Misinterpretation

Language proficiency, recent immigrants, and global health disparities

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In the recent Longitudinal Survey of Immigrants to Canada conducted by Statistics Canada, immigrants reported language barriers as their biggest difficulty next to finding adequate jobs; 4 years after arriving in Canada, 26% of all new immigrants still reported language difficulties in English or French.[1] Family physicians will face these language barriers in caring for new immigrants and this can lead to difficulties not only in obtaining adequate histories, but also in communicating medical advice and health promotion information.

Language and cultural barriers can have adverse effects on the accessibility of care, the quality of care, patient satisfaction, and health outcomes.[1] Communication is considered one of the most important prerequisites for safety in health care.[2] Studies have clearly demonstrated that lack of language proficiency is associated with poor access to health services[3,4] and preventive services.[5] Language barriers also contribute to the inability to book appointments or to follow advice on prescriptions, and contribute to overall poorer quality and poorer outcomes of care.[6,7]

Case description

Mrs A., a 38-year-old recent refugee from Sierra Leone, gave birth to a baby girl at a tertiary care hospital. The infant, delivered uneventfully at term, was diagnosed with Down syndrome and was noted to have a substantial heart murmur. The infant was admitted to the neonatal intensive care unit (NICU) for monitoring and, after an echocardiogram, was found to have a ventricular septal defect. The infant, in stable condition, was booked for cardiac surgery in 6 months' time.

In the NICU, Mrs A. was noted to speak "broken" English; this raised a red flag in the eyes of a NICU nurse, and a child protection agency was contacted. On assessment, the agency discovered that 2 of Mrs A.'s 4 previous children had died in Sierra Leone younger than 5 years of age. The agency was also concerned with the perceived low intelligence level of Mrs A., given her broken English and, on observation, discovering that she placed a pillow in the crib for her newborn. Mrs A. also suffered from some degree of hearing deficit resulting from a bomb attack in Sierra Leone in which she escaped death by jumping from a second-floor window. Before immigrating to Canada, Mrs A. had worked for 4 years as a nanny, caring for 2 sets of twins in Nigeria. The agency was concerned with the mother's ability to care for her child and recommended that the child be removed from its mother and placed with a foster parent. The medical staff and agency communicated with Mrs A. through her adult son, who had immigrated to Canada a few months earlier.

The attending resident family physician, impressed with the mother's commitment to wellness and prenatal care, did not feel that Mrs A. was an unfit mother, but was unable to influence the assessment process. The case went to court, again with the adult son translating, and the outcome was that the infant was apprehended into the care of the child protection agency and placed in a foster home. Mrs A. retained supervised visitation rights but was deeply distressed by the loss of her daughter. The resident physician brought this case to the attention of an interdisciplinary team at a local refugee health clinic.

The refugee health team brought Mrs A. and the adult son to the clinic to clarify the situation. Using a standard technique of interpretation (**Table 1**), the team ascertained that the son had not been accurately interpreting what was said to his mother; he was a student with a part-time job who was finding the added burden of helping his mother difficult. When the son was repeatedly asked to directly interpret the spoken words, Mrs A., until then withdrawn and quiet, came to life as she realized that she had the right to fight for the guardianship of her newborn daughter.

The local Sierra Leonean community was then contacted and a qualified interpreter was provided. This revealed the urgent need to find a lawyer for Mrs A., and the process was started to recover her lost daughter. The mother's hearing deficit was addressed with a hearing aid. Six months later, after the surgical procedure and successful court hearings, the daughter was returned to Mrs A. Both mother and daughter have done very well with uneventful medical follow-up; however, mother and son remain estranged.

Discussion

The inability to express one's wishes and needs in health encounters can result in poor health outcomes and in disempowerment of patients.[8] Working effectively

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Table 1. Helpful tips for family physicians working with interpreters

Beginning the medical interview
• Budget time for set-up, interpretation, and debriefing.
• Formally introduce yourself to the interpreter and patient.
• Invite the interpreter to sit next to the patient.
• Instruct the patient to look at the physician while the interpreter is speaking (when culturally appropriate).
• Insist on direct interpretation.
• Explain that the interpreter can request a time-out to clarify issues.
During the medical interview
• Use short and simple sentences when speaking.
• Avoid jargon—medical or otherwise.
• Ask 1 question at a time.
• Speak directly to the patient in a normal voice (maintain eye contact when culturally appropriate).
• Request a time-out to clarify issues.
• Watch for nonverbal communication.
• Ensure you are communicating effectively by requesting that the patient repeat the message back to you.

through interpreters is one avenue to ensure quality and safety of care.[9]

In this case, Mrs A. arrived to Canada speaking Krio, a creole language native to Krios (a community of descendants of freed slaves) that is spoken by 4 million people in Sierra Leone. Mrs A.'s Krio was misinterpreted as broken English, which was considered an indicator of lower intelligence. The death of 2 of her children was perceived as another indictor of a limited parenting capacity, yet the under-5 mortality is 30% in Sierra Leone[10] and, given Mrs A.'s experience as a refugee, the loss of 2 children during wartime would not be exceptional. The use of a pillow for her infant was considered another serious concern; there was no appreciation given to the history of difficult living conditions experienced by Mrs A. in Sierra Leone, where a pillow might be a luxury. The hearing deficit, also cited as a concern, was treatable with hearing aids. A critical issue in this case is the use of a family member for interpretation in several critical situations, including in the medical assessments and the legal hearing; our legal system holds that it is a right to have qualified interpretation. Assessments are an important part of child welfare; however, the quality of those assessments also needs to be ensured as such assessments can have dramatic effects on families new to Canada.

The quality of patient care is improved with the use of professional interpreters.[11] Key points to remember are that professional interpreters provide the best outcomes and working with interpreters demands set-up time and some practice. When done properly, working through an interpreter can improve communication and allow for relationship development. Working with interpreters can be improved with attention to some basic tips (**Table 1**). Advances are being made with respect to improving cultural and linguistic competency standards,[12] but physicians must remain aware of the risk for suboptimal care in the context of language and cultural barriers.

Conclusion

This case illustrates the challenges of health-related assessments in the context of language barriers and

Practical interpretive and linguistic resources for family physicians

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- Ontario Council of Agencies Serving Immigrants. *Settlement.org* [website]. Ontario Council of Agencies Serving Immigrants: Toronto, Ont; 2007. Available from: **www.settlement.org/site/HE**.
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global health disparities, as well as the risk associated with using family members as interpreters. Family physicians can play a leading role in ensuring quality health care for new immigrants by learning how to effectively communicate through interpreters, insisting on qualified interpreters, and resisting the tendency to turn a blind eye to suboptimal care in the face of language and cultural barriers. The reflective awareness and advocacy on the part of the resident physician in this case provides a positive lead for us to follow.

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Competing interests
None declared

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EDITOR'S KEY POINTS

- The ability to communicate effectively with patients is central in the provision of good health care.
- Although it might be convenient to use family or community members as interpreters, this practice can result in accidental or (rarely) deliberate misunderstandings.
- At the very least, professional interpretation should be used in situations where complex or difficult situations are being discussed.

POINTS DE REPÈRE DU RÉDACTEUR

- La capacité de communiquer efficacement avec les patients est essentielle à la bonne qualité des soins.
- Même s'il peut être utile de recourir à des membres de la famille ou de la communauté comme interprètes, cela peut être la source de malentendus involontaires ou (rarement) délibérés.
- À tout le moins, il faudrait recourir à un interprète professionnel lorsqu'on discute de situations complexes ou difficiles.

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