



# Spanish-Speaking Patients Have Limited Access Scheduling Outpatient Orthopaedic Appointments Compared With English-Speaking Patients Across the United States

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**Purpose:** To evaluate whether Spanish-speaking patients can obtain appointments to outpatient orthopaedic surgery clinics across the United States at a similar rate as English-speaking patients and to examine the language interpretation services available at those clinics. **Methods:** Orthopaedic offices nationwide were called by a bilingual investigator to request an appointment with a pre-established script. The investigators called in English asking for an appointment for an English-speaking patient (English–English), called in English requesting an appointment for a Spanish-speaking patient (English–Spanish), and called in Spanish asking for an appointment for a Spanish-speaking patient (Spanish–Spanish) in a random order. During each call whether an appointment was given, the number of days to the offered appointment, the mechanism of interpretation available in clinic, and whether the patient’s citizenship or insurance information was requested was collected. **Results:** A total of 78 clinics included in the analysis. There was a statistically significant decrease in access to scheduling an orthopaedic appointment in the Spanish–Spanish group (26.3%) compared with English–English (61.3%) or English–Spanish (58.8%) groups ( $P < .001$ ). There was no significant difference in access to appointment between rural and urban areas. Patients in the Spanish–Spanish group who made an appointment were offered in-person interpretation 55% of the time. There was no statistically significant difference in time from call to offered appointment or the request for citizenship status between the 3 groups. **Conclusions:** This study detected a considerable disparity regarding access to orthopaedic clinics nationwide in the individuals who called to establish an appointment in Spanish. Patients in the Spanish–Spanish group were able to make an appointment less often but had in-person interpreters available for interpretation services. **Clinical Relevance:** With a large Spanish-speaking population in the United States, it is important to understand how lack of proficiency with the English language may affect access to orthopaedic care. This study uncovers variables associated with difficulties scheduling appointments for Spanish-speaking patients.

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Spanish is the second most spoken language in the United States, second only to English. As of 2019, 41 million people in the United States older than the age of 5 years identified Spanish as their primary language, of whom 3 million reported speaking English “not at all” and 6 million spoke English “not well,” classifying them as having limited English proficiency (LEP). Another 7 million reported only speaking English “well.”<sup>1</sup> All patients with LEP are entitled to language support from organizations receiving federal assistance. Formal language support may be provided through various interpretation modalities, including electronic interpreters, bilingual staff, and qualified in-person interpreters per Title VI of the 1964 Civil Rights Act.<sup>2</sup> It has been well documented that patients

with LEP are at a greater risk for having poor communication with physicians who do not use any form of language support, increasing the likelihood of lower-quality treatment<sup>3</sup> and increasing the rate of safety events.<sup>4</sup> Effective communication between physicians and their patients during outpatient appointments is also crucial to establishing a doctor–patient relationship and results in improved medical care.<sup>5</sup> Individuals who do not have this relationship are at risk for receiving lower-quality services from their health care provider.<sup>6–10</sup> Those who cannot access a provider at all are at even greater risk for worse health outcomes.<sup>11,12</sup>

A study published in 2019 by Greene et al<sup>13</sup> examined access to orthopaedic care for Spanish-speaking patients in California. The study concluded that there was no significant difference between Spanish-speaking and English-speaking patients regarding obtaining an appointment to an outpatient orthopaedic surgeon. However, they noted several limitations in their study, including only collecting data in a single state and lacking a third category of patients who spoke solely Spanish to establish an appointment.

The purpose of this study was to evaluate whether Spanish-speaking patients can obtain appointments to outpatient orthopaedic surgery clinics across the United States at a similar rate to English-speaking patients and to examine the language interpretation services available at those clinics. We hypothesized that patients who called orthopaedic clinics using only Spanish would have less success scheduling an appointment. We also hypothesized that Spanish-speaking patients would have longer wait times from call to an offered appointment and have their citizenship and insurance information asked more frequently.

## Methods

### Participants

The “Find an Orthopaedist” search tool provided by the American Academy of Orthopaedic Surgery was used to generate a comprehensive list of all orthopaedic surgeons who identified as specializing in sports medicine in the United States as well as their primary location of practice. Providers caring for exclusively pediatric populations or veterans were excluded as well as alternate providers, including athletic trainers, physician associates, sports medicine fellows, or nonoperative sports medicine physicians. All providers were organized into 4 different geographic regions (Midwest, Northeast, South, and West) as defined by the U.S. Census Bureau. Using the 2012–2016 American Community Survey 5-Year Estimates from the U.S. Census Bureau, population demographics were recorded for each city in which each surgeon’s practice resided and the city was identified as either Rural or Urban based on Economic Research Service U.S.

Department of Agriculture Rural-Urban Continuum Codes. All offices were numbered, a random number generator was used to select 20 offices in each region which resulted in ten urban and ten rural offices being selected in each geographic region.

### Procedure

Each of the randomly selected offices were called via telephone by a Spanish-speaking investigator to request an appointment with a pre-established script ([Appendix 1](#), available at [www.arthroscopyjournal.org](http://www.arthroscopyjournal.org)). Two of the 4 investigators (M.C., A.M., S.M., A.A.) who called clinics are native Spanish speakers and the other 2 have advanced degrees in the Spanish language. The investigator stated that he/she was calling on behalf of their father who needed an appointment with an orthopaedic surgeon for evaluation of shoulder pain. Before the call, the investigator used a die to establish the preferred language for the visit. The numbers 1 and 4 indicated that the call would be conducted in English for an English-speaking father, the numbers 2 and 5 indicated that the call would be conducted in English for a Spanish-speaking father, and numbers 3 and 6 indicated that the call would be conducted in Spanish for a Spanish-speaking father. One week after the initial contact, the investigator called the same clinic again with the same scenario, but this time flipped a coin to randomly choose one of the remaining 2 language options. The following week, the clinic was called one more time with the final remaining language option. The same script was used for all telephone calls.

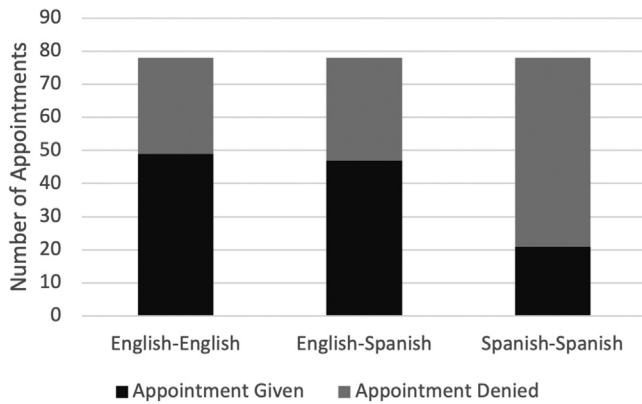
With each telephone call, the following data were collected: (1) Whether an appointment was given; (2) number of days from the call to when the appointment was offered; (3) the exact mechanism of interpretation available for the appointment (in-person Spanish Interpreter, Spanish-speaking physician, Interpreter via device [iPad/telephone], or if patient was asked to bring a bilingual speaking friend or family member); (4) whether the patient’s citizenship status was asked; and (5) whether insurance information was asked and whether this impacted access to an appointment.

### Analysis

$\chi^2$  analysis was conducted for access to appointment, interpreter services available, insurance information, and citizenship status asked. Time to appointment was not in a normal distribution, thus a Kruskal–Wallis H test was used and revealed no significance between variables that were not related.

## Results

Two clinics were excluded because of inconsistencies with the script between calls of the same clinic; thus, data from 78 clinics were analyzed. In total, 39 of 50



**Fig 1.** Number of appointments given and not given among the English–English, English–Spanish, and Spanish–Spanish groups.

states were accounted for in our analysis. The majority of practices included were private orthopaedic groups, accounting for 60 of 80 clinics. Academic institutions had the second most representation at 18 of 80 clinics. One Veterans Affairs clinic and 1 community hospital clinic also were included.

### Access to Appointment

There was a statistically significant reduction in the ability to schedule an orthopaedic appointment in the Spanish–Spanish group (21/78, 26.6%) compared with English–English (49/78, 61.3%) and English–Spanish (47/78, 58.8%) groups ( $P < .001$ ). There was no significant difference between the English–English and English–Spanish groups (Fig 1).

When comparing the ability to obtain an orthopaedic appointment between urban and rural areas, we found no significant difference between the 3 groups. Of the patients in the Spanish–Spanish group who were able to make an appointment, 13 of the appointments were made by a Spanish-speaking receptionist or other employee; 9 were made via an over the phone interpretation service.

Reasons why the patients in the Spanish–Spanish group were unable to obtain an appointment revealed that 24 clinics did not understand the language, did not offer alternative ways of communication, and did not make an appointment. In none of these cases was over-the-phone interpretation available. Five clinics offered a call with an interpreter, but the call was lost or disconnected. In 4 instances, the caller was on hold for more than 45 minutes and the interaction was ended. In 1 instance, the call was able to be forwarded to the interpreter, but connection with the clinical scheduler was lost. There were 5 instances in which the clinic said they would call back with an interpreter but did not. There were 2 instances in which the clinic stated an interpreter service was available but did not provide the

information. There were 3 instances in which the patient was asked to call back the next day when a Spanish-speaking individual was present. Lastly, there was 1 instance in which the patient was transferred to an interpretation services software hotline that was meant to purchase interpretation software.

### Time to Appointment

When an appointment was established, there was no statistically significant difference in time to appointment between the English–English, English–Spanish, and Spanish–Spanish groups. The average amount of days from a call to an offered appointment was 9.9 (standard deviation [SD] 7.2; confidence interval [CI] 8.1–11.6) for the English–English group, 10.5 (SD 10.4; CI 8–13) for the English–Spanish group, and 7.8 (SD 6.6; CI 5.2–10.4) for the Spanish–Spanish group.

### Access to Qualified Interpreter

Patients in the Spanish–Spanish group who were offered an appointment (21 clinics), 15% of clinics had a physician who spoke Spanish, 55% of clinics offered an in-person interpreter, 27.5% of clinics offered electronic interpretation, and 2.5% of clinics asked the patient to bring a bilingual family member (Fig 2).

Of the patients in the English–Spanish group who were offered an appointment (47 clinics), 6.6% of clinics had a physician who spoke Spanish, 38.6% of clinics offered an in-person interpreter, 45.3% of clinics offered electronic interpretation, and 3.9% of clinics asked the patient to bring a family member (Fig 2).

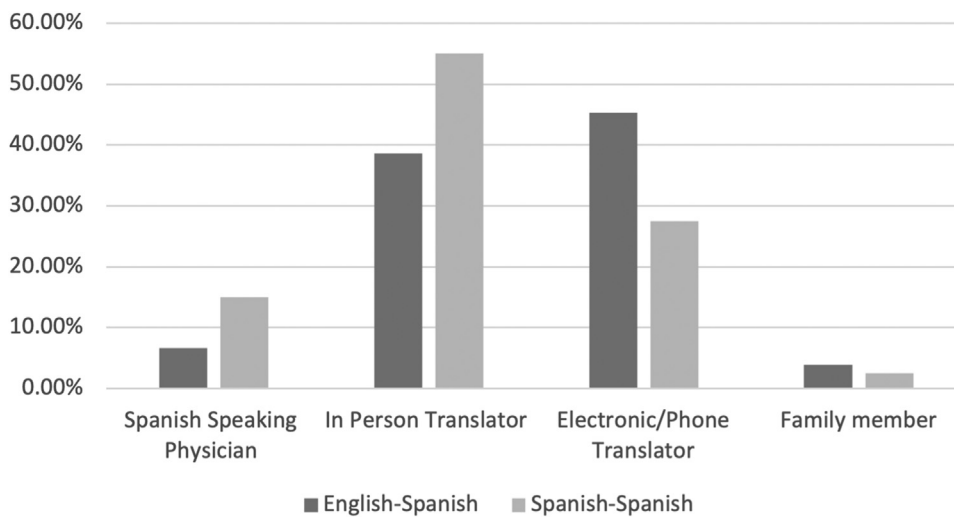
### Citizenship Status and Insurance information

Insurance information was asked for 51 of 78 calls in the English–English group, 50 of 78 in the English–Spanish group, and 21 of 78 calls in the Spanish–Spanish group. The Spanish–Spanish group was asked significantly less than the other 2 groups ( $P < .001$ ). There was no statistically significant difference between the English–English group and English–Spanish group.

Citizenship status was only asked for during 1 call in the English–English group and was not asked during any calls in the English–Spanish or Spanish–Spanish groups. No significant difference was found between the groups ( $P = .3$ ).

## Discussion

The most important findings of this study demonstrate that there was a significant reduction in the ability to schedule an outpatient orthopaedic appointment in Spanish compared with scheduling an appointment in English in clinics randomly selected throughout the United States. It has been well documented that patients with LEP are less likely to receive preventative appointments and services,<sup>14–16</sup> which is



**Fig 2.** Percentage breakdown of type of interpretation services offered (Spanish-speaking physician, in-person interpreter, electronic interpreter, or asked to bring a Spanish-speaking family member) in the English–Spanish and Spanish–Spanish groups amongst the patients that were able to schedule an appointment.

consistent with our findings. This study highlighted multiple variables that may be associated with limited access to care for Spanish-speaking patients. First, a patient must have the ability to secure an appointment with a provider before any discussion of the utility of interpretation services during an office visit are measured. Only after a patient has secured an appointment do we have the opportunity to determine whether effective or appropriate care was given based on the language services available. We believe that the ability to secure access to an appointment has more to do with the language-comprehension abilities between the patient and scheduling staff rather than language comprehension issue between patients and physicians, which is less commonly discussed in the literature.<sup>17</sup> A limited number of clinics in this study had bilingual receptionists available to schedule appointments, and in those instances a majority of the time receptionists did not have the tools or were unaware of the tools necessary to continue the interaction to schedule an appointment. Even when digital over-the-phone services were available for a receptionist to use, there were numerous technical issues, including loss of connection, prolonged call times, and lack of call backs that arose preventing the appointment to be scheduled in a reliable, timely, way. This study did not collect or examine the challenges solely Spanish-speaking patients have in navigating phone trees which may be an added barrier to obtaining an appointment. Given these findings, we recommend that more attention and resources be directed at implementing better interpreter services during the initial phase of scheduling appointments.<sup>18</sup> It also should be acknowledged that clinics that have minimal-to-zero Hispanic patients in the surrounding area may not accurately describe a lack of access since their populations may be less likely to be Spanish-speaking. Future

studies should expand on these findings by incorporating a larger sample size of clinics.

In the event a Spanish-speaking patient was able to establish an appointment, only a small fraction of clinics had a Spanish-speaking physician. A study published by Seible et al.<sup>19</sup> examined patient reported outcomes in 83 Spanish speaking patients with cancer who were seen by bilingual physicians that spoke both English and Spanish vs English speaking physicians that used a professional interpreter service. They concluded that patients receiving care from a bilingual Spanish-speaking physician had better patient satisfaction and higher technical quality of care than patients being taken care of by a physician using a certified interpreter. While having a bilingual physician is the gold standard, more than 50% of the time an individual in the Spanish-Spanish group had access to an in-person interpreter.

In contrast to the study by Greene et al,<sup>13</sup> most of the patients in this study had access to a certified in-person or electronic interpreter and were less likely to rely on ad hoc interpreters. Professional interpreters are the best solution to overcoming language barriers between patients and physicians who do not speak the same language, as the patient and have been proven to increase health care delivery to patients with LEP.<sup>20,21</sup> A systematic review including 28 studies examining communication errors, patient satisfaction, and clinical outcomes between professional interpreters and ad hoc interpreters reported positive benefits in all domains when patients used professional interpreters compared to ad hoc interpreters.<sup>22</sup> An ad hoc interpreter is typically defined as an untrained person who is called upon to interpret, such as a family member interpreting for their parent, a bilingual staff member pulled away from other duties to interpret, or a self-declared bilingual

person in a hospital waiting-room who volunteers to interpret.<sup>23</sup> Professional interpreters undergo a standardized certification process and are the most skilled in medical interpretation, the least likely to make errors, and the only type of interpreter associated with overall improvement of care for patients with limited English proficiency.<sup>24,25</sup> However, professional on-site interpreters may not be immediately available, and professional telephone interpreters may feel impersonal or be difficult to use for patients with hearing or speech impairments.<sup>26</sup>

Although rare, there were a few instances in this study in which a Spanish-speaking patient who was able to obtain an appointment was asked to rely on family/friends for interpretation services because the practice itself did not have access to a qualified interrupter. Family members often have inadequate language skills, resulting in greater rates of clinically significant errors.<sup>25,27</sup> Family members also may interpret information selectively to fit their own beliefs. This disconnect highlights an important discrepancy. Even if a Spanish-speaking individual obtains help securing an appointment, the patient may have limited interaction with their physician because of a lack of communication, potentially leading to repeat visits, unnecessary evaluations, and lower quality care.<sup>28</sup> Although bilingual staff may be convenient and available, their language skills are usually not tested and may be inadequate.<sup>29</sup>

This study expanded on multiple limitations of Greene et al,<sup>13</sup> which focused on a single state, whereas our study included sports medicine orthopaedic clinics from around the country. The study by Greene et al<sup>13</sup> was limited to 50 clinics, whereas this study included 80 clinics, increasing the power of this study. Most importantly, a third category of Spanish-speaking patients was incorporated while calling for appointments to better isolate if Spanish-speaking patients who are not bilingual have equal access to orthopaedic care. Although this study was limited to orthopaedic clinics, further studies should examine whether access to appointments is also limited in other surgical and nonsurgical specialties in the United States. Additional studies using this protocol can also be done to determine if similar disparities are found in other languages.

### Limitations

This study included several limitations. First, this study does not quantify the level of satisfaction Spanish-speaking patients have with different interpretation modalities. Most often patients were offered an electronic interpreter, and although previous research has examined visit quality between in-person and electronic interpreters, this study does not add to that body of knowledge. Second, we acknowledge that 80 orthopaedic clinics around the United States is a fraction of all orthopaedic clinics. Because clinics were

chosen at random, it is expected that clinics established in areas with a larger Hispanic population may have a greater proportion of Spanish-speaking physicians who can accommodate the population in need. Rather than choosing clinics at random, a certain number of clinics can be called in each state in proportion to the number of Spanish speakers available in that state. Lastly, as in the study by Greene et al,<sup>13</sup> having a 65-year-old fictitious patient with government insurance may have introduced bias when scheduling an orthopaedic sports medicine appointment since Medicare does not routinely cover language services.<sup>30</sup>

### Conclusions

This study detected a considerable disparity regarding access to orthopaedic clinics nationwide in the individuals who called to establish an appointment in Spanish. Patients in the Spanish–Spanish group were able to make an appointment less often but had in-person interpreters available for interpretation services.

### References

1. Census - Table Results. <https://data.census.gov/cedsci/table?q=spanish%20speak&tid=ACST1Y2019.S1601>. Accessed March 4, 2022.
2. Title VI of the Civil Rights Act of 1964 42 U.S.C. § 2000d Et Seq. Published August 6, 2015, <https://www.justice.gov/crt/fcs/titlevi-overview>. Accessed July 9, 2022.
3. Al Shamsi H, Almutairi AG, Al Mashrafi S, Al Kalbani T. Implications of language barriers for healthcare: A systematic review. *Oman Med J* 2020;35:e122.
4. Chauhan A, Walton M, Manias E, et al. The safety of health care for ethnic minority patients: A systematic review. *Int J Equity Health* 2020;19:118.
5. Brandl EJ, Schreiter S, Schouler-Ocak M. Are trained medical interpreters worth the cost? A review of the current literature on cost and cost-effectiveness. *J Immigr Minor Health* 2020;22:175-181.
6. Jacobs EA, Sadowski LS, Rathouz PJ. The impact of an enhanced interpreter service intervention on hospital costs and patient satisfaction. *J Gen Intern Med* 2007;22:306-311 (suppl 2).
7. Jacobs EA, Shepard DS, Suaya JA, Stone EL. Overcoming language barriers in health care: costs and benefits of interpreter services. *Am J Public Health* 2004;94:866-869.
8. Moreno MR, Otero-Sabogal R, Newman J. Assessing dual-role staff-interpreter linguistic competency in an integrated healthcare system. *J Gen Intern Med* 2007;22:331-335 (suppl 2).
9. Martinez EM, Carr DT, Mullan PC, et al. Improving equity of care for patients with limited English proficiency using quality improvement methodology. *PediatrQualSaf* 2021;6:e486.
10. Soleimani J, Marquez A, Fathma S, Weister TJ, Barwise AK. Detecting professional interpreter use among patients with limited English proficiency: Derivation and validation study. *SAGE Open Med* 2022;10:20503121221098144.
11. Espinoza Suarez NR, Urtecho M, Nyquist CA, et al. Consequences of suboptimal communication for patients with

- limited English proficiency in the intensive care unit and suggestions for a way forward: A qualitative study of healthcare team perceptions. *J Crit Care* 2021;61:247-251.
12. Ramirez N, Shi K, Yabroff KR, Han X, Fedewa SA, Nogueira LM. Access to care among adults with limited English proficiency [published online July 26, 2022]. *J Gen Intern Med*. doi:10.1007/s11606-022-07690-3.
  13. Greene NE, Fuentes-Juárez BN, Sabatini CS. Access to orthopaedic care for Spanish-speaking patients in California. *J Bone Joint Surg Am* 2019;101:e95.
  14. Fiscella K, Franks P, Doescher MP, Saver BG. Disparities in health care by race, ethnicity, and language among the insured: Findings from a national sample. *Med Care* 2002;40:52-59.
  15. Sentell T, Shumway M, Snowden L. Access to mental health treatment by English language proficiency and race/ethnicity. *J Gen Intern Med* 2007;22:289-293 (suppl 2).
  16. Woloshin S, Schwartz LM, Katz SJ, Welch HG. Is language a barrier to the use of preventive services? *J Gen Intern Med* 1997;12:472-477.
  17. Kornbluth L, Kaplan CP, Diamond L, Karliner LS. Communication methods between outpatients with limited-English proficiency and ancillary staff: LASI study results. *Patient Educ Couns* 2022;105:246-249.
  18. Hilder J, Gray B, Stubbe M. Health navigation and interpreting services for patients with limited English proficiency: A narrative literature review. *J Prim Health Care* 2019;11:217-226.
  19. Seible DM, Kundu S, Azuara A, et al. The influence of patient-provider language concordance in cancer care: Results of the Hispanic Outcomes by Language Approach (HOLA) randomized trial. *Int J Radiat Oncol Biol Phys* 2021;111:856-864.
  20. Abbato S, Greer R, Ryan J, Vayne-Bossert P, Good P. The impact of provision of professional language interpretation on length of stay and readmission rates in an acute care hospital setting. *J Immigr Minor Health* 2019;21:965-970.
  21. Jacobs EA, Lauderdale DS, Meltzer D, Shorey JM, Levinson W, Thisted RA. Impact of interpreter services on delivery of health care to limited-English-proficient patients. *J Gen Intern Med* 2001;16:468-474.
  22. Karliner LS, Pérez-Stable EJ, Gregorich SE. Convenient access to professional interpreters in the hospital decreases readmission rates and estimated hospital expenditures for patients with limited English proficiency. *Med Care* 2017;55:199-206.
  23. Karliner LS, Jacobs EA, Chen AH, Mutha S. Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health Serv Res* 2007;42:727-754.
  24. Flores G, Laws MB, Mayo SJ, et al. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics* 2003;111:6-14.
  25. Paradise RK, Hatch M, Quessa A, Gargano F, Khaliif M, Costa V. Reducing the use of ad hoc interpreters at a safety-net health care system. *Jt Comm J Qual Patient Saf* 2019;45:397-405.
  26. Taylor DL, Sierra T, Maheshwari D, Hall C, Leung K, Flynn M. Satisfaction with telephone versus in-person interpretation services in limited English-proficient urogynecology patients: A randomized controlled trial. *Female Pelvic Med Reconstr Surg* 2021;27:388-392.
  27. Leanza Y, Boivin I, Rosenberg E. Interruptions and resistance: A comparison of medical consultations with family and trained interpreters. *Soc Sci Med* 2010;70:1888-1895.
  28. Juckett G, Unger K. Appropriate use of medical interpreters. *Am Fam Physician* 2014;90:476-480.
  29. Elderkin-Thompson V, Silver RC, Waitzkin H. When nurses double as interpreters: A study of Spanish-speaking patients in a US primary care setting. *Soc Sci Med* 2001;52:1343-1358.
  30. Ponce NA, Ku L, Cunningham WE, Brown ER. Language barriers to health care access among Medicare beneficiaries. *Inquiry* 2006;43:66-76.

## Appendix 1

### Call Scripts:

#### English:

Hello, my name is \*\*\* and I am calling to schedule an appointment for my father Carlos Gonzalez. He has had shoulder pain for about 3 months, and it is hard for him to lift his arm now. Our primary care doctor told us to see physical therapy, but it has not helped, so his primary care doctor told us to call for an appointment with an orthopaedic surgeon.

#### English (Spanish speaker):

Hello, my name is \*\*\*, and I am calling to schedule an appointment for my father Carlos Gonzalez. He has had shoulder pain for about 3 months, and it is hard for him to lift his arm now. Our primary care doctor told us to see physical therapy, but it has not helped, so his primary care doctor told us to call for an appointment with an orthopaedic surgeon. He only speaks Spanish so I was wondering if you have any Spanish-speaking doctors or other resources to help him at the appointment.

#### Spanish (Spanish speaker):

Hola, Mi llamo \*\*\* y estoy llamando para programar una cita por mi padre, Carlos Gonzalez. El tienes dolor de hombro cerca de tres meses, y es difícil levantar su brazo ahora. Nuestros médico de cabecera que nos dijo ver fisioterapia, pero no ayudo. Así, su médico de cabecera nos dijo llamar para una cita con un cirujano ortopédico. Solo habla español, así que me estaba preguntando

si tienes algunos doctores que hablan español o otro recursos para le ayudar en la cita.

### Standard Answers if Asked:

*Age:* 65

*Insurance:* Medicare

*Availability:* Next available appointment

Proxima cita disponible

*Diagnosis (From PCP):* Possible rotator cuff tear. His doctor said he might need surgery.

Posible desgarró del manguito rotador. Su médico dijo el podría necesitar

cirugía.

*History:*

He has been in pain for the past 6 weeks. He thinks he hurt it unloading groceries from

the car. He cannot lift his shoulder very high. Pain has not gotten better with rest, ice, ibuprofen or Tylenol.

El ha estado en dolor por el 6 semanas pasado. El piensa que se le lastimó descarga de comestibles del carro. El no puede levantar el hombro tan alto. El dolor no mejora con descanso, hielo, ibuprofen ni Tylenol.

*Imaging:* He does not have X-rays.

El no tiene radiografías

*Phone:* This is a good number to reach him. I am the one who keeps track of his appointments.

Este número está bien para me contacto. Soy el persona que realiza un seguimiento de sus citas.