



The Patient Language Gap

PRESIDENT'S MESSAGE



By Satya N. Chatterjee, MD

"The difference between the almost right word and the right word is really a large matter - it is the difference between the lightning bug and the lightning." - Mark Twain, 1888 letter

FOR THE PAST THREE YEARS I have attended the meetings of the Medical Leadership Council on Language Access sponsored by the California Endowment. Our objectives were the following:

1. Do patients with Limited English Proficiency (LEP) receive less than ideal medical care?
2. If so, identify reasons, then improve our ability to communicate with our LEP patients
3. Identify funds to provide this service.

LEP is a national issue. *The Wall Street Journal* wrote about it in January 2003 ("For all Immigrants, Doctors' Orders Get Lost in Translation"), and the *New York Times* in April 2003 ("When a Patient is Lost in Translation").

The issue is even more important in California. According to the 2000 census, 12.4 million Californians spoke a language other than English at home and 6.2 million Californians are LEP. One hundred accepted foreign languages are spoken in California. In Los Angeles alone, 17 principal foreign languages are spoken by 95 percent of people with LEP. They speak Spanish, Cantonese, Mandarin, Tagalog, Korean, Armenian, Vietnamese, Persian, Japanese, Russian, French, Arabic, Cambodian, Pacific Island, Thai, Italian and Hebrew. Another 5 percent speak Somali, Portuguese, Hmong, German, Hindi, Filipino, Pustu, Urdu, Lao, Ukranian, etc.

California's growing diversity is one of our sources of industrial strength, dynamic economy and varied culture. We should not discourage legal immigration that builds up our economic strength and technical man power.

Solutions

What can be done for these 6.2 million people in California? The answer from one doctor was surprising, "Send them back home." That, of course, is absurd reasoning. Among the more practical solutions are these:

1. First, they should learn English. There are many obstacles and we, as fellow Californians, should offer a helping hand. State and local government can provide classes in more locations, arrange for tuition by giving loans, obtain cooperation from work places to arrange free time, and arrange for child care if both parents want to learn English. All this will cost money, but will provide an efficient and knowledgeable work force that benefits California as a whole.
2. Physicians, especially in California, should be encouraged to learn a foreign language. This is already encouraged in California law by a Loan Repayment Program administered by the Medical Board. After all, Europeans speak at least

two, if not three, languages. I speak three and a half myself (English, Bengali, Hindi and German).

3. Using a friend, family member, secretary, and custodial or cafeteria staff as interpreters is problematical. Their knowledge of medical terminology may be scant and, in addition, there is now the privacy issue to contend with. A family member, even a child, may be acceptable if translation does not entail any drug history, sexual history or psychological problems. This is a practice-oriented decision. In my practice, I sometimes use the services of a family member.
4. The ideal solution is a professional interpreter from a licensed agency. In my practice, this arrangement is easy because the workers' compensation carriers arrange and pay for it. A new patient costs around \$100 including travel time. In other practices, contract interpreters cost about \$40 an hour. Only the states of Hawaii, Montana, Oregon, Washington, and Utah have an interpreter financing policy. California has none.

Mandates and policies

Language access complaints are filed under Title VI of the federal Civil Right Act of 1964. In 1974, the U.S. Supreme Court ruled Title VI prohibits discrimination based on limited English proficiency. In 1998, President Clinton launched a federal initiative and in 2000 the Centers for Medicare & Medicaid Services (CMS) issued final regulations for the Medicaid Managed Care Program requiring language access.

The law is not at all clear on who pays for interpreters. The suggestion that physicians should pay is absurd and so is the idea of making the patient pay. Payment should be the responsibility of insurance companies. Medicare and Medicaid should contract out interpreter services, perhaps at \$20 per visit; HMOs and PPOs might be at \$30 per visit. The county could pay for indigent patients at Medi-Cal rates.

Locally, large hospitals, medical groups or large office systems should pool together to form a strong interpreter program. Dedicated employees can be identified and given extra training as interpreters at little added cost. One person should be identified to coordinate the service between facilities and departments.

Lastly, a telephone interpreter service is available, but not ideal. Examination rooms have no speaker phones, some patients may be hard of hearing, and the cost is \$5 per minute.

We all agree that interpreter services will definitely improve the health care of LEP patients. We, and lawmakers in particular, have to determine who pays. The time has come, and it is now. This issue can no longer be put on a back burner; that would be tantamount to turning our backs on patient welfare.

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