

COMMENTARIES

Le entiendo: The Power of Intermediate-Level Fluency in Patient Care

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There is something about the way my Ob/Gyn attending greets her Latina patients saying “Hola, mami,” that softens the anxiety around their eyes, holds their pregnant stomachs a little softer, chips at the language barrier that exists in almost every other sector of their lives. The relief is palpable; when you have already been flagged as a “high-risk pregnancy” due to your prior cesarean delivery or your rising blood pressure, removing the additional diagnosis of “non-native English speaker” releases a significant amount of weight. High-risk pregnant populations are the primary demographic of my attending, who works at a federally sponsored Ob/Gyn clinic 3 days a week. And because the clinic is a community health site, the majority of her patients are uninsured and non-English speaking. To give patients the best care possible, communicating in their native language is just as critical as learning their medical history. At this clinic, the two are integrated because included in the standard briefing of every patient before going in to see them is a note of their preferred language, whether it be Spanish, Amharic, French, or (rarely) English.

During my first time at the site, I was struck by how *gringa* my preceptors’ Spanish sounded. I had assumed that any physician who operates at a predominantly Spanish-speaking site would be a native Spanish speaker. Instead, it was clear that her level of Spanish was not much higher than my own, which is a patchwork accumulation of 5 semesters of undergraduate Spanish and 1 year living in Bogotá, Colombia. The medical vocabulary was a bit of an adjustment, but I quickly became comfortable with the clinic flow and was impressed by the degree to which she was able to communicate to her patients, despite her accent and imprecise grammar. Patients asked follow-up questions when they were confused, but it lacked the annoyance that accompanied the *no le entiendo* (I don’t understand) I had received from locals so many times in Colombia. Eventually, it gave me the confidence to use my own Spanish to communicate with her patients because I did not fear that I would be met with heavy sighs as they tried to parse through the words my tongue couldn’t form correctly. I was used to feeling guilty about my inability to communicate perfectly, but at the clinic I am proud to be able to even greet a patient warmly at the door.

Now, I enter the room before my Ob/Gyn attending in order to take a patient’s history. I am excited when it is a Spanish-speaking patient, as I introduce myself in Spanish and explain that I am going to call an interpreter before getting

to know the patient. One 37-year-old mother of two, and pregnant with her third, was no different. Her first pregnancy was complicated by an unexpected cesarean delivery, and her current pregnancy was marked by gestational diabetes that was proving difficult to control. She had been told that she would have to be induced early at 35 weeks to prevent further complications if she went into labor naturally, but she was struggling to find childcare for her young children and was worried about the date that was currently set for her surgery. As the patient became emotional, I was grateful for the interpreter because I could focus more on responding to the patient in real-time with my body language as opposed to trying to translate every word. But my patient could tell that I was listening and understanding, as we kept eye contact the entire time. And when the interpreter finally hung up as I went to get the physician, the patient continued to speak to me in Spanish. I assured her that we would help her make a plan.

The difference between speaking to my preceptor's patients and the experience I had in Colombia can be attributed to many different factors, the largest of which being the inherent privilege that comes with wearing a white coat. This may be especially true in Latino culture, where more respect can be ascribed to authority. There is also the inherent nature of the communication being about health care, and the fact that many of her patients do not have a choice in the matter of trying to understand her Spanish; to not do so would be to jeopardize their health and the health of their baby. But as a future health care provider, there is relief that comes with the understanding that patients are eager to understand a physician who attempts a second language, which is not always the case when speaking a second language outside of a clinic setting.

At the same time, the experience of working at a predominantly non-English clinic site has raised questions about the logistics involved in and ethics around translation services. My preceptor's Spanish is strong enough to conduct a medical history and physical examination in Spanish without the use of the interpreter. However, an interpreter is needed for her Amharic-speaking patients. This clinic uses a phone translator service, in which on-call interpreters are available via phone. The interpreter is put on speaker while the physician speaks, then the interpreter, then the patient, and the interpreter again. While the alternative is not receiving any care at all, the difference between the physician's ability to communicate to her Spanish-speaking patients compared with her Amharic-speaking patients is greater than just the effort it takes to dial up an interpreter. The gap between the two is not just the language itself, but also the culture, trust, and respect that comes with the language.

I feel this difference myself. Even though I use a phone interpreter for any non-English-speaking patient, taking a medical history of a Spanish-speaking patient feels more fluent and natural than taking the history of a non-Spanish-speaking patient as I laugh and smile in real time, as opposed to waiting for

the interpreter. I can repeat words and phrases back to the patient in their native language, using gestures to ask for clarification or to demonstrate that I understand. Even the little formalities at the beginning and end of a conversation— “*Como va todo?*” (*How is everything?*) and “*Que te vaya bien*” (*Take care*)—crack away at the sterility of an awkward head nod and forced smile, crack away at the otherwise impenetrable power dynamic. There is immeasurable value that comes with speaking a patient’s native language, even when an interpreter is still part of the conversation.

As I entered medical school, I was filled with the hope that I could eventually conduct an entire visit with my patients in Spanish. Yet I struggle with the ethics surrounding and the confidence needed to conduct an entire patient visit in Spanish. Am I good enough? Would it ethically be right to use my Spanish, which might be imprecise, to communicate to a patient when there is an interpreter option? At what point do the scales tip between the benefit of creating shared understanding via the use of a patient’s native language vs the harm that inaccurate medical information could do to a patient?

The legal history of providing interpreter services to limited-English proficiency patients began with Title IV of the Civil Rights Act of 1964, in which antidiscrimination laws meant that patients at federally funded sites had a legal right to medical care in their preferred language.¹ In 2000, this legal basis was expanded specifically to health care, in which Order 13166 “Improving Access to Services for Persons with Limited English Proficiency” mandated medical interpretation be available to any patient who requests it.² The Department of Health and Human Services offers competencies that an interpreter must meet in order to be seen as qualified, accurate, and impartial.³ First, the interpreter cannot be a family member because personal involvement in the patient’s medical information might compromise the neutrality of the interpretation. Additionally, although national certification is not required to interpret, under the Affordable Care Act, some assessment of an individual’s competency in a secondary language is required before an individual can interpret: “The fact that an individual has above average familiarity with speaking or understanding a language other than English does not suffice to make that individual a qualified interpreter for an individual with limited English proficiency.”⁴ However, the guidelines surrounding needing an interpreter are ambiguous for physicians who speak second languages. There are no regulations as to whether a physician needs to be certified in order to conduct a visit in a second language. Certification is available, but it is not required. It is up to the physician’s discretion as to whether they feel comfortable speaking the language, and unless a patient specifically requests an outside interpreter, the physician is not obligated to provide one. My preceptor said that although she knows her Spanish is only high-intermediate, she doesn’t ask Spanish-speaking patients if they want an interpreter, and that she will only

call one when she feels as if the patient is struggling to understand her. During my time working with her, no patients have requested an interpreter, nor has it appeared as if any patient has walked away confused.

The legality of medical interpretation is important to protect patients from harm and misinformation, and I will likely continue to use an interpreter until my Spanish significantly improves. But these regulations should not prevent medical students from pursuing a second language. I share my experience as an intermediate-level Spanish speaker who uses an interpreter and still sees the incredible benefit of using a second language in a clinical setting. It does not matter that I am not fluent or that an interpreter is still part of the clinic experience. The patients with whom I can use Spanish are grateful that I can translate their words and gestures simultaneously and can understand the cultural nuances of their treatment desires. And while this does not mean that I should accept my Spanish as *good enough* and choose to not improve it to the extent that I can, it does mean that I should recognize that speaking a second language in a clinical setting does not need to be all-or-nothing to be beneficial. I felt this myself as a patient in Colombia, where I had to be a patient in a foreign language for the first time. The smallest amount of English in that setting would have been reassuring, even if it was just to confirm that the pain I was experiencing was located in the right region.

As medical students, we can get wrapped up in the idea that we must be the best at something for it to be valuable, but shades of gray are what demonstrate to our future patients that we are human too. Using a second language with patients offers common ground, demonstrates our equality, and shows that we are listening and understanding as much as we possibly can. If we aim to be physicians committed to cultural understanding and empathy, we should view language coursework as equally important as biochemistry or anatomy. We should not be deterred by not being fluent, nor should we use the availability of interpreters as an excuse for not improving our language skills. There exists a middle ground, one in which we use language to build trust and community, and interpreters to ensure accuracy.

I think often of the words the 37-year-old pregnant mother, who came into the clinic for not only medical, but also social care, said to us on her way out the door. After we had managed to coordinate with the hospital to push her surgery date a few days later, she let out tears of relief: *“Estoy muy agradecida de que alguien como usted esté aprendiendo mi idioma. Sinceramente, gracias por aprender sobre mi y mi gente. Dos conversaciones diferentes ya se han convertido en una”* (I am so grateful that someone like you is learning my language. Seriously, thank you for learning about me and my people. Two potentially different conversations have converged into one).

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