



Lost in translation: Physicians' perspective on how language barriers affect diabetes care & outcomes among Latino patients with limited English proficiency (LEP)

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Introduction

- At least 21 million of US Latinos, the largest and fastest growing minority population in the US, have limited English proficiency (LEP).
- Latinos are disproportionately affected by diabetes. Poor diabetes outcomes among them are at least in part due to language barriers.
- Few studies have explored physicians' perceptions of impact of language barriers on diabetes care.

Specific Aims

- To examine physicians' perspectives on how language barriers influence diabetes management and outcomes.

Methods

- Approach: qualitative
- Study site: urban safety net teaching hospital
- Sample: faculty & residents, internal medicine clinic
- Recruitment: e-mail; word of mouth
- Theoretical framework: interpretive phenomenology

Participant Demographics

Physician Characteristics	14
Rank	% (N)
Faculty	64 (9)
Resident	36 (5)
Years since graduation	
≤ 15 years	71 (10)
> 15 years	29 (4)
Gender	
Female	50 (7)
Male	50 (7)
Race/Ethnicity	
African American	7 (1)
Asian	29 (4)
White	64 (9)
Hispanic	0 (0)
Other/Unknown	0 (0)
Spanish fluency	
Very good to excellent	36 (5)
Fair to none	64 (9)

Findings: Key themes

Interpersonal level

- harder for doctor to "get" patient
- harder for doctor to get patient "buy in"
- patient more passive
- doctor less able to convey to patient that they care
- less trust from patient
- less assertiveness from doctor
- doctor misses on nuances
- frequent mismatch between doctors' / patients' expectations about mutual roles

Health systems level

- interpreters not always available
- some interpreters poorly trained
- lack of agreement on interpreter role
- equipment malfunctioning takes away precious time
- lack of supporting bilingual staff

Societal / Cultural levels

- poor LEP patients greater difficulties w/multiple co-morbidities
- LEP patients poorer than Latino English proficient patients
- cultural divide harder to bridge



The neighborhood



The setting



The population

Doctor-patient level

Her English is pretty good, but some nuances get lost, especially concerning the specifics of her diabetes care, such as when do you use your sliding scale and when you shouldn't, and if your sugar is lower, how much should you give yourself? So I think there probably was something lost in translation

You're not having the instantaneous connecting facial reaction, questions, concerns; all of that affective component of communication is really lost when you're working through an interpreter. Not to mention the issue of interpretation errors and summarizing, and who knows what else goes on in the interpretive process that is unknown to both parties

With the LEP patient there's a lot less give and take. A lot of me talking and then not responding or just okay, without really me being convinced, pushing that they got it and they internalized it; and I often feel that I want to repeat it again and again or say, what are you thinking or tell me back what we're deciding here.

Health systems

There are so many system issues. I've been here almost three years now. During my first few years, you literally could not call an interpreter at 5:00 p.m., because it's their change of shift, and then you're waiting on them to page you back, and then you have to call a language line. I'm like, "Well, why can't I just call the language line straight up?" Then you go and get some machines and then, "Oh, we don't have enough machines."

If there are small things I want to communicate, I don't want to wait another 10 minutes to call the Video Monitor Interpreter (VMI). If you had enough Hispanic or Cantonese medical assistants (MAs) you could pair them up with your panel and plan ahead. Like, "Oh, this is my Cantonese day." Just give me a Cantonese MA. That would save so much time, make my life so much easier.

Sometimes [the interpretation] doesn't make sense... I've had encounters where I'm asking the patient, 'Are you having pain?' and the patient says, 'No,' and the interpreter says, 'Yes.' I'm like, 'Interpreter, the patient just said 'no.' How can you get no and yes?'

Societal

When I first met this Latina patient her A1c was 14, she had very severe PTSD due to partly coming to the United States, partly because of the history of political violence, and what happened to her coming here. She is a little developmentally delayed. She was very anxious, also very limited literacy. Right after 9/11 we had police in the hospital, and she was afraid to come past the police. We would have to go out and get her, and one of our MAs who spoke Spanish made friends with her. First, she would always miss appointments. Then, she would start coming, but she was so afraid because they would look in the bag and all of that.

So now it feels like the inconvenience of coming is harder than sticking with your routine. I'd just do home visits. Because, how long do [patients] spend getting here? And they have to finance it. Then the registration makes no sense. You register, you're sent to the other line [and you have] to pay, you come back and wait some more. I understand why they would miss visits.

Conclusions

Physicians caring for poor Latinos with diabetes and LEP report three levels of difficulties

- Language discordant care creates deep difference in doctor-patient interactions; increases communication barriers; views on its influence on outcomes is mixed
- Health system issues magnify communication problems
- Poverty magnifies management of multiple co-morbidities

Policy Implications

- Improve interpreter services
- Train more bilingual personnel (physicians & support staff)
- Structural barriers (poverty) require interventions beyond health realm, i.e., economic & social policies tackling the social & political determinants of health

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