REALITIES AND MYTHS OF LINGUISTIC BARRIERS IN HEALTH CARE

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Introduction and Aims: The Cultural Consultation Service (CCS) receives consultations from primary care and specialty medicine to clarify the diagnosis and treatment plan of immigrants and refugees. The CCS routinely works with patients from linguistic minorities: of the first 360 cases referred, patients spoke 31 languages from 31 countries, making the use of interpreters an absolute must in this clinical setting. The CCS is a microcosm of broader trends: approximately 20% of the Canadian population is foreign-born. Diversity in medical settings is becoming the norm in urban centers, raising questions of access to and quality of care for Canada's immigrant and refugee citizens. This paper aims to examine the myths and realities of linguistic barriers in health care by reviewing relevant clinical examples, proposing solutions, and raising questions for further inquiry.

Myths: 1) Generally speaking, there is not enough time or money to regularly use interpreters in the care of patients from linguistic minorities. Interpreters are a luxury that can be discontinued in the interests of expediency and cost-saving; 2) When interpreters are necessary, non-professional interpreters are sufficient; 3) In most clinical settings, patients from linguistically diverse backgrounds speak French or English well enough to describe their health problems without interpreters; and 4) Immigrants and refugees should provide their own interpreters, if needed.

Realities: 1) Not offering interpreters to patients from linguistic minorities may compromise health or life, with loss of time and money in the long term. The use of interpreters should be a basic medical act fundamental to ethical and competent health care (Worlds Apart, Part 1, Stanford University, 2003); 2) Use of non-professional interpreters in clinical medicine should be a last resort; 3) Patients from linguistic minorities often speak some French or English but not enough to comfortably explain their health concerns; and 4) When interpreters are not provided, immigrants and refugees may seek health care elsewhere or not at all.

Examples: 1) *Interpreters are not a luxury but a medical necessity*. An emergency department doctor tells a 36 year-old Albanian male that his blood type is A+. He understands HIV+, begins to obsess about AIDS, and searches the Internet for 4 days and nights. His wife brings him to the hospital where he is evaluated by a psychiatrist. Language barrier is noted, but an interpreter is never used. The patient is discharged home, given a follow up appointment with his family doctor, and given an urgent outpatient appointment with a psychiatrist. Unfortunately, the patient throws himself beneath the wheels of a moving tractor trailer and dies of his injuries before making it to the evaluation (Government of Québec report, 2005); 2) *Professional interpreters should be used whenever possible, rather than family members or other non-professionals*. A 39 year-old Chinese woman, whose husband acts as the interpreter, comes to the emergency

department. The husband wants his wife to continue working despite the presence of severe psychotic symptoms, a request that the patient seems to accept. Due to language barrier, and without a professional interpreter, direct access to the wishes of the patient is impossible. She is eventually discharged to the care of her husband at her own insistence; 3) *Many patients speaking a second or third language would benefit from a language interpreter who speaks their first language*. A middle-aged couple from Bangladesh is referred for the assessment of the wife's chronic depression, which is exacerbated by tensions with her husband. A Bengali-speaking interpreter translates the questions the psychiatrist asks the couple, to which the husband responds exclusively. After a little while, the interpreter, who has noticed that the man does not speak Bengali fluently and has an accent, inquires from which part of the country they come, only to discover that the couple comes from the same region as he does. The interpreter shifts languages, allowing the woman to understand and speak for herself, thus interacting directly with health care professionals for the first time since arriving in Canada 15 years ago; 4) *The responsibility to provide interpreters should not be put upon immigrants and refugees*. A 58-year-old Arabic-speaking woman from Algeria is illiterate, receives welfare, has few social contacts, and speaks virtually no French or English. Her application to learn French in Québec is refused because of illiteracy in her mother tongue. She needs an interpreter to function in public venues. When interpreters were no longer provided by her medical institution, she stopps medical follow up (for peptic ulcer, hypertension, panic disorder) because she can no longer communicate with her doctors. Given the nature of her problems (intimate partner violence, marital separation), it is not culturally appropriate for the patient to use her daughters as interpreters.

Proposed Solutions: 1) Access – Interpreters must be offered to all patients whose mother tongue is other than French or English; 2) Response – There needs to be a mechanism put in place to ensure that interpreters are available in urgent care settings; and 3) Training – Health care professionals need to be taught from the beginning of their education about the politics and practicalities of language in health care settings, including working with interpreters in the clinic.

Questions for further inquiry: 1) Will the use of interpreters need to become official health policy (provincial or institutional) before we see progress in this vastly neglected area? 2) Interpreters are used routinely in legal settings – should medical settings be any less important? What can the health care system learn from the legal system in this regard? 3) If interpreters are not offered, or are not available, what kind of health care do linguistic minorities receive compared to those who are fluent in French and/or English?