of Healthcare Organizations – standards require hospitals to offer education to patients and families to enable them to meet patients’ ongoing healthcare needs. Explanations and instructions must be presented in ways that are understandable to patients and their families, taking into account their culture and language (JCAHO 1997).

NCQA – National Committee on Quality Assurance – accredits MCOs – managed care organizations– and produces HEDIS (say HE-dis) –Health Plan Employer Data and Information Set. HEDIS data enable health care purchasers to evaluate the performance of MCOs. HEDIS asks MCOs to report how many doctors and staff serving Medicaid patients speak a language other than English, and the availability of out-of-plan interpreters for all members. HEDIS also asks for an inventory of all materials in languages other than English (NCQA 2006).

Although practice in most communities continues to reflect a long-held assumption that providers have no obligation to bridge language barriers, or that it is patients’ obligation to make themselves understood, in most instances the assumption is wrong as a matter of law. While enforcement of civil rights laws and supporting regulations has been sporadic, healthcare professionals and organizations can anticipate increasing pressure to comply with federal, state and private mandates to ensure linguistic access to services and information for persons with limited English proficiency and low health literacy.

Conclusion

Mismatches in providers' and patients' logic, language and experience, including racial discrimination, contribute to disparities in healthcare access and quality with significant negative health and economic consequences for individuals and the public. Public policies are in place to motivate healthcare organizations and providers to bridge communication gaps between themselves and their patients. Increased funding for language services and better enforcement of existing legislation and regulations are needed to achieve improvements.

###

References

- Census Bureau, American Community Survey (2005) Table S1610. Language Spoken at Home, Accessed online 11.19.06 http://factfinder.census.gov/servlet/STTable?_bm=y&-qr_name=ACS_2005_EST_G00_S1601&-geo_id=01000US&-ds_name=ACS_2005_EST_G00
- Shin HB, Bruno R (2003) *Language Use and English-Speaking Ability 2000*, Census 2000 Brief. Washington, DC: Census Bureau. Accessed online 11.18.06 at <http://www.census.gov/prod/2003pubs/c2kbr-29.pdf>
- Civil Rights Act of 1964, 42 U.S.C. Sec 2000d; 45 C.F.R Sec 80
- Collins JW, David RJ, Symons R, Handler A, Wall SN, Dwyer L (2000) Low income African –American mothers’ perception of exposure to racial discrimination and infant birth weight. *Epidemiology*; 11:337-9
- Diversity Rx.org (undated) *Why Language and Culture are Important*. Accessed online 11.18.06 www.diversityrx.org/HTML/ESLANG.htm
- Doak C, Doak L, Root J. (1996) *Teaching Patients with Low Literacy Skills*, Second Edition (1996) Philadelphia, PA: J.B. Lippincott Company
- Fadiman, A (1998) *The Spirit Catches You and You Fall Down* New York: Farrar, Straus & Giroux
- Hasnain-Wynia R, Yonek J, Pierce D, Kang R, Greising CH (October 2006) *Hospital Language Services for Patients with Limited English Proficiency: Results from a National Survey*. Health Research & Educational Trust, National Health Law Program. Accessed online 11.19.06 at <http://www.hret.org/hret/languageservices/content/languageservicesfr.pdf>
- JCAHO (1997) *Comprehensive Accreditation Manual For Hospitals*, 1996:9-10
- King G. Williams, DR (1995) Race and Health: a multi-dimensional approach to African American health. In: Levine S, Walsh DC, Amick B, Tarlov AR (eds) *Society and Health: foundation for a nation*. Cambridge MA, Oxford University Press
- Krieger N. (2000) Discrimination and Health. In: Berkman L, Kawachi I, ds. *Social Epidemiology*: Oxford: Oxford University Press: 36-75
- Karlsen S, Nazroo J (2002) Relation between racial discrimination, social class and health among ethnic minority groups. *American Journal of Public Health*; 92:624-31
- Mateo J, Gallardo EV, Huang VY, Niski C (Feb 2004) *Providing Healthcare to Limited English Proficient (LEP Patients: A Manual of Promising Practices*. Sacramento:

California Primary Care Association. Accessed on line 11.20.2006 http://www.hablamosjuntos.org/pdf_files/Providing_Healthcare_LEP_Feb2004.pdf

McKenzie K (2003) Racism and Health. *British Medical Journal*; 326:65-6

NCQA (2006) Volume 5: *HEDIS Compliance Audit Standards, Policies and Procedures*
Paasche-Orlow MK, Taylor HA, Brancati FL (2003) Readability standards for informed consent forms as compared with actual readability. *New England Journal of Medicine*; 348(8):721-6

Perkins J, Vera Y (1998) Legal protections to ensure linguistically appropriate health care. *Journal of Health Care for the Poor and Underserved*. Nashville ppS62-S80.

Philipson SJ, Doyle MA, Gabram SG, Nightengale, C, Philipson EH (1995) Informed Consent for Research: a study to evaluate readability and processability to effect change *Journal of Investigative Medicine* 43(5):459-67

Young DR, Hooker DT, Freeberg FE, Informed consent documents; increasing comprehension by reducing reading level. *IRB*. 1990:12(3):1-5