

COMMENTARIES

Slow Burn: The Impact of Language Barriers on My Father's Burn Unit Hospitalization

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Shao inhales sharply. Each breath stings. Overlapping sounds of beeping monitors, rolling carts, and chattering voices surround him. But he can't utter a word. Through vision blurred by ointment on his eyelids, he makes out the white, sterile walls of a hospital room. When he closes his eyes, the space around him erupts into flames, and he is taken back to the night of the fire.

Last year, my home in Tennessee caught fire with my father, Shao, inside. It was a grease fire in our kitchen. My father had been cooking before he stepped away, then returned to the stove engulfed in smoke and flames. Instinctively, he ran to the sink mere feet away from the stove to gather water to put out the fire. Scrambling through the unwashed dishes that sat in the sink, he grabbed the biggest pots and bowls to fill. My father then squinted and winced against the blistering heat as he shuttled pot after pot of water.

"I forgot you could call 911," he would later explain solemnly, now in disbelief at his blunder. "I panicked and forgot."

My mother shared later that my father confessed he also felt responsible to stop the fire himself. "He told me, 'I caused it. I need to fix it.'"

When my father felt he had extinguished the fire, he called my mother who was at work at the time. My parents have this daily ritual where my father calls my mother to ask when she will return that night. She preemptively told him she would be back at 6:30 p.m.

"I think you should come home now," he urged.

My mother returned to see our kitchen completely charred. Smoke and ash permeated the rest of our home. She looked at my father. "You need to go to the ER."

He initially refused, claiming that he was okay. Eventually, he conceded. However, he was adamant that he could still drive. So with my mother in the passenger seat, he drove himself to the hospital. Immediately, the staff rushed him into a bed in the critical care wing. There, the doctor diagnosed him with second-degree burns to his face and third-degree burns to his forearms. He

needed to be admitted. However, our local rural hospital did not have the means to care for him, so he was flown to a hospital in Nashville an hour away. There, he stayed in the burn unit for a week.

During his weeklong hospitalization, my father could not speak. Smoke inhalation had burned his throat. And having left home with only a dying phone, he had no way of communicating with us beyond a message to my mother every few days when he found a kind nurse with a phone charger. This gave my father time to think, and his thoughts spiraled. In his silent prison, my father spent days wracked with shame and guilt over the fire.

Alone in his hospital room with little connection to his family or the world outside, my father relied on correspondence from his care team. His nurses and physicians were kind, but he sometimes found communication difficult. As a first-generation Chinese-American who learned English from scratch when he immigrated to the U.S. in his thirties, my father often did not make out what his providers said to him, particularly with the clinical aspects of his care plan.

"If doctors said medical sentences or medical items, I don't understand it," my father sighed.

However, with his voice gone, my father was unable to speak up when he felt lost.

"I just used some body language," he noted while waving his hands.

His providers, in turn, could not truly gauge my father's understanding. My father, a proud man, would smile and nod to signal that he was free from any doubts. So, smile and nod he did all the way through his hospitalization.

My father's experience is just one of countless examples of immigrants facing language barriers when accessing health care in the United States. Even for native English speakers, navigating communication in U.S. health care settings can prove difficult. For patients without English fluency, this challenge can entirely preclude them from seeking medical care when they need it. And this is a growing issue.

In 2013, 25.5 million people, or 8.5% of the United States population, reported that they spoke a language other than English at home and spoke English "not very well," "not well," or "not at all." Since 1990, the number of Americans with limited English proficiency has increased by 80%.¹ This growth immediately impacts health care workers, as 80% of health care workers encounter patients with limited English proficiency annually while 43% of health care workers encounter them daily.²

Language barriers impact health care by leading to miscommunication between health care providers and patients, which hurts the satisfaction of both parties and decreases quality of health care delivery and patient safety.³ For instance, a study published in the *Journal of Hospital Medicine* that

examined whether patients' primary language influences their hospital outcomes found that Chinese and Latinx patients that do not speak English face a higher risk for readmission, even after accounting for other socioeconomic factors and comorbidities.⁴

Many solutions have been explored to address language barriers in health care. The best solution, though also one of the most challenging to achieve, is recruiting, training, and hiring more bilingual providers to practice medicine so that patients are better able to access direct language-concordant care. If existing providers at a health care facility are bilingual, they should be certified and receive dedicated medical interpreter training to ensure that they can provide patients with complete care.⁵

A more common solution is the integration of interpreter services. Often, family members accompany patients to translate. However, this should not be relied upon as these individuals typically do not have medical training and may alter the dialogue spoken by either the patient or the provider during translation, leading to miscommunication and increasing the chances of medical errors arising.⁶ Ideally, interpreters can be hired on-staff for frequently encountered languages, such as Spanish. Video and phone interpreter services are also options, particularly for areas that are medically underserved. Of the two, video interpreter services may be linked to better patient retention of information and diagnoses than phone interpreter services, though the former is more expensive.⁷

However, also important to consider is that interpreter services face drawbacks of increasing both the average cost and duration of doctors' visits.⁸ One way to maximize interpreter services while minimizing cost could be to use them only at three key times during a patient visit: admission, patient teaching, and discharge. Using interpreters at these points reduces the risk of both medical errors and hospital readmissions.⁵

Another more cost and time effective option could be the use of online translation tools, such as Google Translate and MediBabble.³ A study following the implementation of online translation mobile phone applications in health care settings resulted in an increase in satisfaction for the majority of both medical providers and patients surveyed. When asked if this option is "free and easy to access," "saves time at the visit," and "improves health care delivery and patient safety," 92% of respondents agreed with each.⁹

Nonetheless, regardless of interpretation services used, it is important to emphasize that first and foremost, physicians should operate as advocates for their patients. This requires clear mutual understanding between the two parties. In both language-concordant and language-discordant care, doctors should always maintain communication best-practices. These include speaking slowly, avoiding the use of jargon, actively listening, keeping good eye contact,

showing engagement and interest in the patient through facial expressions and body language, and having respectful, empathetic, and sensitive attitudes and tones of voice.¹⁰⁻¹³

Even in our discussion, my father conveyed deep appreciation for members of his care team who took the time to rephrase their wording to help him understand. These basic principles lay the foundation for good communication that must be coupled with interpretation in language-discordant doctor-patient relationships. Without them, a physician will be a poor communicator regardless of language.

As technology has advanced in the fields of health care and medicine, robust interpretation and communication options are growing increasingly available to tackle language barriers separating patients from providers. However, these tools may be squandered if providers do not first possess foundational knowledge of the negative impact that language barriers can have on patient health outcomes. Recognizing the emotional and psychological burden of not understanding one's own care will help providers recognize the full context of their patients' experiences. This, in turn, can guide health care providers when thinking about what services are available and when to use them. By bridging the language divide, we can ensure patients, like my father, never find themselves voiceless and alone, but instead supported by a medical team that offers them full understanding and autonomy over their own care.

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