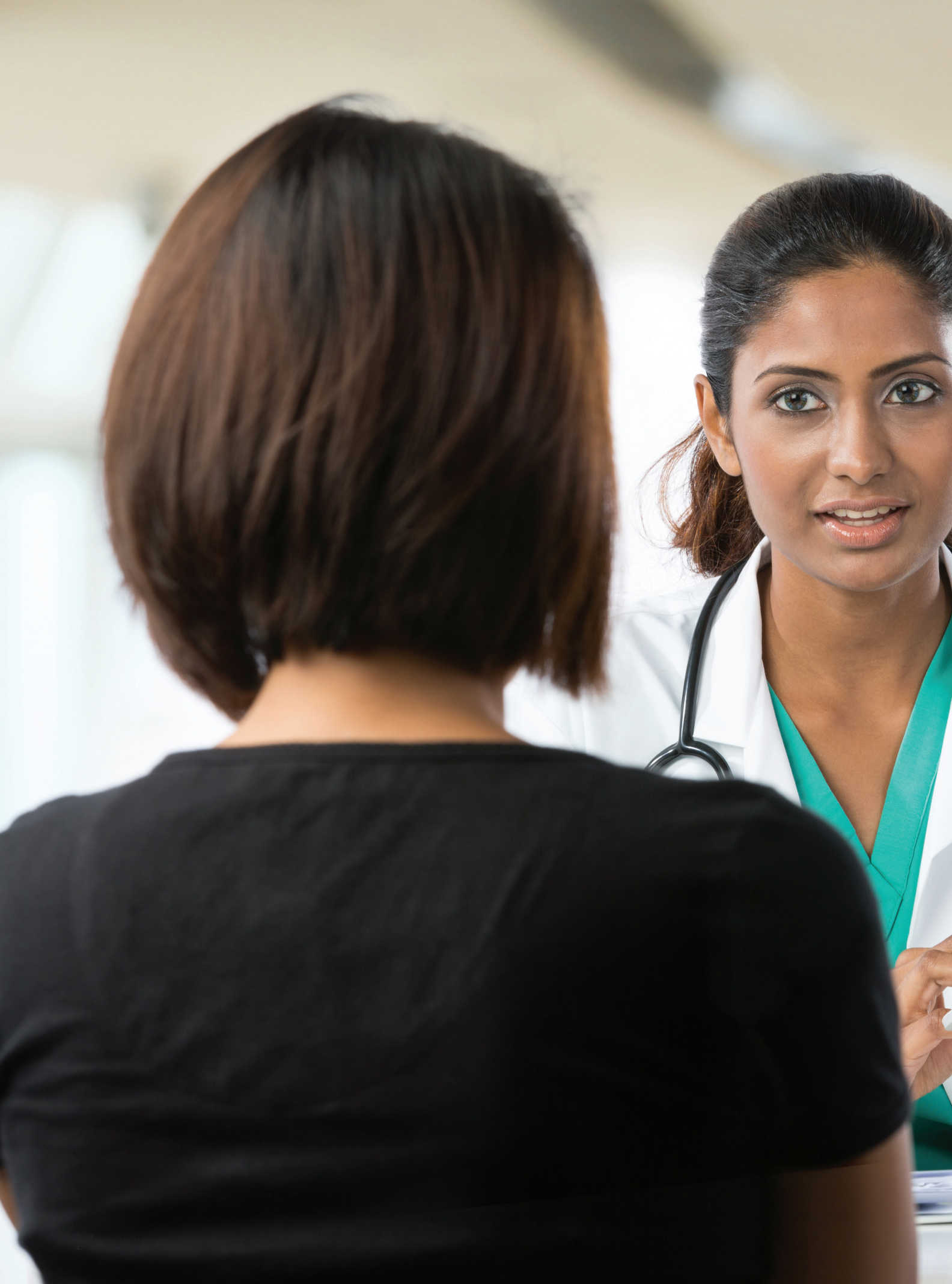

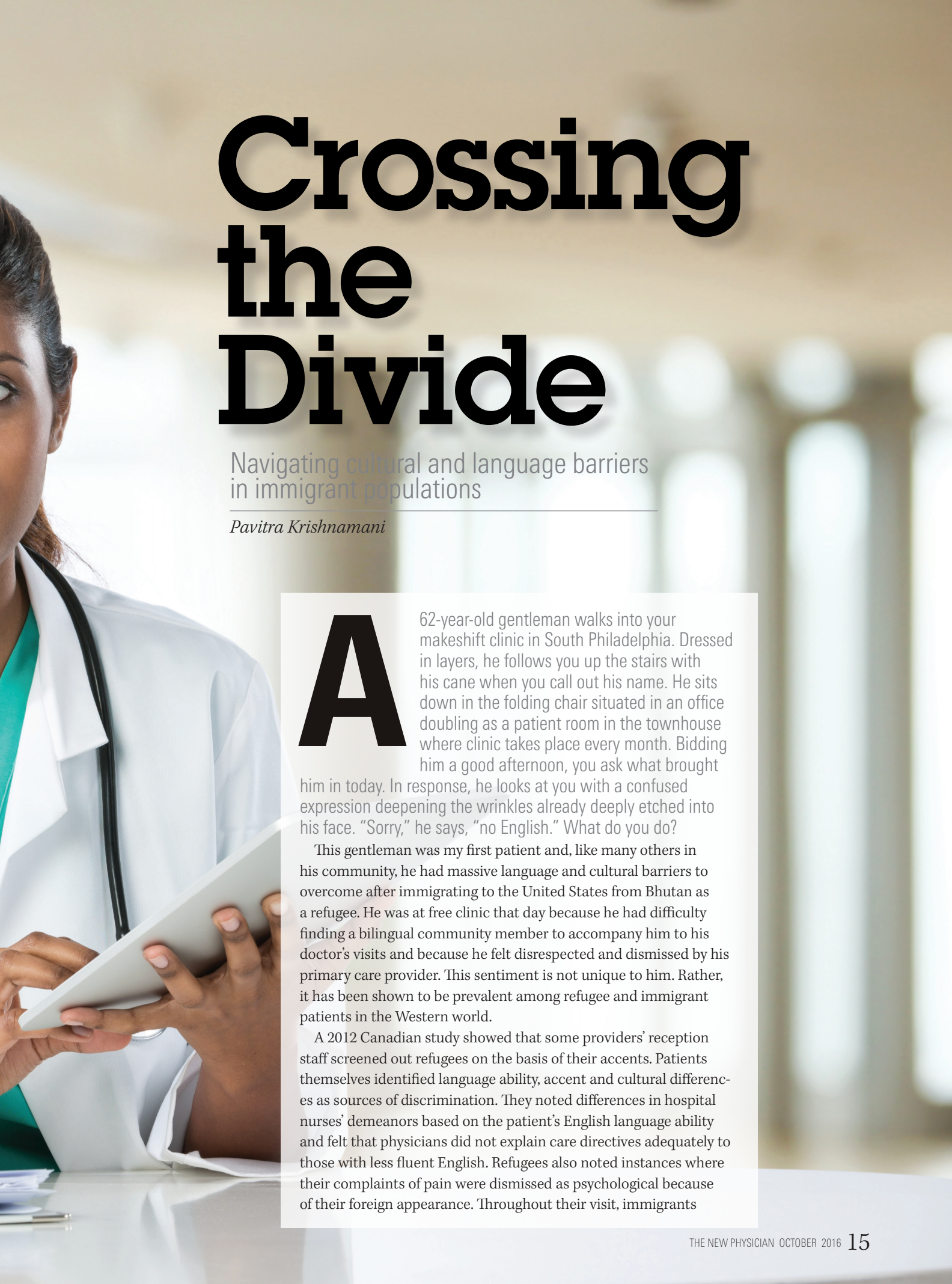

Crossing the Divide

Navigating cultural and language barriers in immigrant populations

Pavitra Krishnamani

A 62-year-old gentleman walks into your makeshift clinic in South Philadelphia. Dressed in layers, he follows you up the stairs with his cane when you call out his name. He sits down in the folding chair situated in an office doubling as a patient room in the townhouse where clinic takes place every month. Bidding him a good afternoon, you ask what brought him in today. In response, he looks at you with a confused expression deepening the wrinkles already deeply etched into his face. "Sorry," he says, "no English." What do you do?

This gentleman was my first patient and, like many others in his community, he had massive language and cultural barriers to overcome after immigrating to the United States from Bhutan as a refugee. He was at free clinic that day because he had difficulty finding a bilingual community member to accompany him to his doctor's visits and because he felt disrespected and dismissed by his primary care provider. This sentiment is not unique to him. Rather, it has been shown to be prevalent among refugee and immigrant patients in the Western world.

A 2012 Canadian study showed that some providers' reception staff screened out refugees on the basis of their accents. Patients themselves identified language ability, accent and cultural differences as sources of discrimination. They noted differences in hospital nurses' demeanors based on the patient's English language ability and felt that physicians did not explain care directives adequately to those with less fluent English. Refugees also noted instances where their complaints of pain were dismissed as psychological because of their foreign appearance. Throughout their visit, immigrants

experienced impersonal health care when providers refused to attempt their names because of complexity and assumed cultural stereotypes to be true when they were not.

In South Philadelphia, free community clinics provide safe havens where refugees can seek culturally sensitive care for minor health concerns. The majority of these are coordinated by Refugee Health Partners (RHP), an organization I led as vice president last year. RHP's initiatives are fueled by my colleagues at Thomas Jefferson University who regularly navigate language and cultural barriers to positively impact the health of resettled refugees in the region by providing access to education, clinical, public health, and advocacy services.

"I feel a lot of both RHP's and my personal ability to help patients get the care they need relies...on the trust and relationships we build in the community," says Alison Presti, a former assistant clinic director at RHP clinics. "One of the most valuable aspects of my experience working with RHP is learning the power of community outreach programs. It is so easy for people, especially those who are new to the country and who do not speak the language, to slip through the cracks."

Amanda Nemecz, a patient advocate for the refugee community, worked on making sure the people RHP worked with did not slip through these cracks. "This involved ensuring that all refugees had good access to health care services in the United States [by] signing up patients for health insurance, helping them make appointments, ensuring that translators would be available, and helping with overdue bills," she says. "I thought that this was the most valuable part of this experience—having to really become part of their lives."

Nemecz told the story of a refugee family who hadn't understood their rights in the United States. "Their housing situation was most definitely not to code and because of that, their utility bills were far beyond what they could afford," she says. "They had lived like this for several months because they were unaware that the government had regulations about the quality of apartments that landlords are responsible for upholding. I think the first step to negotiating cultural and language barriers is ensuring clear communication. This almost always includes a competent translator, one who is competent in both the language and the culture."

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"Translators are the best way to communicate with patients, and often you can find student volunteers that are more than willing to help," says Dilru Amarasekera, former co-chair for RHP's Health Services committee. "There are [also] usually community members in migrant populations that are fluent in English or have been in the country for much longer and can act as a liaison between you and the community. These community liaisons are essential to understanding the culture, advertising health services, and maintaining a great relationship and presence within the community," she says.

Amarasekera acknowledges that this interpretation may not always be available and recommended using simple language to communicate in these situations. "We once had a patient who came to us extremely hypotensive and we were unable to get his pressure

up. He didn't speak any English, but we had to communicate to him that we needed him to go to the emergency room. Before we had the help of a student translator, it involved a lot of trying to use extremely simple sentences and phrases, like 'hospital' and 'drink water,' that had a higher chance of being understood by the patient."

This is true even when communicating with patients who may know English but have learned it in an accent different from our own. One of my patients, a visitor from India, found herself in the hospital after developing a kidney stone while visiting her son, who lives in the United States. She was being managed by the hospital's internal medicine team while passing the stone through a stent. The patient did not know much English and relied on her husband to relay information and concerns about her situation to the team, but her providers had difficulty understanding her husband's "broken English."

When I first met her husband, I realized that he spoke English perfectly well, but in a rather thick Indian accent that was difficult for her provider to decipher. Reciprocally, her physician relayed care information very quickly in what, to the patient, was a thick American accent. Simply slowing down, using dates instead of days, and using hand gestures helped facilitate communication between the patient and our team throughout her time at the hospital.

When a provider's ability to verbally counsel a patient is steeply limited by a language barrier, using pictures or guides in a patient's native language can help describe conditions and care directives. Amarasekera uses pictures to describe routes and times of administration to teach patients how to take their medication when translators were not available. "For example, circling a patient taking a pill through the mouth [to show them a pill should be taken orally] or circling a sun versus a moon [to teach them when a pill should be taken] helps us communicate… with a patient who can't completely understand our verbal directions by using pictures that are common to both cultures."

Patient education outside of a clinical setting is also absolutely necessary and it needs to be tailored to the community we hope to reach. Naila Ijaz, former co-chair of RHP's education committee, described her experience using community feedback to inform the organization's education projects. "When we saw that women in our Iraqi Women's Health group did not understand [the information they needed] while sitting through PowerPoint talks, we changed our format to include visual worksheets with questions," Ijaz says. On the visual worksheets, multiple choice answers to questions like "Which is the best season to receive the flu vaccine?" used clip art images to represent seasons of the year so language would not be a barrier, she explains.

"Language barriers can be…crossed with the help of interpreters, but cultural barriers cannot be so easily eliminated," Ijaz cautions. "That's something we need to learn by spending time with the communities…. We always found community leaders to be extremely helpful in navigating cultures—it was easy to communicate with them to learn about the needs of the community," she says. "It also helped to watch some films from their native lands."

Presti agrees. "Especially as an outsider to their community who is not well versed in all of their cultural traditions and who can't personally relate to the struggles they have gone through as a refugee, it is incredibly important to build those relationships to better understand the community's needs and…build trust within the community in order for them to allow us to help them," she says.

It is easy to avoid reaching out to folks who look different and speak a different language, but something as simple as starting the conversation with "hello" in a patient's native language shows patients that you really care about their health and well-being. Patients start looking at you while they describe their concerns rather than at the translator, and they are more willing to offer information that they may hesitate to disclose to someone who they perceive as more estranged. As Presti puts it, "Doing a little bit of research on the people you may be working with can not only enable you to…make them feel more comfortable… but it also gives you a better understanding of the context in which they are presenting."

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