

bab·ble***–noun***

1. inarticulate or imperfect speech.
2. foolish, meaningless, or incoherent speech; prattle.
3. a murmuring sound or a confusion of sounds.

There is no “Babble” in Medicine

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On June 22nd, the University of California San Francisco (UCSF) Website published an article by Dr. Brad Cohn and Dr. Alex Blau entitled “UCSF Medical Students Create Free Medical Translation App, Conquering Language Barriers to Patient Care.”⁽¹⁾ This article applauded the creation of a translation iPhone application aptly called “MediBabble” that claims to assist medical providers in communicating with limited English proficient (LEP) patients. At the time of its creation, both doctors were medical students working at UCSF and San Francisco General Hospital (SFGH) who teamed up to address the shortage of available medical interpreters.

Intrigued by the MediBabble article, two UCSF medical interpreters, the authors of this present paper, reviewed the application. These medical interpreters, with a combined experience of over 30 years in the interpreting field, would like to bring their professional expertise into this discussion. To begin, we absolutely agree; there *is* a shortage of available professional medical interpreters. Prior to addressing specific issues pertinent to the health care interpreting profession and its role in the delivery of medical care in contrast with technological substitutions, we believe it is necessary to make some clarifications.

Drs. Cohn and Blau assert that medical translators from UCSF were consulted during the creation of MediBabble for language “accuracy and cultural appropriateness”. This was a misrepresentation that put some interpreters on alert. Firstly, no medical translators are employed by UCSF, only interpreters. In fact, not a single interpreter from UCSF was consulted. Upon investigation, further concerns emerged due to statements from Cohn that “nationally certified medical interpreters” were consulted and then recorded speaking vetted phrases. In fact, no national certification for medical interpreters exists for the languages offered in this application, with the exception of Spanish, and then only since December 2010. ⁽²⁾ Only pilot certification tests for Russian, Cantonese and Mandarin were scheduled for June 2011. Certifications for Haitian Creole, French, German, Hindi, Urdu and Arabic aren’t even on the calendar. In regard to cultural appropriateness, we have yet to encounter a competent interpreter or expert from any culture, in any context, that could approve the use of this device to ask a question included in the App such as, “Are you able to achieve orgasm during sexual intercourse?” We shudder to think that anyone coming out of medical school who anticipates this sensitive personal discussion would conduct it mediated by a hand-held technological device.

Clearly, there is a place for technological advances in translation, but computer generated interpretation in the healthcare environment warrants serious caution because of the stakes involved. Plagued by problems with linguistic register, dialect variety, localization and translation error, this application gives the provider a false assurance that he or she is being understood. A more thorough analysis of the real merits and the potential risks of this App are needed. It needs to be evaluated in the context of the

wealth of studies in medicine and public health that point to the same conclusions: patient-centered, culturally and linguistically appropriate services in health care vastly improve health outcomes for LEP patients.^(3, 4, 5, 6)

MediBabble is not designed to provide this type of care. It also leaves out the other, even more important half of the equation: The Patient. According to Gloria Garcia Orme, RN, MS, Director of Language Services at San Francisco General Hospital:

“This application uses closed-ended questions to elicit yes or no answers or gestures from the patient asking them to point to the affected body part. This shows a complete lack of understanding for real communication. Patients do not speak in yes or no answers. This is a very disappointing application and hopefully those who provide care to LEP patients will not rely on this when there are other resources such as phone, video or live interpreters available.”

Limited to yes/no responses and pointing to his/her body parts, the patient does not have the opportunity to offer the clinician a complete description or sequence of symptoms, much less provide a meaningful psycho-social history. This contradicts the AMA Code of Medical Ethics⁽⁷⁾ which states that “The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives”, to have his “questions answered” and “make decisions”, none of which is possible for LEP patients without the use of quality interpretation. MediBabble is reductionist and seriously impairs the quality of patient care. How many pull down menus would it require, for example, to obtain a complicated gynecological history? Is it truly more expedient than waiting a few minutes for an in-person interpreter or a few seconds for a telephonic or VMI interpreter?

The UCSF website lent hasty and unwarranted legitimacy to this mobile App that does not facilitate effective communication between provider and patient. The danger

is that MediBabble permits a clinician to *feel good* about the *intention* to communicate with no bearing on whether communication takes place. Studies discussing how practitioners or medical students *feel* about their patient communication are not the same as studies of the communication, or the serious clinical errors that result. ⁽⁸⁻¹⁴⁾ It is important that a patient “likes” the provider who seemed “friendly” when he tried to speak Spanish. But the practice of medicine must not be about subjective assessments of patient cognition and provider satisfaction but about real clinical outcomes. ⁽⁸⁾

Cohn and Blau cite a report from the U.S. Department of Health and Human Services (USD HHS) ⁽¹⁵⁾ on ways to reduce disparities in health care delivery to racial and ethnic minorities, and allude that this App concurs with specifically recommended strategies. Notably, The USD HHS strategies include the training of “*promotoras*” or community health promoters, as well as an online national registry of certified interpreters. Both strategies call for cognitive, reflective human beings capable of contextual based split-second decision-making. In April 2011 the USD HHS Office of Minority Health awarded a grant project to the national Certification Commission for Healthcare Interpreters to further its national credentialing program. ⁽¹⁶⁾ In July 2011 another grant was received from the Robert Wood Johnson Foundation to further support the development of certification in two additional languages; yet Cohn and Blau speculate that their App “might make a registry [of interpreters] unnecessary.”

The accumulated knowledge of best practices, and the documented results from the presence or absence of these, has spurred a broad range of stakeholders to establish interpreter protocols and ethics. Healthcare industry and policy stakeholders including representatives from federal government agencies are among those contributed to the

establishment of standard measures of language competencies guaranteed through national certification for healthcare interpreters. It is challenging to discern how MediBabble might fit into this framework and how its creators dismiss this body of expertise. This is akin to putting medical apps like ProceduresConsult, EpocratesRx, or QxMD Cardiology (accessible via UCSF Library Mobile Resources section) into the hands of interpreters and then speculating that we might no longer need licensed health practitioners.

Can health care providers that use MediBabble really deliver care that is equitable as required by law under Title VI of the Civil Rights Act of the U.S. Constitution? ⁽¹⁷⁾

Can it be considered *meaningful care* according to CLAS (Culturally and Linguistically Appropriate Services) standards? This begs an additional, more worrisome question:

Does medical school curriculum adequately prepare medical students for work in institutions that are bound by these legal standards? Are they familiar with CLAS mandates 4, 5, 6, and 7; the current federal requirements for all recipients of federal funds? ⁽¹⁸⁾ Are new doctors and hospital administrators aware of their obligations with mandates 4 and 6 in particular? ⁽¹⁹⁾

Standard 4

Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5

Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6

Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7

Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

There is no known provision stating that there is an opt out of compliance with CLAS mandates or the Title VI Civil Rights Act of 1964 and Executive Order 13166 of 2000⁽²⁰⁾, nor is telephone wait time on hold, or a lack of funding for adequate interpreter staffing a justification for violations of civil rights. The use of MediBabble constitutes noncompliance and defies the premise of equity in care.

We were surprised to learn from the MediBabble article about Dr. Lawrence Tierney's collaboration on the development of this App. As Associate Chief of the Veterans Affairs Medical Service Administration and Professor of Medicine at UCSF, Dr. Tierney co-edited the book entitled, "Patient History: Evidence Based Approach", the first chapter of which stresses the following:

"The study of the patient begins with the history, a history taken by a skilled listener too, for it is only the skilled listener who can hear the vocal inflections that suggest the importance of things to the patient. It is only she who can read the nonverbal cues that illuminate the meaning of the words. It is only he who can understand not only what is said but the often times vitally important information gathered when things go unsaid by patients."----Faith T. Fitzgerald, MD ⁽²¹⁾

The pretense that a computer application could accomplish this is unrealistic. MediBabble lacks the crucial human capacity to communicate and incorporate complex ideas, emotions, nonverbal cues or variations of vocal inflections. The patient-centered interviewing skills espoused in Tierney's book include open ended questions, non-verbal encouragement, relationship-building and emotion-seeking skills all of which require that the patient be able to communicate meaningfully instead of supplying yes or no responses to a preordained set of questions. Dr. Tierney's book also warns that "rigid adherence to a

template means missing potential opportunities” in history taking and insists that “the doctor-patient interview is ultimately a conversation between two people.”

The impact of Tierney’s work on medical students would be greatly enhanced by the inclusion of expertise from language access and LEP specialists as well as lessons from the deaf community. For example, deaf and hard of hearing patients have achieved higher levels of provider compliance with the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act through major lawsuits. It is no longer sufficient to expect a deaf patient to read a doctor’s lips but instead to provide meaningful access to care via the use of Registered Interpreters for the Deaf trained in American Sign Language and deaf culture.

It is precisely the lack of awareness about meaningful access and the essential role of interpreters that puts LEP patients at risk. Tamara Miller, Deputy Director of Civil Rights for the USD HHS Office of Civil Rights states:

"Knowledge is the key. Health care providers need to understand what the federal laws require in terms of providing language assistance for patients and their companions in healthcare settings. Without effective communication between patient and provider, not only might there be a violation of federal law but also quality of care suffers." ⁽²²⁾

Practitioners, no matter how well meaning, regularly make unreliable and inconsistent self-assessment of their language communication skills without the knowledge, skills or standard measures required for that assessment. MediBabble seems to replicate this deficiency in its design. It does not take into account the real life context in which this App may actually exacerbate the inequities already experienced by the LEP patient population. It will contribute both to a practice and an atmosphere of inequity by

giving the impression that practitioners can dispense with qualified interpretation and still practice medicine responsibly. In fact, even without MediBabble, some providers seem to think this. In violation of multiple policies, practitioners also regularly rely on friends, family members or house staff to interpret.^(23,24) Amy Wilson Stronks, former Project Director for Health Disparities and Principal Investigator for the Hospitals, Language, and Culture study of the Joint Commission called attention to the present environment of inequity for LEP patients as Principal Investigator of a Hospital Language and Culture Study of fourteen Florida hospitals in its final report in March of 2010:

“It was evident that hospitals in our study group were providing a variety of tools, resources and services to meet their patients’ cultural and linguistic needs. However, there appears to be several inconsistencies and gaps between what language tools, services and resources hospitals are providing and what resources and practices staff actually use. Our data suggest that staff were not always aware of the availability of language tools and resources and even when they were, did not use these tools and resources frequently. A large majority of staff responding to the survey still use “someone accompanying the patient” to communicate with LEP patients, despite evidence that this practice contributes to miscommunication and serious medical errors, and is highly discouraged by several legal and regulatory bodies. In Addition, the large majority of study hospital utilizing bilingual staff as interpreters are not testing the competency of these staff.”⁽²⁵⁾

What this report points out, unfortunately, is not limited to Florida but is also prevalent in multicultural, forward thinking San Francisco Bay Area. As in Florida, some language groups suffer greater consequences than others.

Perhaps a new term should be incorporated into the practitioner lexicon: The Limited Spanish Speaking Provider (LSP). The more egregious example is the health practitioner who has assessed him or herself to be sufficiently proficient and attempts, without the use of a professional interpreter, to explain a treatment plan, a complex medical procedure, a pharmaceutical regimen, a discharge plan or even palliative care,

stages near the end of life and Do Not Resuscitate orders. It is troubling because reliable statistical data from the USD HHS National Health Disparities Reports point out that “Hispanics have consistently had the worst record with access to health care and the highest gaps in health disparities, compared to the non-Hispanic population groups.” These reports also point out that “there is a critical need for cultural competence training of physicians, health providers and the general healthcare workforce; and language services including interpreters of oral communication and translators for written communication.”⁽²⁶⁾

LEP Patients come for medical expertise, not “fairly good” or a “couple of years of high school” medicine, nor the fraction of it rendered by less than competent speakers of a language. The frequency with which providers “wing it” among Spanish-speaking patients is astoundingly prevalent and well documented in public health literature.⁽²⁷⁾ A scenario with practitioners using the medical encounter as a chance for “practicing” their second language is embarrassingly common. Language classes and listening to the patient are among some alternative, appropriate ways to learn a language that are consistent with the purpose of the medical visit and fee for services. It is also more consistent with professional advocacy obligations of many health practitioners.^(28, 29)

This lack of professionalism weakens integrity and puts practitioners as well as health institutions at risk for malpractice. At a time when equity in health care delivery is of paramount focus, it results in a population that receives “some” medical expertise, from practitioners who insist they know “some” Spanish. Attempting to do this in Chinese, Russian or any other language seems utterly unacceptable but perhaps, in

California where everyone seems to know “a little” Spanish, it is a language in which providers somehow feel entitled to practice.

The level of linguistic deficiency is troubling but confusion becomes compounded when culture comes into play. The notion of cultural “competency” implies achievement of a static capacity or skill. An alternative term might be cultural “appropriateness” or “responsiveness” which implies receptivity to difference. It also requires a life long commitment to learning, becoming adept at recognizing what one does not know and when to ask for help.⁽³⁰⁾ An alarming absence of this is the example of providers who sometimes regard non-English speaking patients who “look Mexican” as Spanish speaking. More and more frequently these are speakers of Mexican and Central American indigenous languages (such as Mixteco, of which there are over 100,000 in California and Oregon alone).⁽³¹⁾ It takes a competent interpreter to alert the provider that in fact, for these patients, Spanish is a second language; a “competent interpreter” is one who knows a language and culture well enough to recognize when it is not a patient’s first language. Upon being informed, many providers acknowledge their surprise by assuming that these languages are “dialects” of Spanish. This would be commensurate with classifying Navajo or Choctaw as dialects of English. These patients often bear the double burden of hearing providers speak broken Spanish, a language over which they may have limited command to begin with. Some providers, unaware of the cultural differences in demeanor and body language ask if those same indigenous patients are “slow”, or have assumed that a mother who sits by her baby’s bedside and lets the nurse do all the care is not bonding with her baby or is incompetent. It is not until a qualified interpreter arrives does the practitioner find out that it may be considered disrespectful in

certain indigenous cultures to make eye contact or to interfere with the work of a health professional, even with one's own baby. This is one more example of a way in which a lack of linguistic and cultural competency contributes to the systematic discrimination of the LEP patient population on the basis of national origin.

Paradoxically, some providers who have the strongest command of Spanish or another second language are those most aware of their limitations and among those that insist on the use of professional interpreters. They sometimes struggle to get appropriate language services for their patients but to their credit they insist, and should be commended.

Contrary to the idea that linguistic competency can be learned in a crash course of "Medical Spanish",^(32, 33) learning a list of vocabulary in a second language is the last step in language acquisition not the reverse.^(34, 35) A skilled interpreter can learn a list of vocabulary and deliver on any topic, but a practitioner armed with just the same vocabulary list could not provide for informed consent. There is no such thing as a "medical" language, only language proficiency enriched by medical vocabulary.

There is socio-cultural and extra-linguistic expertise that can only be obtained by a human being familiar with a patient's world view and the ability to navigate between both the provider's and patient's worlds. The term "native speaker" is being used less frequently in the interpreting profession because it does not describe relevant, necessary levels of capacity, but instead, an emotional and political identification with a language or ethnicity. It gives no indication of skill or appropriate cultural exposures required to negotiate nuances among people within the same language groups.

Providers or medical students who are “native speakers” may or may not be competent interpreters. A provider who practices medicine in a second language should be tested just as medical students from abroad must pass English language competency tests. By nature of the interpreting task, a practitioner can not interpret unless he/she is willing to repeat every utterance in both languages for all monolingual parties present: during rounds, family meetings, or when resident and attending are together with patient in a teaching hospital. Interpreters are trained to seek clarification when appropriate and to alert providers to potential cognitive pitfalls and gaps in their explanations that may need a fuller description of the medical condition or health plan.

A more intimate understanding by practitioners about the role of an interpreter may help to alleviate the apparent intangible quality of communication that eludes modern medical practice when it comes to other languages and cultures. Just like doctors and surgeons have benefitted from the cultural wisdom obtained through a community of practice over centuries of trial and error and specialization, the interpreting profession has existed for thousands of years and is also specialized. This paper focuses on the more recent experiences of language access professionals in response to this relatively new development: the unexamined use of computational devices to “communicate” with LEP patients. More in-depth analysis is required to see why such computational devices would have been contemplated to begin with.

The Quick Fix: Professionals from many fields have long been frustrated by computer generated translations, the renditions of which lack context and meaning. An example from the health field includes translating “stool softener” as a “kitchen chair cushion” instead of an aid for constipation. More serious translation errors have life-

threatening results such as changes in medication instructions. ⁽³⁶⁾ In the same way that word processing has transformed the use of typewriters; software has brought translation to a whole new level. Nevertheless, professional translators never use computer generated translations, rather, they use software programs to aid them in the human work of translation. The use of professional interpreters is the world standard for important transactions and negotiations that lead to legal, business, policy or international agreements, especially where precision is paramount.

Translation software has come a long way since grammar rule-focused computer renditions of the last few decades. Presently, the more advanced type of computer-generated translation software is cloud based, meaning it relies on its connection to a network where its capabilities are stored and activated. This type of App accesses massive amounts of data gleaned from texts previously translated by humans, consumer searches and recordings. Algorithms are then used to put forth statistical computations on phonemes and the corresponding word orders of different languages, appearing to bridge the language barrier. ⁽³⁷⁾

The “Wow” factor is very human when dealing with gadgets and technological innovations. This occurred during the demonstration of the latest hand held device, called “Google Translate” which was recently showcased at a conference in Berlin. ⁽³⁸⁾ It has a voice translation “conversation mode” in Google’s cloud computing mobile voice translator which simulated a shoe purchase by a tourist. The device rendered a computer generated voice translation of German and English speakers. Even then, the device mistook “what color” for “which cable” on two consecutive tries. The mistake of buying the wrong color shoes is one that can be remedied. Loss of a human life can not.

Even though MediBabble is not at this “conversation mode” level, more advanced voice translation software might lead one to hope that if an App could reach this level of complexity, it might be appropriate to use in the medical setting. The thought of an App to simplify the sometimes frustrating world of doctor-patient communication can be tempting. Yet, regardless of how simple we would like things to be, we can not rely on the translated renditions of a computer, no matter how massive its database, that “estimates” the patient’s words based on statistical computations of similar word orders uttered by others in the past. The computer is not rendering the patient’s words, only a statistical calculation of the word order.

The assumption that MediBabble or even the more advanced voice recognition translation tools should be used in delivering medical care places the LEP patient right on the razor’s edge of the famous 14th century philosopher, William of Ockham’s much misapplied dictum: “What can be done with fewer assumptions is done in vain with more” or “entities should not be multiplied beyond necessity” interpreted by scientists as, ‘the simpler explanation is more than likely the truest’. As a result, it is often times mistakenly applied in the complicated world of the social sciences. Human communication is sociolinguistic, psychosocial, contextual and dynamic.

Another stated goal of MediBabble inventors is to enable the feeding of medical histories directly into a patient’s electronic medical record (EMR). This is alarming because of the high rate of error plaguing this technology. Far more advanced in its voice recognition features than a translation application, the medical dictation technology is becoming more widespread. Nuance Complete Solutions Health Care has developed Dragon Medical to respond to physicians’ frustration with the highly structured format of

the Electronic Medical Record. A white paper published in 2008 by Nuance criticizes the EMR system for not allowing the production of patient narratives in the physician's own words "which is vital for giving a truer picture of patient assessment."⁽³⁹⁾ Physician Jason S. Shapiro of Columbia University Department of Bioinformatics states:

"Narrative allows us to share complex ideas...its use in the medical record is extremely important for clinicians because it allows them to synthesize disparate facts and data elements to paint a picture rich with meaning that is easily interpreted by other clinicians."⁽³⁹⁾

If clinicians have the need to produce patient narratives then isn't there even more pressing need for LEP patients themselves to communicate their symptoms in their own words to clinicians?

An additional study conducted in 2003, funded by the Veterans Health Administration Health Services Research and Development Service, reported "a significant number of adverse drug events (ADE) were found in a careful review of data that routinely fails to make it into the EMR."⁽⁴⁰⁾ The study found that if based on clinical EMR data alone, only about 14% of the ADEs were detected. However, the "non-electronic nursing notes increased overall adverse drug event incidence by nearly a third." This study underscores that "nursing narratives are a rich (albeit difficult to process) source of ADE surveillance data" which gets by-passed in the tight computer fields of EMRs. The convenience of the EMR was found to lull clinicians into "a false sense of security" because it is providing an incomplete clinical record.⁽⁴⁰⁾ Shouldn't this be a reason to consider how we can assure the quality and veracity of information that will be entered into a patient's EMR?

According to Cohn and Blau, MediBabble has been downloaded 8,000 times. Does this mean that it is already in use by practitioners? If so, who has authorized its use? Scrubdin, a medical apps shopping site to which one of the inventors is a contributing editor, gave this App the 2011 Medical Apps award.⁽⁴¹⁾ The award was sponsored in part by Lenovo, a Beijing based technology company. Another site, iMedical Apps also praised it as a “must have” application. The editors and writers listed on these websites are mostly medical residents and medical students with no apparent language expertise with which to make an assessment of MediBabble’s marvel; interpreters, translators or language specialists have yet to publicly add their names to this applause.

Our concerns about this App are based on notions of responsible provision of equitable quality healthcare. Putting MediBabble in the hands of practitioners and expecting accurate, informed, participatory health care is like putting a stethoscope in the hands of an interpreter and expecting a diagnosis of a heart condition. As testing of interpreters becomes increasingly more standardized and rigorous, requiring more stringent qualifications for competency, MediBabble creators seem comfortable in waving this aside. If this were a new drug with potentially life threatening consequences, would it also get the proverbial thumbs up, or would it be tested by the FDA?

Given the explosion of the Apps market, the FDA is presently clarifying the scope of its regulatory authority over the use of Medical Apps in health care environments.⁽⁴²⁾ It has opened a public comment period until September 19, 2011 under its Draft Guidance for Industry and Food and Drug Administration Staff: Applying

Human Factors and Usability Engineering to Optimize Medical Device Design. ⁽⁴³⁾ On its website provided for comment, the FDA gives the rationale for their involvement:

“To understand use-related hazards, it is necessary to have an accurate and complete understanding of how a device will be used...human factors engineering (HFE) and usability engineering (UE) considerations that are important to the development of medical devices include three major components of the device-user system: (1) Device users, (2) device use environments, and (3) device user interfaces. For safety-critical technologies such as medical devices, the process of eliminating or reducing design-related use problems that contribute to or cause unsafe or ineffective medical treatment is part of a process for controlling overall risk.” ⁽⁴³⁾

We sustain that the human component in healthcare interpreting is essential for the provision of equitable, quality healthcare which can not be replaced nor optimized by computer generated renditions. Given the environment, current practice and prevalence of non-adherence to basic language access requirements already in place ^(19, 44, 45), the utilization of devices such as MediBabble will only put LEP patients at further risk of negative health outcomes.

The FDA, in addressing human factors, is exerting its authority over medical apps from which symptoms, diagnosis or responses to treatment may be obtained and from which medical errors could result. Since the creators of MediBabble claim that their App is capable of assisting doctors in patient history taking from which, according to Blau, “ninety percent of diagnoses” are derived, we hope the FDA will evaluate this App and ultimately recognize the danger that it presents.

“A Native Speaker in your pocket”: MediBabble has been marketed as a tool for disaster relief in resource poor locations. Medical students from Universities Allied for Essential Medicines (UAEM) seem to “like” it as evidenced through its unqualified support on MediBabble’s Facebook page. They may even believe that it could help them

save lives in their global health efforts. What is the history of the testing and use of inferior, unreliable technology among vulnerable populations? Do medical students still learn about the distribution of Nestlé baby formula to poor mothers who will necessarily dilute the mixture; the export of the outlawed Dalkon Shield; or experimentation with syphilis on African-American men in Tuskegee? Is this gadget appropriate or ethical in the context of a refugee camp or post conflict zone?

The Institute of Medicine calls for equity: “providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.”⁽⁴⁶⁾ This position has been publicly supported by the International Federation of Medical Students’ Associations (IFMSA) in its August 2010 Policy Statement.⁽⁴⁷⁾ National and international health experts and field workers have long identified training of local health promoters and interpreters as an effective way of providing an equitable standard of care. This also provides long term benefits to the region after international aid workers have gone, leaving behind an empowered local population with marketable skills that promote economic development.

Medical students eager to alleviate suffering in the world have blogged about their life-altering experiences which highlight an essential and common component to all of their different narratives: human to human communication heals patient and practitioner. When those experiences have occurred outside of the country, more often than not, it has been ad-hoc as well as professional interpreters who have helped to facilitate this. No, a health practitioner can not put an interpreter “in their pocket”, but what doctor that really wants to communicate with a patient would want to?

An urban Emergency Department in the United States such as the one at SFGH is not a refugee camp in a post-conflict zone, absent a health-care infrastructure or electronic grid. In the United States, vulnerable populations are, in theory, protected by multiple layers of legal regulations and in medicine, by ethical protocols. Why export a mode of communication, not a step down from in-person, video monitor or phone interpretation, but a giant leap backward in quality, minus the defining human, for the convenience of pulling out a gadget from one's pocket? Surely medical training is incorporating the need to learn to communicate appropriately with a diverse set of human "players".

The medical community needs to bear in mind that not only are there legal mandates but there is also a moral imperative. Documentation supports the use of quality, human generated interpretation as opposed to substitutes which "translate" into adverse medical events ^(5, 48) and ultimately cost more. ^(5, 49, 50)

Despite the documented health benefits, legal obligations and fiscal incentives to provide appropriate language assistance in health care, language services are underutilized. The Joint Commission does not preclude the use of bilingual staff, but requires them to be adequately trained and competent in both languages in healthcare encounters. This is not happening in a consistent manner. ^(19, 25, 33) Many practitioners routinely turn down interpreters, and cross professional boundaries as they "get by", use a medical student, a family member, a friend, a clerk or patient care assistant unofficially self-assessed as "bilingual". These, by nature, constitute inequities in access, provision and quality of care. They violate many institutional language access and interpreter policies backed by federally binding law. It is beyond our capabilities to provide an

estimate as to the prevalence of these events within UCSF, but we encounter them daily, sometimes in the wake of adverse and disastrous results. Inadequate use of qualified language access services is certainly one part of the puzzle of disproportionately negative health outcomes for minorities and LEP patients that is no mystery.^(26, 27, 33)

Every health practitioner reading this might ask him or herself, “Do I use an interpreter with about 37.6% of my patients which reflects the non-English speaking population of San Francisco?”, or, “Do I use an interpreter with one in five of my patients, which reflects the non-English speaking population of California?” The great preponderance of peer reviewed evidence shows that if not, there is a high probability of breakdowns in communication and risks to health outcomes.^(4, 6, 12 - 14, 19, 24, 27, 32, 33, 44, 48, 49) In the age of drug resistant strains of HIV, TB and Staph infections, isn't competent communication with such a large segment of the population a serious public health priority?

Undoubtedly, there is frustration about insufficient, readily available interpreter resources. But as a wise common-sense proverb asks, “Why go to hell to light a cigarette?” Here is where Ockham's razor could be applied. Rather than looking to a free cyber application that will inadequately attempt to bridge the language barrier in a cognitively removed, reductionist manner that exacerbates so many of the dangers already out there, we can work toward a more effective solution. Rather than painstakingly pulling down twenty menu questions with yes/no answers that take far longer and are less reliable, why not take two minutes on hold for a phone interpreter to get a better quality standard of language access that will truly help address health inequities rather than contribute to them? Why not make the effort to speak with

department directors, or email those risk management staff or CEOs empowered to allocate sufficient resources for effective language access and proven best practices?

Every choice to use a competent health interpreter, or not to use one, is an ethical choice which seriously impacts health outcomes. Well intentioned and heartfelt as it may be, a physician's expert medical care is only as good as its delivery. Surely, if a hand-washing campaign like the one at UCSF has been able to lower the rates of in-house contracted infections; we are capable of successfully meeting this other challenge for health equity, quality of care and patient safety. We call upon health professionals, wherever they may be to insist on equity through qualified, competent and appropriate language access services, to practice medicine ethically and to "do no harm".

1. link to UCSF MediBabble article: <http://www.ucsf.edu/news/2011/06/10099/ucsf-students-create-medical-translation-app-conquer-language-barriers> Cited, July 19,2011.
2. link to CCHI website: <http://www.healthcareinterpretercertification.org/index.html> Cited, August 12, 2011.
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