Communicating With Immigrants: Medical Interpreters In Health Care

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Effective communication between health care providers and immigrants who may speak little or no English is the foundation of evaluation and treatment and the most important component of the doctor-patient relationship. An immigrant in Rhode Island may speak any one of a number of languages; Spanish, Portuguese, Cambodian and Italian are the most widely spoken. Although many physicians and other health care providers are fluent in a second language, the majority use only English for verbal communication with patients. Because of the large percentage of immigrants to Rhode Island who speak **English as a second language** (**ESL**), or no English at all, health care practitioners must rely on medical interpretation services.

Impact of Medical Interpretation

The Civil Rights Act of 1964 prohibits discrimination against national origin as it affects people with **Limited English Proficiency (LEP).** Since 2000, hospital and private practices receiving federal funds have been required to provide interpreation services, and uniform training requirements for all interpreters must be established. Since 2000, hospitals and private practices receiving Federal funds have been required to provide interpretation services.[1] Due to the large number of immigrants and number of different languages, hospitals have struggled to comply with this requirement, and often resort to the use of patients' family members, friends or ancillary staff without formal training in medical interpreting. Communication through untrained interpreters may omit physicians' questions, give shortened or biased patient responses, and provide an inadequate information exchange to permit accurate diagnosis and treatment. In fact, even professional, trained interpreters may not have received training in medical terminology.

Research in interpretation error is limited. In one pediatric study, interpreting errors were common, with an average of 31 errors in each of 13 recorded doctor visits. Patients with untrained interpreters were much more likely to have interpretation errors that could result in serious medical consequence during the visit, compared with those with a staff interpreter.[2] Other published studies report positive benefits of professional interpreters on communication, utilization, clinical outcomes and satisfaction with care.[3]

Hospitals and private practices that receive federal funds are required to provide interpreter services.

Utilization of interpreter services in health care settings is variable. The **emergency department** (**ED**) serves as the entry point into the US health care system for immigrants and patients with LEP. Although professional interpretation has been associated with improvements in patient satisfaction, communication, and health care access, these services are largely under-utilized in EDs. The barriers to implementation include a facility's reliance on untrained *ad hoc* interpreters, the perceived time and labor associated with obtaining and working with interpreters, and the costs of professional interpreter services.[4]

Translation Options in Rhode Island

In Rhode Island the impact of various interpretation methods has been measured. In the clinic setting, telephone and patient supplied interpreters were associated with longer visit times in an academic medical clinic, but the use of hospital-based interpreters was not.[5] Patients and physicians have been found to have the highest satisfaction with professional interpreters. However, when this service is not available, patients have higher satisfaction than physicians, using family members and friends as interpreters.[6] An effective service learning program has been developed to train undergraduate and medical students in medical interpreting, as well as to develop cross-cultural skills.[7]

Access to interpreter services for immigrants in Rhode Island is achieved thorough several means. Hospitals and health care systems offer interpreter services for patients via a contract with a professional translating service for on-site interpreting, most often Spanish and Portuguese, and with access to telephone interpreting services for almost any other language needed. Clinics, private practices and other settings may also have on-site or per diem interpreter services, but telephone interpreting services are also used. Family and friends continue to be used in all health care settings.

Conclusion

Inadequate medical interpretation services hinder the delivery of optimal health care to persons with LEP. Professional trained interpreters result in improved communication, health care access, patient satisfaction and clinical outcomes for limited English-speaking populations.

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Common Illnesses In Rhode Island Immigrants: A Primer For Health Care Practitioners

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Between 2000 and 2006, Rhode Island's foreign-born population increased by 12.7%.[1] [The figure includes some, but not all undocumented residents, depending on how many do not report to the census.] During this period the state gained over 18,000 immigrants, bringing the number of foreign-born residents to over 137,000, or greater than 10% of the total population. The majority of immigrants are from Portugal (17.6%), Dominican Republic (13.7%) and Guatemala (7.6%). Columbia, Italy, Canada, Cambodia, United Kingdom, China and Laos account for another 22.7% of the immigrants to Rhode Island. Over 10% of immigrants originated from Africa: the state has growing communities of Liberians, Nigerians and Ghanaians.

These immigrants may be at risk for diseases not commonly seen in the native-born Rhode Island population, especially immigrants from tropical regions of Africa and Asia. Newly arrived immigrants may bring with them illnesses native to their region, although many will have had some disease screening performed prior to their initial arrival. Immigrants to the United States through legal channels are required to be screened for communicable diseases of a public health significance, and present documentation of having received vaccination against vaccine-preventable diseases, including mumps, measles, rubella, polio, tetanus and diphtheria toxoids, pertussis, influenza type B and hepatitis B.[2]

Undocumented immigrants require special consideration because they may not have had any prescreening or previous immunizations.

First or second generation immigrants who have lived in the US for some time but who have **visited friends and relatives (VFRs)** in their homeland may also be at risk for tropical or travel related diseases. In 2002 VFRs represented 40% of US international air travelers. VFRs have a higher risk of acquiring malaria, typhoid fever, cholera, and hepatitis A, compared with the traveling population overall. In 1999, 39% of imported malaria cases in US were in VFRs, making them 8 times more likely to acquire malaria than US-born traveler. In addition, 77% of imported typhoid cases and 78% of imported cholera cases in US are in VFRs.[3] VFRs are at increased risk for disease, because 1) adherence to pre-travel advice, including vaccines and prophylaxis, may be low;[4] 2) they may stay abroad for prolonged periods; 3) they may eat in less sanitary settings than other travelers; and 4) they may have closer proximity to local populations with various infectious diseases.

Using traveling populations as a guide to immigrant illnesses, surveillance data from 30 geo-sentinel sites from 6 continents have shown that malaria, dengue fever, rickettsial infection and parasite-induced diarrhea are common causes of fever and illness.[5]

The objective of this manuscript is to give the practitioner an understanding of the common febrile diseases of travelers, to provide an approach to use in evaluating and treating recent immigrants, and to identify and treat immigrants with life-threatening febrile illnesses.

Approach to Immigrant/ Imported Disease

Immigrants may present to a primary care provider or specialist with a variety of symptoms. Respiratory problems, abdominal pain, bone-joint-muscle pain, and non-specific symptoms are generally the most frequent symptoms reported by immigrants at the primary care level.[6] Fever may also be reported. When considering infectious diseases imported by immigrants, the health care provider can limit the differential diagnosis by considering the geographic location the patient has traveled from, the length of the incubation period and the immunizations they were previously given. Other initial considerations for the health care provider are what illnesses are common, and whether the immigrant's illness could be life-threatening or a public health emergency.

Infectious diseases imported by immigrants can be divided into three 3 groups.[6] The first includes common illnesses such as upper respiratory infections, urinary and skin infections. Of the disease entities that an immigrant might import to RI, communicable diseases, such as tuberculosis, viral hepatitis, STDs, HIV, are the most serious in terms of public health. The third group includes