Cultural competence and the use of a qualified medical interpreter can be of critical importance in the clinical setting. It is an essential element in determining the quality of patient outcomes, for the communication upon which diagnosis and treatment is often based may be heavily affected by cultural differences and linguistic barriers between the patient and provider.

This is not simply an issue of the comfort levels of the respective participants, or of a mandate to be politically correct or user-friendly by showing an awareness that the patient comes from a different culture. It can be diagnostically crucial. A lack of cultural awareness can lead to misdiagnosis or treatment errors. Conversely, a practitioner with a clear grasp of the patient’s culture may be better able to differentiate between cultural and pathological issues, and to better assure the likelihood of the patient following through on the treatment plan after discharge.

This issue can show up in any discipline, but is perhaps most acutely visible in psychiatric cases, where word choice, body language, and religious or spiritual beliefs can comingle in diagnostically significant ways.

Take, for example, the case of a woman in her early thirties from Central America. She had been hospitalized for an attempted suicide and severe depression. She had six children under the age of sixteen back in her native country. Her husband had abandoned her and the children. Her elderly, diabetic mother was taking care of the children, while the patient came to the United States to work and send money home to support them. The patient was undocumented, working in a laundromat. She had few friends and no family here, and felt quite alone. She fell sick, was taken to the hospital Emergency Room, where it was discovered that she was HIV positive. She was discharged, and put in contact with the AIDS clinic for treatment. She then received word her mother’s diabetes had become so severe that she had had to have both legs amputated, and was therefore no longer able to care for the patient’s six children. The patient’s mother moved to a neighboring village to live with another daughter who could care for her, leaving her six grandchildren unattended. The cumulative stresses of all this became unbearable, resulting in the patient’s suicide attempt.

An Armenian resident was on duty one morning during this patient’s hospitalization. She was not familiar with Hispanic culture, nor, it seemed, with the stresses facing poor immigrants in this country. That particular morning, the patient was in a cheerful mood. Her anti-depressant medicines had finally started to take effect, and she had gotten her first good night sleep in weeks. The resident asked the routine questions of “How are you feeling today?” and “Do you have any thoughts of wanting to hurt yourself or others?”, to which the patient smilingly replied that she had slept well, was feeling
much better, and emphatically had no such thoughts. The resident concluded she was nearly ready for discharge, and would no longer need anti-depressants. She then sent the patient out with a nurse and the interpreter for them to administer a cognitive survey to the patient.

In the survey, numerous red flags appeared that made it abundantly clear that the patient was not in nearly as good shape as her upbeat mood and sunny smile seemed to indicate. The nurse and interpreter returned to the resident to inform her of this. Whether out of conviction, or the defensiveness of inexperience, the resident insisted that she was comfortable with her diagnosis and treatment plan—essentially dismissing the nurse’s and interpreter’s concerns. Then the attending physician appeared, and asked the resident, “Bring me up to speed on this patient, I don’t know her.”

The attending physician was Indian, and no stranger to cultural differences. She listened to the resident very politely without interruption. Only the raising of an eyebrow at the resident’s conclusion that anti-depressants could be suspended gave any indication of the attending physician’s perspective. When the resident completed her report, the attending finally spoke:

“Let me educate you as to the cultural differences for which this patient is at a higher risk of a repeat attempt than the symptomology alone might indicate!” She proceeded to elucidate a number of cultural factors—the stress of undocumented immigrants living in fear of deportation, the stigma of HIV/AIDS in the Hispanic community, the economic strains under which the patient was living, the level of the patient’s medical ignorance to understand her condition due to her limited education, the constant frustrations created by the language barrier, and her justifiable anxiety about being so far away from her children. The attending physician then concluded, “Therefore, she absolutely must continue with the anti-depressants, as well as have significant ongoing outpatient therapy.”

The reality is, the cultural competence of the attending physician probably saved (or at least certainly prolonged) the patient’s life, for had she been discharged without anti-depressant medication, the strains under which she was living and to which she would return at discharge, would have made a repeat attempt highly likely. Conversely, the resident’s lack of cultural awareness put the patient at risk, seriously compromising the patient outcome and success of treatment.

Another psychology case illustrates a slightly different issue related to patient safety and the importance of working with an experienced interpreter: the challenge of distinguishing between pathological and cultural factors in a patient who does not speak English.

A young Mexican man was admitted to the Emergency Room for an attempted suicide. He had slashed his wrists. The physician was Chinese, and unfamiliar with Hispanic culture. In taking the medical history, it appeared that the young man had a drinking problem, was trying to quit, and was probably experiencing hallucinatory withdrawal symptoms at the time of the suicide attempt. In the natural course of things, the physician then administered the standard cognitive survey test, and seemed puzzled by a number of the patient’s responses. The interpreter apprised the physician of the questions in the survey that were culturally biased, but the physician still seemed perplexed. After completing the test, the physician asked the interpreter to accompany him to the office to help him make a phone call to the patient’s brother, leaving the patient to wait in the examination room under security surveillance.
for his safety. The physician confided to the interpreter that he was uncertain as to how to proceed. “I could possibly just discharge the patient with a recommendation that he attend Alcoholics Anonymous meetings at a local group that holds meetings in Spanish. But I’m uncertain of how much of the patient’s responses were due to culture, and how much of them were due to pathological causes.”

The interpreter responded, “Doctor, I’m not qualified to give you a medical opinion, but what I can tell you is that, even taking into account his sixth grade rural Mexican education, there is some very strange ideation going on that does not seem to be related to either his education or culture, and you might want to consider at least having a thorough psychiatric work-up done on him before discharging him, to make sure there’s nothing more going on there.”

The physician thanked the interpreter, and in fact recommended the patient be admitted for evaluation. Rightly so, for the patient ended up being hospitalized for ten days to get him through the detoxification process, and educate him as to the support systems available to him upon discharge. This was key, as without that education, there was little likelihood the patient would faithfully attend any support group meetings, as the very concept of Alcoholics Anonymous, or even a support group, was alien to his culture. In this case, the physician’s lack of knowledge of Hispanic culture made him ask important questions, and effectively use the interpreter’s knowledge and skills to improve the patient outcome. When an interpreter is seen as a valued member of the treatment team, rather than an inconvenience to have to deal with, the outcomes are often improved.

Patient safety issues can also come into play through the misreading of body language or even physical appearances. Body language can easily be misinterpreted to the patient’s peril. Many immigrants are culturally conditioned to be passive and submissive in the face of medical authority, as a matter of respect. For some, direct eye contact is also avoided, for it is considered rude and confrontational. The parents of a child brought into the ER for burns were questioned about what had happened, and they responded that the baby had suddenly grabbed a cup of hot coffee from the table while sitting in a high chair in the kitchen in the instant that the mother turned away from the child to turn off the stove. The parents’ downcast eyes, avoidance of eye contact, and clear distress, however, gave the nurse the impression that they were hiding something, possibly guilt, and she considered calling for child protective services.

The best of intentions on the part of the provider could lead to severe emotional trauma for both the patient and the family, due to lack of cultural awareness. Immigrant families- especially undocumented ones- often live in a state of fear of the authorities, including the fear of deportation or separation from their American born children, who have the full protection of the law. They are therefore reticent to divulge any information without assurances it cannot be used against them, and are generally ignorant of their rights. They also have no idea about HIPPA regulations or the Patient’s Bill of rights’ protections. Language barriers and ignorance of the parents’ rights compounds this fear.

When there is a question of possible abuse or neglect, if child protective services are called in, the law requires an investigation be made. This can require a home visit by an inspector, as well as extensive interviews of everyone in the house, or at the scene, at the time of the incident. This can take
days to complete, and requires a court ruling before closure. During that time, the child may be removed from the parent’s custody for safety—though efforts are generally made to place the child in the custody of a close relative or friend, if possible.

Obviously, such a process can be extremely distressing to undergo for anyone, but still more so when the family does not speak English, and is living in fear of deportation. Sometimes, simply being aware of cultural differences in body language and behavior can prevent unnecessary investigative processes, and limit the provider’s efforts to the direct care of the patient, sparing the family the additional trauma. This is another example of where a qualified interpreter’s expertise can be crucial in distinguishing between misunderstanding the family’s behavior, and identifying legitimate reasons for concern for the patient’s safety.

Many aspects of patient safety are, of course, compounded by a language barrier, and yet can easily be remedied. One major safety issue has to do with the prescription of medicines. Typically, a physician will write the patient a prescription and either send it electronically to the patient’s pharmacy, or hand the patient a paper copy, without realizing that the dosage instructions will not be understood, because they are written in English. Trusting that a verbal explanation will be fully understood and retained is inadvisable, as stress may make that retention of information difficult for some patients or family members, who may be feeling overwhelmed with the both the health and cultural challenges facing them at the time of discharge.

This can be further complicated if the physician writes out numbers, rather than using standard numerical notation. For example, in the instructions, “Take once a day”: for a Hispanic patient trying to read an English label, there is a danger it will be misunderstood, for the English word “once” is also a Spanish word. However, in Spanish once means eleven- and there have been cases of a patient taking a medication eleven times mistakenly, because of the medication label not being in Spanish! This is easily remedied by the physician simply putting a notation on the prescription to the pharmacist, asking that the label be printed in Spanish. As more languages are being used, this option should always be requested. If such printable instructions in the patient’s language are not available through the pharmacy, an interpreter, in the prescribing physician’s presence, should write out the instructions in the patient’s language to prevent misdosage.

Religious beliefs can also factor into clinical settings, in a variety of ways—some helpful, some obstructive. The provider’s cultural competence can be crucial in such situations, and an interpreter’s skills may be essential to the outcome.

In one case, a Mixteco-speaking family from Mexico had a child in the NICU. He was extremely sick and placed on ECMO support. The parents were devout Roman Catholics and devotees of the Virgin of Guadalupe— the Patron Saint of Mexico and Latin America. They insisted that a statue of the Virgin they had brought be blessed by the chaplain and hung in the baby’s crib. The treatment team were very responsive and complied with the parents’ wish, and the baby promptly began to improve, to the point that he was sent to a regular care floor. The statue, of course, went with him! Of course, the parents were convinced that the Virgin’s intercession had made the ECMO work. The staff acknowledged that
there was certainly no way to disprove that, or determine how much of the child’s improvement was
due to faith, and how much due to medical intervention. At the very least, the staff’s sensitivity to and
compliance with their spiritual needs greatly improved the parents’ experience, relieving some of the
stresses inherent in dealing with a seriously ill child.

Religious belief, it must be said, can at times also work against the treatment plan, or impede
patient and family understanding of the healing process. Take, for example, a young Mexican boy with
leukemia, a year and a half into a three-year course of treatment. He was responding beautifully, was
ahead of the curve, and his prognosis for full recovery was excellent. His parents, uneducated Mexican
peasants from a remote area in Baja California, were models of caring parenting. The mother, with only
a sixth grade education, was on top of every appointment, dosage, treatment and symptom. She knew
that if her son had a fever, diarrhea, vomiting, or bleeding she had to take him to the ER right away.

On one such visit, what came out in the ER was that the parents were convinced the child was
going to die, no matter what the medical team did. So great was their conviction of this that it was
reported that while passing by a cemetery on the way to the hospital Emergency Room, the child had
asked his parents, “Are you taking me there?” The child’s oncologist was stunned and perplexed, for
there was no discernible reason for the parents to think this was the case.

Fortunately, the oncologist, nurse, and child life specialist had all been working together with
the same interpreter throughout the child’s illness. Calling the parents in for a family consult, the
oncologist carefully and lucidly explained that the child was doing extremely well, and the symptoms he
suffered that required the parents bringing him to the ER were not caused by the cancer, but by the
medicines. He explained that as the child grew, the dosages had to be constantly adjusted, as they were
based on his weight. He reassured the parents that there was every probability their child would be fully
cured if he completed the recommended course of treatment.

For all the oncologist’s efforts, it was clear there was still a cloud of doubt hanging over the
parents that his explanation had not resolved. The child life specialist intervened and asked the mother,
“Do you have any spiritual resources to draw upon to help you deal with the stress of all this?”

The mother then blurted out, “Well, the priest came when he was first diagnosed, and gave him
last rites!”

As luck would have it, the oncologist was Roman Catholic and the interpreter was a former
Episcopal priest. They both realized instantly that the parents had assumed that receiving the sacrament
of anointing was understood by the parents to be the Church basically assuring their son would go to
heaven- but also, de facto, pronouncing a death sentence on him! With the oncologist’s permission, the
interpreter was able to explain to the parents that the rite of extreme unction was not a death sentence,
but was intended to bless, comfort, protect, and if God willed it, heal. It was emphatically not the case
that the Church had declared the child was going to die! The mother burst into sobs of relief, and there
were no more such distressing episodes for the remainder of the child’s treatment. He was pronounced
cured and is doing very well- a happy and healthy child.
Here again, the lack of awareness had created a terrible burden for the parents that could have been avoided. A number of factors came into play: the priest who administered the sacrament, assuming erroneously that the family must have a more sophisticated understanding of the theology behind the rite than was the case, simply by being Catholic; the parents’ deeply rooted cultural belief that the priest only comes when the doctors can do no more, as a last gasp protection before death to save the patient from eternal damnation; the fact that the medical team was unaware that this sacrament had been administered from the outset, and had not thought to ask about their spiritual beliefs earlier.

The theology of the sacrament may be legitimate, but misunderstanding it compounded the family stress significantly, and it was only resolved by the combined knowledge and skills of the medical team and the interpreter. Fortunately, the interpreter’s serendipitous previous pastoral knowledge was instrumental in helping resolve the situation, and the superb coordination and excellent chemistry between the interpreter, oncologist, nurse, and child life specialist made for an exemplary experience of teamwork that resulted in a much improved outcome for both the patient and family.

The line between religious belief and superstition, particularly among patients of limited education, living in poverty, and often coming from rural backgrounds, is sometimes hard to distinguish, but may have bearing on the diagnosis. In one case, a young Hispanic patient in his late twenties had been admitted for psychiatric treatment for depression. While hospitalized, he suffered a cardiac event, and was transferred to the cardiology unit. The cardiologist taking his medical history, asked whether anyone in his family had died young or suddenly. The patient responded that yes, his younger brother had died six months ago. When asked what the cause of his brother’s death had been, the patient said, “He died from a curse put on him in our village. And I think maybe that’s why I’m sick now- it could be a curse from the same brujería [witchcraft].”

Fortunately, the cardiologist was culturally competent, and realized that belief in the power to curse was not a sign of the patient’s psycho-pathology, but rather, a commonly held belief among rural Latin Americans that the power to use occult forces for punishment or revenge against others was real. Had she not known this, she might have thought the response was evidence of a pathological problem requiring anti-psychotic medication, and prescribed him unnecessary medications. The interpreter was able to confirm to the cardiologist that the belief in the power of black magic was commonly held among rural Latinos, as well as many other immigrant populations from around the world.

It is important to understand that there are not just different socio-economic and religious cultures in question, but different medical cultures as well. The American medical culture is nearly the polar opposite of the medical cultures of Latin American immigrants. Not only are most immigrants, especially from rural backgrounds, ignorant of their own anatomical functions, organs and bodily systems, they are conditioned to passivity before medical authority- so the very notion of patient rights or our HIPPA laws is utterly alien to their experience.

Two other well-known features of the American medical culture are equally foreign and even shocking to most Hispanic immigrant patients: the notion of an advanced directive or living will, and the
concept of hospice care. To most poor immigrants the presumption of telling the doctor what may or may not be done to the patient if he or she is no longer able to make a decision seems outrageous and presumptuous in the extreme. Who is the patient to tell the doctor what to do? After all, the doctor is the authority and knows best! Equally shocking to many is the concept of hospice care. The idea of bringing a stranger into the house to care for a dying loved one— or worse, sending them off to die in a place that is neither their home nor a hospital is even a possible cause for ostracism by their community. At least, until it is properly explained.

Once the patient understands that an advanced directive can give him or her the peace of mind of knowing their loved ones will not fight over decisions, or be saddled with crushing expenses for life support that cannot restore consciousness or quality of life, and that their own wishes to be allowed to die will be respected, it makes more sense to them. And once they understand that hospice care in no way replaces the family’s loving attention, but rather, frees the family from some of the burden, so as to be able to have quality time with their dying loved one without having to also shoulder all the exhausting demands of physically caring for them as well, then these things are often welcomed.

Providers too, need to be educated, and understand that these stalwarts of the American system should not be glibly taken for granted as being understood. They should educate patients and families gently to their potential benefits. They should also be prepared that the patient or family may still refuse either or both of them, even if an advanced directive or hospice care would be to their advantage. Cultural change is hard to achieve quickly when one is already under the duress of end of life illness. Understanding their options, however, should be considered as an integral part of patient rights, and even patient safety.

Another patient safety concern touches the issue of time-management from a provider’s perspective. The demands placed upon physicians are often considerable, and time management is always a matter of concern. Consequently, there are some providers who feel annoyed at having to use interpretation services, believing, erroneously, that this necessarily slows the process and is more time-consuming. Others may feel it incumbent upon them to demonstrate their caring, and attempt to speak in the patient’s language without having real fluency. Both of these errors can lead to potential safety risks, as some may seek short cuts by by-passing the services of a qualified interpreter.

When the provider understands well how to work with an interpreter and the chemistry is good, it is a virtually seamless experience that does not discernibly lengthen the consultation time. When the provider attempts to communicate in the patient’s language, insisting that the interpreter not interpret, however, the consultation time is often lengthened considerably. The reason is that when the patient’s language is not spoken fluently by the provider, the patient is likely not to understand, requiring that the interpreter then ask what was and was not understood, and then repeat the entire communication. This is often the case for patients of lower educational level, who may have fewer associative thinking and linguistic skills to decipher the provider’s attempted communication. It also can create strains between the interpreter and provider, who may feel offended or annoyed that the interpreter is repeating everything. Conversely, the interpreter may feel frustrated that (s)he is not being permitted exercise his or her profession, or even is being undervalued or disrespected as a trained professional member of the
patient care team. This inappropriate and avoidable ego tension can undermine the effectiveness of the communication process, and the patient is the one who suffers the most from it.

The best practice for providers who are sincerely trying to communicate, but are not certifiably fluent in the patient’s language, is to greet the patient, exchange some pleasantries, and then let the patient know that that is the extent of their fluency, and they are going to turn the rest of the communication over to the interpreter for the sake of the patient’s understanding and safety. The patient is thus assured both of the provider’s caring and humanity, and of the accuracy of the communication. It is a win/win.

There is no question that the effective use of qualified interpretation services is an essential ingredient in maximizing the patient outcome. However, another challenge and temptation to both the provider and patient that may put thorough communication at risk is the use of unqualified interpreters. This most typically shows up in one of two ways: the patient bringing a relative (often a child born in America) or friend to interpret; or a practitioner grabbing a random member of the personnel who “speaks a little” of the patient’s language. Both of these options are a liability, and neither should be used unless there is absolutely no alternative in an emergency.

Family members and friends should not be used, even if fluent in English, for two fundamental reasons. First, familiarity with English does not guarantee familiarity with medical terminology, and the medical details are absolutely essential to assure informed consent, patient rights, and patient safety. Providers often acquiesce to a family member interpreting out of convenience, but this should be avoided. Even if the interpreter is only there as a back-up, in case something is not understood, for legal and ethical reasons a certified interpreter should be used for the peace of mind and safety of both the patient and provider, unless both the provider and the patient have signed off on the interpreter’s services. Such a policy can be explained to the family member or friend with no disrespect to their language skills, and most will express relief, admitting their anxiety about not understanding certain terms.

However, the need for certified interpreters is also a matter of respect for the family member or friend being asked to interpret. It is not appropriate to expect a family member or friend, even if fluent in English, to deliver information that may be unwelcome or emotionally difficult to receive. That puts an enormous strain on the interpreter, and may even result in an effort to edit or soften the news, and thereby distort the communication. That is a violation of the patient’s rights, as well as an emotional strain on the family member or friend, and should therefore be avoided. It may also, inadvertently, violate patient privacy, unless the patient has explicitly granted the family member or friend permission to know the medical details of the case.

Likewise, the use of a random staff member’s linguistic ability can be equally problematic—especially if the staff member is not native speaking. A receptionist, service staff member, or technician may be totally unequipped to interpret the specific information needed, especially if it is highly technical. This can lead to mistranslations and misunderstandings that can put the patient at risk. High school or college language experience is great for helping reach out to and bond with the patient or the
family, but is generally a poor substitute for accurate and qualified medical interpretation, and may even violate hospital policy or HIPPA regulations.

An ongoing challenge in patient safety and understanding is found in the reality that healthcare providers tend to be accustomed to speaking in medical jargon, rather than in “ordinary language” even in English. If a patient simply nods while the provider is speaking, it is naturally tempting for the provider to assume that the patient has understood, without regard to the patient’s cultural background. Moreover, an interpreter may even interpret the language of the doctor perfectly, and yet the patient still may not understand. It is therefore incumbent upon the interpreter to check for understanding if there is any doubt, and if necessary, ask the provider to “lower the register” and put the information in simpler terms. However, the provider is also responsible to check for understanding, and not assume that a nod is sufficient proof that the information has been both heard and understood. Providers and staff members should always bear in mind that understanding is the key, and our highest priority for the Hippocratic Oath to “do no harm” may be unwittingly violated by failing to communicate and confirm that the communication has been fully understood. It is not enough to “tell” the patient, for if the speaker’s word choice is unfamiliar to the listener, the information the speaker wished to divulge has not actually been communicated.

The cultural impasse may be multi-dimensional. Take, for example, the case of a Hispanic premature newborn with hydrocephaly. A shunt had been placed in the baby’s head to drain the fluid off the brain and relieve the pressure. The procedure was carefully explained to the parents prior to their consent. The surgeon had reassured the mother that the baby’s head would have a normal appearance, in time. He also explained that it was too early to tell, but that it might be the case that the shunt could even be removed after a while, or be replaced when the baby was big enough with a different kind of shunt that drained the fluid into the stomach.

A day or two after the procedure, the shunt was functioning effectively, resulting in significant subcutaneous swelling that greatly altered the baby’s appearance. The parents were alarmed by this, and fearful their daughter would be permanently disfigured. An interpreter was scheduled for the nurse and nurse practitioner to give the family an update. The nurse practitioner was Asian, and delivered her update with a flat affect and technical terminology. The family did not understand, and started to ask questions about the baby’s appearance, expressing their concern at the disfiguration and their fear that it was going to be permanent. The mother began to cry.

The nurse practitioner proceeded to tell them, dispassionately, that the swelling was from the drainage of the fluid, and that when the baby had grown bigger they would put in a different kind of shunt that drained into the stomach. When pressed about whether the baby would continue to have a grossly swollen head, the nurse practitioner said yes, it was going to remain that way. When asked for how long, she refused to say, repeating that it was going to stay that way. When pressed by the interpreter of a “ball-park” time frame for the swelling to go down- based on an average for other patients with similar conditions, she insisted she couldn’t say. What finally came out was that she couldn’t say because she only sees patients in the NICU, and since hydrocephaly cases are generally discharged before the swelling has been resolved, she didn’t know how long after discharge the swelling
goes away. This did nothing to reassure the parents, who were becoming visibly more agitated. The
parents panicked, and insisted that the surgeon had told them otherwise, that she might not even need
the other shunt, and that they wanted to talk to the surgeon directly. They clearly felt they had been
lied to.

The surgical residents team passed by at that point, standing out in the hall, and the interpreter
went out to apprise them of the situation. One surgeon was dismissive of the upset, insisting everything
had been explained to the family thoroughly. His attitude was one of annoyance, implying that “We did
our job- it’s their fault they don’t understand.” He actually commented to one of his colleagues- “Well if
they don’t like it, we could just take the shunt out and let nature takes its course!” He was immediately
reprimanded by his colleague, realizing that even as a “joke” the comment was out of line and
unprofessional. Fortunately, the family did not hear the remark. The resident who made the comment
departed after a moment, and the interpreter tried to impress upon the one who had reprimanded him
that, just because something had been said, doesn’t mean it’s been understood. He pointed out the
cultural challenges for the family, who have no anatomical or medical knowledge, and little prior
experience of medicine, and now have a baby who appears to be severely disfigured, despite surgical
assurances she would look normal.

The resident, realizing that trust in the medical team was being undermined by this lack of
understanding, entered the room and, with the interpreter’s help and intervention, succeeded in
clearing up the misunderstanding and allaying the parent’s fears, for the moment at least. He reassured
them that all other indices were positive- the baby was eating well, gaining weight, eliminating
normally- doing all the things she should be doing developmentally. This was a good sign. As for the
swelling, he said it could take weeks to months for the swelling to go down completely, but in the vast
majority of cases, children do recover their normal appearance eventually- and while still infants. He
also confirmed that, depending on the baby’s progress, the shunt might be removed later, or replaced
by the type that drains into the stomach.

After the neurosurgeon and the Asian nurse practitioner left, another nurse and the social
worker, who had both witnessed the whole drama, realized that the cultural misunderstanding cut both
ways. Not only had the family failed to understand the medical team, but the medical team had failed to
understand the family- particularly the Asian nurse practitioner, who seemed totally baffled by the
mother’s upset that she could not tell her if or when the swelling would go away. It was a perfect
illustration of the interface between ethical best practices- which insist that promises cannot be made
nor precise time lines given, when medicine is, at best, still an imprecise science with multiple variables-
and the need for empathy and compassion in relating to patients and families who may have limited or
no understanding of what is happening to the patient.

Patient safety, satisfaction and outcome can often hinge as much on the latter as the former
point. The ability to place oneself in the patient’s position and ask, “How do I want to be treated, and
what do I need to know”, will make it readily apparent that communication skills, especially where there
is a language barrier between the patient and the provider, are fundamental to successful patient
outcomes and experience. There are no substitutes or short-cuts to good communication.