The Patient-Physician Relationship: Overcoming Language and Cultural Barriers

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Abstract

The patient-physician relationship governs the field of medicine, forming the basis for all

relationships, interactions, and procedures in medicine. The degree to which a patient

trusts his physician and thus is willing to be receptive to medical advice and adhere to

assigned treatment is dependent on the quality of his relationship with his physician. The

method of relationship chosen will dictate how the patient feels he is perceived and thus

to what extend he will participate in his healthcare. A patient-centered approach to

medicine will increase this confidence and lead to improved clinical results. Additionally,

the rise of physician burnout has also had an effect on this foundational relationship,

creating division between the patient and his physician primarily due to complaints

against the excessive use of EHRs (electronic health records) and time constraints.

Furthermore, in a country of immigrants, the differences in not only language but also

between separate cultures and levels of health literacy divides physicians and large

populations of their limited English proficiency (LEP) patients. This is a huge detriment

to the patient-physician relationship. Lawmakers have created federal and state laws in an

effort to install legal action to remedy this, but significant work is still needed to fully

bridge the gap. Several solutions have been proposed to do this with the hopeful effect of

finally providing equal and better care to all.

The Patient-Physician Relationship: Overcoming Language and Cultural Barriers

Primum non nocere- this statement, taken from the original Greek Hippocratic Oath, declares that a physician's primary objective in his practice is "first, do no harm" (Gill, 2015, para. 2-3). However, this presents an impasse. How is a physician to implement this when faced with a situation that pits what he believes to be the course of best care against the patient's self-autonomy? How is the physician to respond when his patient is in a non-responsive state and he must assume the responsibility to make a life-changing decision? Further, how is a physician to interact and effectively communicate with his patient when confronted with a difference in language or culture? The aim of this paper is to address the issues related to these questions, exploring current literature reviews and conducted case studies that analyze the patient-physician relationship, and detailing the most common constraints and factors involved in the relationship and their effect. In addition, this paper will explore the effect that language and cultural barriers have on the physician-patient relationship and will evaluate proposed solutions.

Elements of Patient-Physician Relationship

Interactions between a physician and patient are unique. In return for complete vulnerability about intimate issues, physicians provide the patient medical expertise, maintain confidentiality, obtain informed consent, and pledge to provide the best possible care they can (Chipidza, Wallwork, & Stern, 2015). Physicians often become confidents about issues that a patient may not even share with family members and are given the unique opportunity to provide counsel and if needed, medical interventions. The unique relationship between a physician and his patient is built around four primary elements- trust, knowledge, regard, and loyalty- and encompasses a broad yet very personal set of

interactions (Chipidza et al., 2015). Chipidza et al. defined patient satisfaction to be "the degree to which the individual regards the health care service or product or the manner in which it is delivered by the provider as useful, effective, or beneficial" (para. 16). Patient satisfaction during and after a medical encounter is often an accurate indicator of his relationship with his physician, as well.

Both patient satisfaction and the patient-physician relationship are established based on trust, knowledge, regard, and loyalty perceived by the patient regarding his physician. Patient's trust in his physician indicates that the patient trusts the accuracy and intentions of his physician and are assured that his physician also trusts his report of symptoms. Knowledge implies that patients not only trust the knowledge held by his physician, but also appreciates the information shared by him. Knowledge also includes the general medical history knowledge that the physician has about each patient and the information that the patient has about the physician that can create a familiarity between the two. Regard refers to a physician's personal aroma, or his general friendliness, personability, and empathy perceived by the patient during a visit and in interactions afterwards. When a patient feels as if the physician regards him as an individual and supports his health goals, then he is more satisfied with the relationship. Finally, loyalty includes forgiveness by the patient when his physician makes a mistake or is inconvenient, such as running behind schedule. The physician's loyalty to providing continued care and support is highly valued by patients in both forming a strong patient-physician relationship and increasing satisfaction (Chipidza, Wallwork, & Stern, 2015).

Traditional models of the Patient-Physician Relationship

In 1956, Szasz and Hollender introduced an outline that categorized the three main ways that physicians interacted with patients, detailing the concept behind each and how it is acted out in practice: active-passivity, guidance cooperation, and mutual participation.

Active-Passivity

Szasz and Hollender (1956) referred to the first category as active-passivity, describing a relationship in which one member of the relationship- the physician- is active in decision-making and the other member- the patient- is completely passive and simply follows the instructions of the physician. Fully paternalistic, this model considers the patient as incapable of contributing any significant information or perspective in the medical setting and instead solely relies on the superior medical expertise of the physician (Kaba & Sooriakumaran, 2007). The physician acts upon the patient, who is considered little more than his diagnostic. This type of interaction has been commonly shunned except in the event of an emergency medical situation in which the patient is either unable to provide informed consent or the time required to do so would greatly increase the impending risk on the patient's health (Chipidza et al., 2015).

Guidance Cooperation

The second model type recognizes the perspective of the patient but still places the power of decision in the hands of the physician. Guidance cooperation emphasizes that the conscious patient has opinions and goals of his own that may influence his health and that he places his trust in the physician to recognize these and make decisions that respect them (Kaba & Sooriakumaran, 2007). The physician then expects the patient to

fully obey all recommendations or treatments subscribed by him. Thus, the patient is

seeking the guidance of the physician and the physician is expecting full cooperation

(Kaba & Sooriakumaran, 2007). The trust given by the patient is rooted in the physician's

superior medical knowledge (Chipidza et al. 2015). This type of relationship is accepted

for situations such as acute infectious processes that require complete and immediate

obedience to treatments called for by the physician (Kaba & Sooriakumaran, 2007).

Mutual Participation

The final and- considered the most appropriate- model of the patient-physician

relationship is the model of mutual participation. This model establishes its foundation on

the belief that all people, regardless of socioeconomic status or education level, are equal

and that this equality is both critical and beneficial in medical interactions. This belief is

acted out by the physician designating more responsibility to the patient, aiming for an

equal distribution of power between the physician and patient and the development of an

empathetic relationship that allows the patient's concerns to be fully addressed while the

physician still provides medical expertise. The relationship established on the basis of

mutual respect is beneficial to routine interactions between a physician and patient but is

of the utmost importance for the management of chronic illnesses. A patient is much

more likely to be consistent in his treatment of a chronic disease or condition when he

feels that he is being listened to and shares in the responsibility of his health (Kaba &

Sooriakumaran, 2007). Furthermore, both the physician and the patient are more likely to

have an increased sense of satisfaction and fulfillment after this type of encounter, as

both are allotted a certain amount of power over the situation and how to resolve it

(Chipidza et al., 2015).

The Patient at the Center of Medicine

The physician must be aware of the humanity and individualism of each patient, perceiving the patient as more than a statistic or case study. When a patient enters the doctor's office, he is entering as an individual that is greater than his disease. Therefore, understanding the "patient as a person" has become a pillar to the mutual participation model that is most often enacted in medicine. Although the formation of a relationship will require several visits, a physician should actively seek to understand his patient as a person during every encounter, building his arsenal of personal information that is not accounted for in a simple admissions/discharge sheet or chart, but that can provide critical background for establishing a cooperative action plan for bettering the patient's health. Having a broader information basis on both health-related issues and simple life circumstances will positively affect how the physician decides to treat the individual patient, enabling the physician to cater treatment to most effectively benefit the patient in his current state of life. This may involve recognizing how certain socioeconomic characteristics, such as a patient having a manual labor job, may affect his willingness to consult a physician for an injury or issue that he fears may cause him to miss work (Kaba & Sooriakumaran, 2007). Furthermore, the more the physician seeks to improve his relationship with an individual patient, the more the patient is likely to tell the physician about superficial personal information, thus deepening the relationship, and to trust him with more intimate issues that can be negatively affecting his health (Kaba & Sooriakumaran, 2007). When the patient understands that the physician is invested in him as a person and in his health, he is more likely to follow the medical advice given by the physician and adhere to his part in the responsibility of bettering his own health.

Additionally, greater communication between physician and patient decreases several preventable risks, including the risks associated with medical overuse (Newton, 2017).

Time Restraint

A barrier to the development of this relationship is the time constraint placed on physicians. With rushed individual patient encounter time slots, there is literally less time available for a physician to invest in holistically understanding his patient, instead being forced to quickly address the primary complaint independent of discovering other personal factors that may be a large influence on this problem (Kaba & Sooriakumaran, 2007). Although slightly longer in individual appointment length, routine primary care visits administered by primary care physicians now involve much more complex and numerous medical issues for each visit than in previous years (Linzer et al., 2015). In order to not fall behind and still attempt to address all of the problems presented to them, physicians streamline history taking and order more tests, many of which the physician could deem as unnecessary if he had more time allotted to collect a more thorough patient history. These unnecessary tests and procedures plant fear in the patient's mind and inconvenience both the patient and the physician, leading to laboratory visits and quick follow-up appointments that are not beneficial to the patient (Linzer et al., 2015; Newton, 2017). Additionally, "spending too many hours at work" was the second most cited cause of physician burnout (Peckham, 2018, slide 13).

The average routine doctor's appointment is 15 to 20 minutes long, leading to 53% of primary care providers reporting that time pressure in the clinical encounter is a significant stress (Linzer et al., 2015). Furthermore, rushed ambulatory encounters increase the risk and the fear of making clinical and recording errors. The plight of

primary care physicians has been described as a juggle between being done quickly, being done well, or being done cheaply (Linzer et al., 2015). One bowling pin will eventually fall, exposing the patient to unnecessary risk and compromising the physician's pledge to provide the best quality of care for those under his direction.

Role of the Internet

Additionally, the use of self-diagnosing or researching a symptom on the internet before an appointment has influenced the encounter between a patient and physician, as well. When accurate information is found, the internet can help improve the discussion between patient and physician by better informing the patient of his diagnosis and facilitating higher level discussion; however, inaccurate or inadequate information can increase confusion and miscommunication between physician and patient (Kaba & Sooriakumaran).

Physician Burnout- an Increasing Trend

The increase of physicians who are experiencing burnout has had a negative impact on the patient-physician relationship, resulting in a sense of unfulfillment and dissatisfaction for both physician and patient. Burnout is defined to be the "prolonged response to chronic emotional and interpersonal stressors on the job" that result from "an intense and strongly asymmetrical relationship between the 'giver' and the 'receiver'" (Wiederhold, B.K, Cipresso, Pizzioli, Wiederhold, M., & Riva, 2018, para. 3). Wiederhold et al. (2018) explains that with a sense of job dissatisfaction and loss of purpose, burnout physicians experience exhaustion, heightened depersonalization towards their patients, and a lack of personal accomplishment that decrease confidence in work-related decisions and lead to an overarching negative attitude that affects how

patients are perceived. Exhaustion and a lack of personal accomplishment or fulfillment emotionally drains physicians, especially in such a time-consuming, rigorous career. The development of cynicism towards patients is alarming and perhaps poses the greatest threat towards the patient-physician relationship. In an address to medical students in 1927, Dr. Francis Peabody directed them to embrace the practice of medicine by remembering that "the treatment of a disease must be completely impersonal; the treatment of a patient must be completely personal" (Parks, T., 2016, para. 1). When a physician is overwhelmed by clerical demands or an over-ambitious patient load, then patients become less of a person and more of a number, a nonpersonal member of a simple interaction void of personal investment and purely an analysis of human pathology. This altered interaction is not lost to the patients, who have reported that their physician used an increased amount nonempathetic language in their interactions (Chipidza et al., 2015).

Some of the most common causes of physician burnout are also some of the factors that patients cited as being the greatest reason behind their dissatisfaction with care. The physicians use of EHRs and rushed meetings are among the most cited reasons behind both patient and physician dissatisfaction. After the recent introduction of EHRs into healthcare to replace old paper records in an attempt to streamline and universalize medical history records, the vast majority of current physicians rely on EHR's to facilitate daily ambulatory encounters. According to one study, only 27% of a physician's work time is spent directly providing clinical care, while 49.2% of their time at work is being spent on logging and clerical desk work (Sinsky et al., 2016). Furthermore, physicians spend only 52.9% of eye to eye face time in the examination room and 37%

on their computer imputing data into an EHR (Sinksy et al., 2016). It was also observed

in this study by Sinsky et al. that for every hour spent with a patient, at least two hours

were spent on a computer and several personal hours outside the office were also

dedicated to finish EHR clerical work. According to the 2018 MedScape National

Physician Burnout and Depression Report, 42% of surveyed physicians experienced

burnout, with neurologists and critical care physicians leading at 48%, followed by

family medicine (47%), Ob/Gyn (46%), internal medicine (46%), and emergency

department physicians (45%) (Peckham, 2018). Thus, specialties with high level patient

loads tended to have the highest incidence of experiencing burnout.

These specialties are often swamped with a large number of patients, which not

only increases time spent in providing clinical care, but also involves a very substantial

amount of computer work. Although several organization-directed and individual

interventions have been proposed to alleviate physicians' stress, directly confronting

these two issues will produce the most dramatic positive effect in the patient-physician

relationship. In the 2018 MedScape report, the top reason for experiencing burnout was

excessive bureaucratic tasks, such as clerical and charting work on EHR's (Peckham,

2018). However, a universal revision of the EHR system that addresses the often overly-

complex, very time-consuming forms required to complete simple tasks in the

ambulatory setting should be thoroughly considered (Street et al., 2018). This revision

would enable physicians to spend less time on their computers and more time directly

addressing the patient, thus more effectively utilizing encounter time. Additionally, the

increased eye contact and full attention given to the patient will help develop a deeper

mutual relationship and increase patient's confidence that his physician truly listens and

cares for his holistic well-being. The physician also has more time to use EHR's as they were originally intended to be used- as a resource to increase patient understanding and accessibility to their health (Street et al., 2018). Physicians can use EHR's to physically show patients lab results and explain them to the patient, answering any questions he has about his diagnosis.

Intentionally investing effort into communication not only increases a patient's trust in his physician, but also enables the physician to have a better understanding of the patient's health beliefs and use this information to best serve this individual. However, it takes two to form a relationship and thus the level of participation of the patient is also crucial in developing a shared understanding of medical issues. Patients who were more verbal and active in their discussion with their physician were more likely to have viewpoints about medical issues that were similar to their physician (Street & Haidet, 2011). Although partially dependent on individual personality, patients can be encouraged to share more about their mental state by being asked open ended questions or questions that continue to ask for more information in a casual way. This can be done while the physician is using an EHR, when he is simply performing introductory checks, and really anytime throughout the visit. In addition, physicians can be trained to recognize nonverbal cues that indicate biases or leanings in the patient's view of a certain medical issue or topic (Street & Haidet, 2011).

Therefore, the prominence of physician burnout is an epidemic affecting both the physician and patients, resulting in decreased quality of care and satisfaction for both parties involved. The increased utilization of EHR and increased prevalence of rushed meetings are the two primary factors behind physician burnout. Solutions to these issues

include a revision of the EHR systems used with the aim of decreasing meaningless and bureaucratic tasks associated with them. Furthermore, the introduction of increased time slots for longer patient visits may provide physicians ample time to talk directly to their patient, rather than rush patient history to a curt diagnosis.

Overcoming Cultural and Language Barriers

One of the greatest difficulties in the patient-physician relationship is the communication gap caused by language and cultural differences between a physician and a patient. Language barrier is the primary factor contributing to the health disparity between LEP and English-speaking patients (Karliner, Jacobs, Chen, & Mutha, 2007). LEP patients have been found to have lower rates of regular physician visits or preventative services and even with access to care, demonstrate worse adherence to treatment prescriptions and more confusion concerning their diagnosis. Furthermore, LEP patients have a higher rate of medication complications, are more likely to prematurely leave the hospital, forego follow up appointments, and more often report decreased satisfaction with their given care (Karliner et al., 2007; Ku & Flores, 2005).

Although only one of hundreds of language groups spoken in the United States, the Spanish speaking community has greatly increased in recent years and is predicted to constitute one third of the entire US population by 2060 (Burgos et al., 2015). Many Latino immigrants have traditionally migrated to Florida, California, and Texas, states historically more accepting to immigrants and the Latino community. However, Latinos have begun to immigrate to cities and states all across the US, therefore health services aimed at providing quality care to the Spanish-speaking community is not only a state issue, but a national concern (Burgos et al., 2015).

In a telephonic survey conducted by the University of California San Francisco in 11 different languages, patients were asked for their level of English proficiency, their physician's language use, and questions about if they have had problems in medical situations, medication use, diagnosis, or bad reactions due to confusion with communication. The results of their survey included responses indicating that LEP patients were more likely to misunderstand discussions during medical encounters, experience confusion with medication labels, and have adverse reactions to prescribed medication (Wilson, Chen, Grumbach, Wang, & Fernandez, 2005). This study is simply an example of countless studies that have observed the disparity of healthcare between English speaking and LEP patients and the dire need to remedy this inequality of healthcare.

Federal Obligations

A limited English proficient (LEP) individual is defined as a person whose primary spoken language is a language other than English and has a limited ability to write, speak, read, or understand English (lep.gov, n.d.). There are several state and federal laws that protect the right to language assistance for these individuals. Title VI of the Civil Rights Act of 1964 forbids the discrimination of an individual based on color, race, or national origin in any program or agency that receives federal funding. This includes intentional discrimination and discrimination that is the result of a lack of services that enable LEP individuals to gain access to services exclusively described or publicized in English (lep.gov, n.d.).

Signed into law by President Clinton in 2000, Executive Order 13166 mandates that any agency and nonprofit or for-profit organization that is a recipient of federal aid is

required to provide full access to LEP customers. Therefore, any hospitals that receive

federal funding or assistance are required to provide access to language services for their

patients. Federal funding may include loans, tax credits or subsidies, grants, contracts,

and payments through Medicaid and Medicare programs, except for Medicare Part B

(Jacobs, Ryan, Henrichs, & Weiss, 2018; Juckett & Unger, 2014). The Title VI office

established four pillars or standards that must be met in order to maintain funding. They

are as follows:

1. The number or proportion of LEP persons eligible to be served or likely to be

   encountered by the program or grantee;

2. the frequency with which LEP individuals come in contact with the program;

3. the nature and importance of the program, activity, or service provided by the

   program to people's lives; and

4. the resources available to the grantee/recipient or agency, and costs. As indicated

   above, the intent of this guidance is to find a balance that ensures meaningful

   access by LEP persons to critical services while not imposing undue burdens on

   small business, or small nonprofits (lep.gov, n.d., para. 14).

Thus, hospitals or practices located in more ethnically diverse areas or who service a

large population of LEP individuals are required to employ a greater number of

interpreters or have access to a larger interpreter service compared to practices that do

not. The innate importance and effect of medical encounters and many medical programs

on the individual's health and well-being is indisputable. Furthermore, it is vital that

physicians and medical staff are able to effectively and thoroughly communicate the

costs, both in finances and potential health risks, associated with different procedures and treatments.

In order to not overburden these organizations, particularly small non-profits and other businesses, access to services is only required for LEP groups that are regularly or consistently encountered by that specific organization or agency (lep.gov, n.d.). For example, small practices will not be punished for employing fewer interpreters than large hospitals, as long as the number of interpreters available is adequate for the LEP patient population encountered. Hospitals that primarily encounter patients whose primary languages are English and Spanish, for example, will not be punished for not having printed forms in Hindi or another infrequently encountered language for that facility. However, all vital documents, defined as documents that are essential for receiving federal aid, must be translated into regularly encountered LEP languages. If the document is lengthy, then only the information considered vital must be translated (lep.gov, n.d.).

Who is Considered a Qualified Interpreter?

In order to provide care to LEP individuals in the medical setting, interpreters, either in-person or via telephone or video-conference, are critical to facilitate communication between the physician and the patient. Executive Order 13166 indicates that the interpreter or bilingual person providing an interpretation service must be fluent in both languages, including a mastery of agency-associated terminology (lep.gov, n.d.). Furthermore, interpreters should be fluent in both languages orally and in writing and able to translate in such a way that the expression and meaning of the original message is maintained as much as possible (lep.gov, n.d.). Therefore, medical interpreters must be well-learned in medical terminology in both English and the LEP language. They must

also be able to accurately communicate the urgency or tone of the physician he is

translating for in order to reflect the importance of whatever the physician may be

prescribing or advising or to correctly portray to the physician the concerns of the patient.

Interpreters are also expected to be conscious of the cultural and ethical norms associated

with both languages (lep.gov, n.d.). This can include eye contact, what is considered

appropriate physical touch, especially between potentially a male physician and a female

patient, and other behaviors deemed appropriate or inappropriate in that culture.

The Certification Commission for Healthcare Interpreters and the National Board

of Certification for Medical Interpreters are the two institutions that certify interpreters to

qualify as a professional interpreter that are appropriate to be used in the medical setting

(Juckett & Unger, 2014). In addition to ensuring competence in medical terminology in

both languages, interpreters are informed about the Health Insurance Portability and

Accountability Act, emphasizing the importance of maintaining patient confidentiality

(Juckett & Unger, 2014). If a bilingual staff member is used in place of a professional

interpreter, then it is the responsibility of the organization to ensure that this individual

meets all of these requirements, as well (Jacobs et al., 2018; lep.gov, n.d.). If the staff

member does not, then training in interpretation technique and responsibilities should be

taken to ensure that the staff member is not only bilingual, but is a proficient interpreter,

as well (Juckett & Unger, 2014). This is often encountered in the medical setting when

the physician asks for the assistance of a fellow physician, nurse, or other member of the

staff to translate between him and the patient in the absence of a professional interpreter.

Ad hoc interpreters, or family members, friends, or another bilingual bystander,

are often used to decrease wait times or avoid having to pay for professional interpreters.

They are more likely to be unfamiliar with medical terminology, give their own advice,

use euphemisms for sensitive sexual issues, and other slight errors in interpreting that can

lead to increased miscommunication and further consequences (Juckett & Unger, 2014;

Mayo et al., 2016). Section 1557 of the Affordable Care Act prohibits the use of children

as interpreters except for in emergencies if there is no other bilingual person available.

This section was added to protect the child, the patient, and the physician. Children have

a limited vocabulary, especially concerning medical terminology and adult issues, and are

not appropriate interpreters for their parents for personal or intimate issues. Even adult

non-professional interpreters may lack the knowledge of medical terminology in both

languages (Karliner et al., 2007).

  In a study conducted by researchers at the University of California San Francisco

to evaluate the use of professional interpreters for clinical encounters in two urban

hospitals located in San Francisco, researchers investigated interpreter use for three

different clinical encounters- with the physician at admission, with the physician after

admission, and finally with nurses since admission. Results from the three-year study

indicate that 93% of the sample of 374 LEP patients reported wanting an interpreter when

communicating with their physician; however, only 43% reported being asked if they

wanted an interpreter and only 57% reported actually receiving one at admission and

60% since admission. Out of these percentages, only 17% of interpreters used at

admission and only 14% of interpreters used after admission were hospital interpreters.

Thus, the use of an ad hoc interpreter, such as a self-declared bilingual physician, nurse,

family member or other patient as an interpreter, was much more common. Very few

patients reported that their physician could speak their non-English language well

(Schenker, Perez-Stable, Nickleach, & Karliner, 2011).

These results, and results from several other studies that concur, raise concern for

the quality of language services for LEP patients and thus put their overall quality of care

at risk (Fernandez et al., 2011; Schenker et al., 2011). The infrequent use of hospital

interpreters coupled with the very low incidence of physicians who also speak the LEP

patient's preferred language indicates that there is a deficiency in care for LEP patients.

Furthermore, professional interpreters have lessened the gap in critical care between LEP

patients and English-speaking patients, improving patient comprehension and decreasing

errors in communication. Thus, patients who better understand their diagnosis and the

treatment regime prescribed to them can better adhere to it, causing an improvement in

clinical outcomes and patient satisfaction for LEP patients using an interpreter as well

(Karliner et al., 2011).

Costs of Providing Language Services

The barrier to government funding is monetary expense. It is estimated to cost

$268 million a year to provide interpretation services for all inpatient and outpatient

services, emergency department encounters and visits to the dentist (Ku & Flores, 2005).

In a similar fashion, private practices also cite cost as a barrier to providing professional

language services to their patients. However, practices may choose from a variety of

interpretation options with a spectrum of prices. In-person interpreters are the costliest

option, often ranging from costing $45-$150 an hour, depending on demand or which

language is requested. Independent interpreters not affiliated with a language translation

service may also request more. Although pricey, in-person interpreters allow patients to

have face to face interactions, enabling interpreters to pick up on both verbal and visual

cues and translate them for the physician. Additionally, certain medical encounters, such

as those involving mental health patients or patients that are hard of hearing, benefit

greatly from having the interpreter physically in the room. Encounters with pediatric

patients and adult patients from certain cultures, such as Cambodian immigrants from

Southeast Asia, have been shown to be significantly improved by in-person interpreters

(Cruz et al., 2009; Jacobs et al., 2018).

Video remote interpreting (VRI) utilizes web cameras or phones to access an off-

site interpreter and enable the patient to see him face to face. VRI services often charge

between $1.95 to $3.49 per minute with a minimum number of minutes required (Jacobs

et al., 2018). This interpretation method is popular with the deaf community, enabling the

patient to use American Sign Language rather than relying solely on typed

communication (Juckett & Unger, 2014).

Telephonic interpretation is the most popularly used form of interpretation in

medical practices. However, this form of interpretation may be hindered due to

suboptimal clarity of sound or connection and being unable to respond to visual cues or

behaviors (Jacobs et al., 2018). Also, some cultures, such as the Cambodian population

from Southeast Asia, may have a very difficult time articulating sensitive information to a

source that they cannot physically see (Cruz et al., 2009). However, telephonic

interpretation is usually the most affordable form of interpretation, often costing $1.25 to

$3.00 a minute depending on the language requested and the time of day being used.

Language non-concordant physicians can also use telephonic interpreters for immediate

translation services (Jacobs et al., 2018).

Few state governments have policies in place to reimburse translation service expenses paid for by hospitals and private practices. Several of these states have created a centralized telephonic language service, thus reducing cost of the service (Jacobs et al., 2018). Medicaid and CHIP (Children's Health Insurance Program) programs in the District of Columbia and 14 states also have set up a system in which providers can use language services and be completely reimbursed. In other states, providers are required to pay for the costs up-front and then can request reimbursement (Jacobs et al., 2018). However, many states and insurers do not reimburse practices for the language services, expecting instead for patients or the practices to pay out of pocket. For example, Medi-Cal, the division of Medicare for California residents, does not cover interpretation service in their payment to physicians, creating a costly gap for physicians to attempt to fill. Furthermore, Medicare does not cover interpretation services, rendering LEP seniors, a population group that falls under the umbrella of two vulnerable groups, at a disadvantage (Ku & Flores, 2005).

Alternative Forms of Communication

Although required by law to provide language services to their patients, some practices have implemented additional policies to better remedy the communication barrier encountered by LEP patients. In a study conducted at San Francisco General Hospital, a university-affiliated hospital that traditionally serves a low income, ethnically diverse population group, visual aids were used to help patients track their weekly warfarin regime, resulting in greater patient concordance with physician instruction (Schillinger et al., 2005). The transition from verbal to visual modes was especially beneficial to patients who were verbally discordant with their physician (Schillinger et

al., 2005). Visual aids improved patient-physician communication and understanding,

thus enabling an increase in health literacy and understanding for patients, ultimately

leading to better overall care and health for the patient. This study in particular is

important in indicating how drastic the effect of visual aids can be on patients who have a

chronic disease and must juggle several drugs, some of which can lead to adverse effects

if the patient does not understand, and thus does not keep, the proper schedule

(Schillinger et al., 2005).

Proposed Solutions

Thus, with the proven benefits of providing professional interpreters compared to

their absence, the question of *is it worth it to pay for language service* becomes the

conviction *can we afford to not pay for language services?* The monetary cost far

outweighs the time and money saved by the decreased number of returned visits,

complications due to miscommunication, and remedial procedures needed from adverse

drug effects. More importantly, the current health disparity between LEP and English-

speaking patients can be quickly and effectively diminished by valuing and meeting all

patients where they are at linguistically and culturally. Therefore, there have been several

solutions to remedy some of the most common barriers to interpretation services,

language disparities, and cultural unawareness.

The need for increased and improved access to professional, hospital-provided

interpreters, including in-person, telephonic, or VMI interpreters is apparent in several

medical encounter types (Schenker et al., 2011). In order to promote the increased use of

these services, several payment methods have been proposed to help compensate

hospitals and providers for the cost of language services. These include insurance

reimbursement, the establishment of contract agreements between insurers and telephonic

interpretation services, and the development of language banks, or programs that recruit

and train local bilingual people to become professional interpreters. These banks promote

local community participation and the creation of more interpreters for the languages that

are most common in that area; however, the interpretation services provided by the

students of these programs must still be reimbursed in some way (Ku & Flores, 2005).

Although the Certification Commission for Healthcare Interpreters and the

National Board of Certification for Medical Interpreters have recently began to

standardize the qualifications and certifications of what qualifies an individual to be a

professional interpreter, there is still a need to set comprehensive standards for interpreter

use and specific requirements that define what constitutes an adequate interpreter versus

what is unacceptable or considered inappropriate. Also, there needs to be a better system

to identify patients who may need interpretation services beginning at the initial

encounter at the moment of admission (Schenker et al., 2011). Patients need to be better

informed of their rights to professional interpreters and other language services free of

extra charge during the initial encounter or after admission if it is perceived later that an

interpreter may be beneficial (Schenker et al., 2011).

Some have proposed that rather than attempt to use translator services or speak to

the patient using their limited English knowledge, physicians should be required to have

language training incorporated into their studies (Clarridge, Fischer, Quintana, &

Wagner, 2008). This solution, although not extremely popular because it adds stress and

years to physician's already extensive schooling, is supported by several arguments that

advocate why the language burden should be placed on the physician, not the patient. The

first argument made is simply a comparison of numbers. There are only 5.5% Hispanic or

Latino providers practicing in the United States compared to a 16% of the national

population that are of Hispanic/ Latino descent (Burgos et al., 2015). Of this 16%, 36%

are immigrants, thus are less likely to speak or understand English well or very well

(Burgos et al., 2015). In addition, physicians have greater access to language training

during their lengthy academic journey. Finally, the goal of the physician should be to first

and foremost strive to reach the best well-being for his patient, thus it is critical to meet

the patient wherever he is (Clarridge, et al., 2008).

However, this solution has not been universally enacted because it may cause

adverse results. Although bilingual physicians are invaluable, physicians with a

hyperinflated belief in their language fluency can create more confusion and

misunderstanding, resulting in decreased patient care and increased frustration between

the patient and physician. The added stress of requiring language training to a saturated

scholastic career will unintentionally encourage this trend of language learning, simply

adding to the number of ad hoc interpreters who may mean well but may incidentally

create larger problems (Clarridge et al., 2008). Therefore, rather than requiring

bilingualism, optional language training can be offered to medical students who may

already have extensive language knowledge or training. The language offered should be a

language that is commonly encountered in the United States as a whole or a language

often encountered in the geographical area that the medical school serves. Regardless of

language competency, all medical students should be required to learn and practice how

to respectively and effectively communicate with professional interpreters and to

recognize when a patient may need this service (Clarridge, et al., 2008).

Additionally, all medical professionals should be offered cultural competency training. Cultural competency is defined as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or amongst professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations" (Terry, Bazron, Dennis, & Isaacs, 1989, p.7). In a survey of Midwestern health center providers who regularly manage diabetic Latino patients, providers were asked in a printed questionnaire questions regarding their Spanish language ability and Latino cultural awareness (Baig et al., 2014). Of the providers that reported that three quarters of their diabetic patients are Latino, over one fourth claimed to never have undergone and to not currently have access to cultural training. This places physicians at a disadvantage to providing quality care and increases physician stress. Fortunately, physicians who have had formal cultural training and who primarily serve the Latino LEP community in this survey were more aware of cultural differences and how to address medicine through a culturally sensitive mindset. Unfortunately, physicians who mainly serve LEP patients and who have had low cultural awareness also do not have access to training, decreasing their opportunity to develop cultural competency skills. Therefore, simply repetitive interaction with an LEP population is not always sufficient for physicians to develop a high level of cultural awareness, so cultural training should be implemented for practicing physicians.

Cultural training should expand beyond simple language acquisition to include the traditional style of relationship held between patient and physician, relevant religious beliefs, and normal family dynamics, to name a few. For example, many Asian and Latino cultures have traditional folk remedies for certain diseases that they may try

before consulting a physician (Baig et al., 2014). It is important for a physician to be

aware of these practices, their potential benefits and detriments, and to be able to respond

and respectively discuss them with patients. Physicians should also be aware of some of

the main subgroups within a culture, for example differences between cultures in

different Asian countries that are often grouped together (Baig et al., 2014). Although

knowing the precise details of every culture is expansive and impractical, physicians

should at least be aware that there are slight differences in cultures that appear to the

Western world to be identical.

　　　After receiving training, physicians are more confident in their ability to

appropriately and effectively communicate cross-culturally with an LEP patient and

express a desire to continue training in order to improve these interactions (Baig et al.,

2014). Healthcare providers should be educated on the importance of cultural leverage

and its potential to be used to more effectively interact cross-culturally (Fisher et al.,

2007). When a provider applies the method of cultural leverage, he intentionally uses

examples or images from a particular, non-white culture to communicate a health-related

lesson, drawing on examples that are already familiar to a specific minority group to

more effectively communicate a message (Fisher et al., 2007). Although many healthcare

professionals can implement this in different areas or parts of medicine, physicians can

greatly enhance communication using this strategy. By maintaining a cultural awareness

and making comparisons or references to aspects of the culture of an LEP patient, a

physician can more clearly communicate the importance of a certain lifestyle change and

use important cultural values to encourage adherence to treatment. References can

include more obvious aspects of a culture, such as dress, folklore, or music; however,

when foundational values are incorporated, the medical message becomes much more compelling (Fisher et al., 2007). In addition, literature has indicated that matching patients to staff that share the same or similar cultural background, if available, greatly increases patient trust in the physician and his staff, leading to the development of a deeper relationship that will then encourage better communication and satisfaction with care (Fisher et al., 2007).

Health Literacy and Effect

The WHO defines health literacy as possessing the "cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand, and use information in ways which promote and maintain good health" (Ishikawa & Yano, 2008, para. 3). Health literacy (HL) is a key determinant in how much a patient will become involved in decision making. Although specific to literacy and understanding of health-related issues, individuals who are generally illiterate also struggle with health literacy, as well as many well-educated individuals that may still have low HL levels (Ishikawa & Yano, 2008). Additionally, LEP individuals may be confronted with a double barrier to medicine, with health illiteracy in their native language and a general difficulty with English, which fathers an even greater misunderstanding medical information.

Low levels of health literacy may negatively affect nearly all aspects of the patient's health management, including his relationship to his physician. Lower health literacy has been linked to a decreased expressed desire to participate and contribute to shared decision making, instead relying on the physicians or other individuals to give their consent. In addition, low level HL patients are less likely to adhere to disease

management schedules, complete preoperative procedures, and have an increased number

of emergency department visits (Ishikawa & Yano, 2008). Furthermore, low HL patients

are less prone to utilize preventative services, such as cancer screening tests, probably

because they are unaware of them or do not understand their significance and influence

on their health. Although based on an individual's understanding of medical situations,

health illiteracy or low levels of HL are often a community concern. An individual's HL

is often a reflection of his community's overall HL (Ishikawa & Yano, 2008). A decrease

in HL inevitably creates a diminished or at least decreased sense of confidence and self-

efficacy in the individual's self-perceived role in the management of his own health.

However, patients with a higher level of HL are more inclined to engage in meaningful

conversations with their physician, enabling a higher level of understanding of their

diagnostic based on the basic health information that the patient already knew.

Furthermore, a patient with higher HL will seek outside information before visiting his

physician, developing possible questions for clarification of information read online or

more involved questions regarding a specific issue. A better-informed patient is also a

more obedient patient as he is more likely to adhere to physician recommended treatment

when the reasons behind these treatments are better understood. Increased self-

management and involvement in one's health is a critical aspect to a healthcare system

increasingly shifting and functioning on a shared-decision, mutual cooperation model.

Conclusion

The patient-physician relationship governs the field of medicine, forming the

basis for all relationships, interactions, and procedures in medicine. The degree to which

a patient trusts his physician and thus is willing to be receptive to medical advice and

adhere to assigned treatment is dependent on the quality of his relationship with his physician. The method of relationship chosen will dictate how the patient feels he is perceived and thus to what extend he will participate in his healthcare. A patient-centered approach to medicine will increase this confidence and lead to improved clinical results. Additionally, the rise of physician burnout has also had an effect on this foundational relationship, creating division between the patient and his physician primarily due to complaints against the excessive use of EHRs and time constraints. Furthermore, in a country of immigrants, the differences in not only language but also between separate cultures and levels of HL divide physicians and large populations of their LEP patients. This is a huge detriment to the patient-physician relationship. Lawmakers have created federal and state laws in an effort to install legal action to remedy this, but significant work is still needed to fully bridge the gap. Several solutions have been proposed to do this with the hopeful effect of finally providing equal and better care to all.

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