

ment is the perceived ability of individuals to manage their illness personally by being able to identify resources and navigate the healthcare system. That is, self-management is a task patients engage in but also one that providers assist in by eliminating barriers (e.g., coordinating care or arranging referrals) and performing strategies (e.g., engaging in advocacy and supporting patient autonomy) to help patients care for themselves outside the medical encounter.

In summary, while both patient-centered and relationship-centered care emphasize the communication between patients and providers, relationship-centered care stresses the importance of the patient-provider relationship, while patient-centered care underscores communication tasks that are essential to meeting health goals and needs (see Theorizing Practice 3.2). And despite the fact that there are differing assumptions between the two types of care, overall, both “[provide] a context for understanding the ways provider-patient communication predicts outcomes, and [pose] questions for the pathways linking process and outcomes” (Duggan & Thompson, 2011, p. 419), which is explored next.

Theorizing Practice 3.2 **Patient-Centered Communication**

Mrs. Myers is a 74-year-old, Caucasian patient who was diagnosed with Stage III colon cancer six years ago. She received treatment at the time and has been cancer free ever since. Yesterday, she presented to the ER with shortness of breath, chest pain, coughing up blood, dry cough, and weight loss. A CT scan and a lung needle biopsy are positive for colon cancer metastasized to the lungs. The five-year prognosis is poor (around 8%) even with chemotherapy. The ER provider must now go and deliver this bad news to her, keeping in mind Mrs. Myers simply thought she had a lung infection and was waiting for antibiotics to go home. Mrs. Myers is widowed with three children and four grandchildren; does not have any other medical conditions that might be complicated by this event; and does not have any preexisting psychological problems that might be complicated by this event.

Write a conversational dialogue between the patient (Mrs. Myers) and the ER provider (you) in which you break this news. Focus specifically on incorporating patient-centered communication functions. For instance, as you write, make sure to specify what verbal statements and nonverbal behaviors relate to each function (e.g., responding to emotions = actively listening, enacting empathy, etc.).



HCIA 3.3

Cross-Cultural Care: When Providers and Patients Do Not Share the Same Language

Elaine Hsieh

During my early days as a healthcare interpreter, I took a patient who suffered from scoliosis to visit rehab services. His illness was so advanced that his spine was bent to an extent that he would look backward as he walked forward. Upon seeing the patient, a young resident could not contain his excitement and with a big smile, he said out loud, “That’s the

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worst case I've ever seen!" The comment caught me by surprise. I didn't know how to interpret the young resident's greeting. I could have interpreted it like a linguistic machine that relays information from one language to another accurately and faithfully (with equal enthusiasm), like I was taught in my professional training (i.e., interpreter-as-conduit). Yet, it felt wrong to do so. My dilemma was not caused by my lack of linguistic skills but something else.

Successful interpreter-mediated provider–patient interactions require all participants to coordinate effectively and appropriately with one another. Through the funding from the National Institutes of Health, I interviewed and surveyed providers from five clinical specialties (i.e., emergency medicine, OB/GYN, oncology, mental health, and nursing) about their needs when working with language-discordant patients. Here are some key findings:

1. Providers across different specialties share certain expectations for interpreters. For example, providers generally envision a competent interpreter as a professional who assumes the linguistic and cultural broker roles (i.e., individuals who bridge linguistic and cultural differences) without interfering with the process or content of provider–patient interactions. Providers also view interpreters as their allies and expect them to be responsible for assisting them in achieving their therapeutic agenda. It is interesting that few providers recognize these two interpreter roles as potentially competing (and even conflicting) demands (e.g., how can interpreters be neutral if she/he is also expected to side with providers?). Rather than viewing professional interpreters as the only solution, providers also strategically utilize different types of interpreters (e.g., a patient's family members or a bilingual nurse) and interpreting modalities (e.g., face-to-face interpreting, telephone interpreting, and video remote interpreting) to maintain provider–patient trust, organizational ethics, and clinical complexities.
2. Providers may hold specific expectations that are unique to their clinical contexts. For example, although nurses value interpreters' abilities to provide emotional support, many mental health providers noted that an overly friendly or supportive interpreter can prohibit provider–patient bonding and thus compromise the quality of care. In fact, some mental health providers do not even want interpreters to greet their patients. They argued that while causal greetings may appear natural in everyday social interactions, asking a war refugee about where he/she is from or how many kids she/he has may trigger unanticipated outbursts of traumatizing memories, resulting in setbacks in the therapeutic processes.
3. Language barriers often entail deeper and greater differences in areas not limited to languages. For example, a Chinese patient may use the term "*shenxu*" to describe his illness, which in English literally means weak kidney. But for male patients, this term can be used to imply various symptoms, including bodily coldness, defective cognition, erectile dysfunction, urinary frequency, among others. Although humor is valuable to promote provider–patient relationship in the U.S., providers' joking or teasing in a medical encounter can be perceived to be insensitive or patronizing in Japanese or French culture. As a result, as interpreters assist in cross-cultural care, they inevitably need to tread in the boundaries of medicine as they bridge the blurry boundaries of medicine, language, and culture.

It is essential to recognize the lack of language services as social injustice and to emphasize the need to provide interpreter services for improving language-discordant patients' quality of care and experiences of health and illness. My recent fieldwork as a Fulbright U.S. Senior Scholar found that immigrant workers from Southeast Asian countries (e.g., Thailand and Vietnam) mostly rely on their employers to be their interpreters when they first arrive

in Taiwan. Because severe illness is listed as a reason for termination of their employment contracts, they may underreport the severity of their illness, seek underground care, or become undocumented to avoid deportation. When patients do not share the same language with the host society, they often experience disparities and social injustice in areas not limited to language.

As we consider the needs of language-discordant patients and identify ways to reduce disparities and challenges they face in health services, we can develop practical guidelines for meeting these needs based on my research findings and other recent studies:

- All participants need to actively discuss their communicative goals and therapeutic priorities to facilitate shared decision making. If patients do not know what to ask, how to ask, or are unaware of their rights, they may not be able to make informed decisions. Providers and interpreters need to be vigilant in ensuring that patients have sufficient knowledge and skills to exercise their autonomy in the decision-making process.
- The meanings of quality of care are contextually dependent. Providers and interpreters need to be sensitive and adaptive to meet the emerging demands. What is meaningful and appropriate in one clinical setting for a particular patient may not be applicable to another. Successful cross-cultural care is dependent on participants' ability to identify and respond to the often changing needs and priorities in a medical encounter.

QUESTIONS TO PONDER

1. Imagine that you need to seek healthcare services when visiting another country, and you also do not share the same language with your healthcare providers. How would that influence your help-seeking behaviors? What kinds of concerns would you have?
2. What are the strengths and weaknesses when a family member serves as interpreter in a healthcare setting? How about a professional interpreter? Who would be better to assist providers to take a medical history? Why is that? How about getting consent for a complex surgery? Again, why?
3. Do you think a doctor and a patient may have different preferences about the type of interpreters to be used during a medical encounter? Why? Would the specific tasks to be accomplished (e.g., discussing end-of-life decision making versus getting a flu shot) influence their preferences? If they have different preferences, who should decide which type of interpreter to use? Why?

Source: Hsieh, E. (2016). *Bilingual health communication: Working with interpreters in cross-cultural care*. New York, NY: Routledge.

■ Health Outcomes

Dr. Austen's communication with Hannah demonstrates a pathway in which communication affects health outcomes. In particular, through Dr. Austen's provision (and framing) of information about Hannah's genetic risk as well as their decision-making partnership regarding the variety of health options, Hannah gained knowledge about the complexities of her genetic test results and managed her uncertainty about the future. She then made the informed health decision to undergo a preventative double mastectomy now but wait a few more years before undergoing a preventative oophorectomy. Moreover, Dr. Austen's active listening, empathetic communication,