# Strategies to Overcome Language Barriers Between Immigrant Patients and Hospital Staff- Health Services in India & USA

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**Abstract:** Language obstacles impair the satisfaction of medical professionals and patients and the provision of high-quality care and patient safety. Several large healthcare organizations offer translator services to improve patient happiness and communication. Miscommunication in the medical industry has the potential to be lethal. With an increasing number of migrant patients and staff who have received foreign training, communication errors between healthcare practitioners and patients are becoming increasingly common. This article aims to investigate the impact of language barriers on healthcare and to provide solutions. Language difficulties have a negative impact on medical practitioner and patient satisfaction and the overall quality of healthcare and patient safety. However, there has been little systematic research on this subject. A major objective of our research is to investigate language barriers and miscommunication between patients and healthcare practitioners, particularly when one or both speakers are conversant in a second language. By writing this essay, the author hopes to raise public awareness about the magnitude of the difficulty involved in delivering health services to a community with significant ethno linguistic diversity.

**Keywords**: Language Barriers, immigrant persons, India, USA, Health Professionals, ethno linguistic diversity, linguistics

## Introduction

Language-communication problems have arisen as a result of globalization, which has been addressed in various ways. Acts and measures taken by officials have swayed between two extremes (Meuter, et al., 2015). They developed translation tools and methods that encourage collaborative participation and thorough communication without imposing a homogenizing and unequal model. We have two conflicting viewpoints here. A uniformity that is "against what is human," forcing many ethnolinguistic communities to "linguicide" their languages. Acceptance of human diversity and applying respect and tolerance principles aided the development of multilingual communication examples, methods, and resources. The first

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model responds to a nation-state political project that is neither functional nor pragmatic nor, of course, realistic in light of the evolution and composition of countries in the twenty-first century.

Migrant flows in transit or destination, within and outside borders, have increased due to the internationalization and globalization of commercial relationships and communication. Borders between cultural and linguistic groupings formerly thought to be far apart fade in everyday life (Pocock, et al 2020). It is no longer rare to meet someone who speaks a language other than our own, and we are not conversing with locals but native speakers from other continents whose languages we are unfamiliar with. These difficulties of intercultural and language communication must be addressed right away. More than merely knowing their languages is required to integrate multilingual and multicultural populations into society or community. This adaptive endeavor necessitates openness and listening to develop successful interpersonal, complete, and open communication.Handling non-communication, misunderstanding, lack of integration, and social involvement is a basic requirement for social functioning.

## The Linguistic and Cultural Problem of Health Communication

As Harvey (2017) points out:

Suppose doctor-patient communication is a challenge between doctors and patients who share cultural contexts and speak the same language. In that case, it is much more so when the doctor and the patient come from different contexts and do not speak the same language, a situation that, although it seems strange and occasional, is not in multicultural and multilingual countries like India (Harvey, 205).

This problem becomes evident, first, in interpersonal communication. Medical care faces the fact that the population it is aimed at describes different ethnic and linguistic characteristics. Both the diversity of the local and immigrant population affect basic aspects of medical care, such as the appointment with the patient, the recording of symptoms and the description of the ailment by the patient, the knowledge of their personal and family situation, the communication of a diagnosis or compliance with treatment.

## Linguistic disagreement and communicative barriers

There are historical, linguistic and ethnographic linguistic disagreements that occur in situations of non-communication due to ignorance not only of the codes and grammatical structures used but of the referential world that it intends to represent and the logical and symbolic connections that give meaning to verbal expression and nonverbal. The art of translating involves knowing and appropriating a reality that is structured, classified and configured according to a cultural worldview, and this is not an easy task, much less since a certain conception and action in the face of health and disease depend on it (Harzing, 2007).

At a terminological level, many difficulties arise in establishing equivalents from one language to another or appreciating nuances of meaning and concept that can be lost in a translation. A good example is one that refers to bodily organs and members. It is well known that there are languages wherein one category objects are integrated that in others deserve different

categories. In Punjabi, the word Mūha (ਮੂੰਹਅਤੇਚਿਹਰਾ) is used to refer to both mouth and face and in Nahuatl (Mexican Language) the same thing happens since tix refers to the face, forehead or eyes. In Catalan, on the other hand, there is a difference between hand (mà) and arm (braç), but not in the Fula language, where the word junngo is used for both terms.In Mandinga the word 'y msoo' is used to name both the heart and the liver and in Nahuatl with 'tihte' it is generically named the entrails, the belly or the belly and specifically the stomach, etc., which is also extended to the denomination of ailments and illnesses (Gannon, 2008).

Suppose the everyday use of language is added, which does not go into technical details or synonyms without a clear distinctive nuance. In that case, the alleged uniqueness of medical language as a scientific language faces the multivocal, equivocal and variable sense of everyday speech. In such a case, clarifying what is being said according to a context and an assumption about what is demanded is left to the medical staff. Even in the same language, the demand may reflect different cultural conceptions of the disease. Suppose we can suspect within our ethnolinguistic community what a user means by saying that they have "a stomach ache", "stings in the back," "a depression," or "a breath in the eye". In that case, we cannot be so sure if another Arabic speaker, originating from another cultural community or social sphere, tells us that he has a "fright", "empacho", an "evil eye", "drooping head", "a stain on the Christian" or that it has "lost its shadow. Thus we plunge into the paradox of not understanding what is apparent and clear.

Grammatical differences are also added when both interlocutors use structurally different languages or the shared language is poorly mastered by the other interlocutor, producing linguistic transfers in the use of morphosyntactic structures that generate confusion. This is made clear by the linguist Klimova, (2012) when commenting that when the patient is Punjabi, negative interrogative sentences are answered in the opposite way to how they would be done in Catalan:

Thus, to a question such as *No t'has pres Les pastilles*[Didn't you take the pills?], the Catalan affirmative answer implies the affirmation of the action (yes=I have taken the pills). At the same time, the negation denies the action (no=I haven't taken the pills). In Ukrainian and Punjabi, for example, the values of the two answers would be the opposite: *yes* would be equivalent to our *no* (yes=it is true that I have not taken the pills) and *no would* correspond to our *yes* (no=it is not true that I haven't taken the pills).

In addition, the fact that the user does not speak the same language or belongs to the same ethnic identity as the staff that attends to him can be a reason for prejudice or neglect when he is labelled a "difficult patient". This happens when it is thought that a user demands excessive attention in terms of effort and time compared to other users (John, 2020). The staff does not receive positive feedback that confirms whether their action is being effective on a professional and emotional level. Added to this are segregationist and discriminatory social and cultural prejudices that mean that an interlocutor does not accept using a certain language in health communication, whether as receiver or transmitter.

Confusion of senses and meanings, untranslatability, false friends, prejudice, lack of empathy, poor command of a language are facts and circumstances that hinder verbal communication, interrelation and interaction between health personnel and users (Ondondo, 2015). The way to

stop them goes through a better knowledge of the responsible population's cultural context and language.Faced with this communicative situation, the resolution mechanisms and strategies that have been adopted in different countries are varied. In all of them, it is assumed that the public administration is the one that must strive to eliminate the language barrier, providing technological, human and financial resources to medical personnel so that they can communicate comprehensively with the user. The requirement that the user be responsible for overcoming this barrier by learning the language used by health personnel, It is a possibility that sometimes contradicts the universal scope of the legislation of democratic countries that considers health care a right that must be made available to all citizens, residents and passers-by, without demanding anything in return. Otherwise, an absurd situation would arise, where the health service would cease to be a "public service". It would be as if the health personnel considered as a patient only that person who wishes to come to the consultation, or that only those who knew how to communicate their morbid state clearly would be sick, without assuming responsibility with that population that does not use their services or does not can report your situation.

Although this is not his intention, this impression indeed ends up nesting in the user who is going to be served and does not perceive the staff to whom he addresses an interest in understanding the request he makes. That is, he does not detect care in his attempt to communicate your health status. Empirical studies (Bano, 2016) have shown that the optimization of communication skills results in the improvement of consultation time management:

In such a way that the doctors who have developed aspects as important as empathy, the exploration of beliefs and expectations of patients, or the patient's participation in decisions, have consumed the same consultation time as those who do not. Even if more interview time were consumed, it would be an investment for the future. As we have already mentioned, patients would have less need to use consultations by improving efficiency [...] and health outcomes.

Regardless of the complexity of the elements that make up the interpersonal communicative act, verbal communication imposes the need to have the same linguistic code, at least for both to acceptably know the code and the referential environment from which each one articulates the information. Otherwise, the interrelation, interaction and feedback is impossible and the situation of non-communication is presently preventing any effective action. The language barrier is thus established crudely, with the prejudice of "he doesn't want to understand me" and "he doesn't know what he wants" or "he doesn't know how to explain to me". As stated by Riaño, (2013) for the case of migration in Catalonia:

The fact that the professional cannot communicate verbally with his patient [...] causes concern and anguish for both interlocutors. Doctors, nurses and social workers who care for these people during their visits to health centers or at home may feel insecure when making a diagnosis or when trying to explain to the patient the treatment they should follow, for not mention the problem of preparing the medical history during the first visit (Riaño, 192).

This situation does not only affect the interpersonal relationship; it extends to the image and relationship that the public health institution has with the community and access to services. The linguistic problem is also a problem of accessibility and information on rights and services.

Several statistical surveys reveal that dissatisfaction with the service received arises, in large part, from communication problems between users and health personnel (Íñiguez-Rueda, 2009). In an opinion poll of immigrant citizens in California (NCM & Bendixen, 2003), health care ranked first among topics of concern over access to employment or education. This was stated by 42% of Vietnamese immigrants, 41% of Chinese and 36% of Latin Americans. This assessment contrasts with the data for the rest of the country, given the idiosyncrasy of California's demographic composition, having 25% of the foreign population. This raises problems not well tackled by the state health system. The basic problem is an absence of communication and relational skills that shows a bleak picture:

[...] Patients incapable of adequately communicating their symptoms or understanding the instructions of prescribed medications, or children forced to act as impromptu interpreters for their parents who could be facing life or death situations, are frequent realities. The repercussions of communication failure are profound for medical care and the impact on medical ethics. It can lead to unnecessary surgeries, inadvertent symptoms and the prescription of overdoses, in addition to those incidents that undoubtedly generate a parallel subsystem of medical care for those who have a limited understanding of English (Ncm and Bendixen, 19).

Six situations are extracted from this study that favor the maintenance of the language barrier and that can be extrapolated to other places with similar characteristics: 1) lack of knowledge of the rights that protect the health, 2) difficulty or inability to understand the medical situation when there is no one to explain it in the patient's language, 3) difficulty or inability to understand the instructions when discharged from the hospital, 4) difficulty or inability to understand the instructions for the use of prescribed medications, 5) feeling of receiving a poor or very poor medical service, and 6) tendency to trust or prioritize the media in the language of the health institution as the primary source of information on medical care.

To these should be added the ineffectiveness of health campaigns not designed in the language of the foreign population, the difficulty in making themselves understood and the help of "improvised" unqualified interpreters. This problem directly affects health, by preventing proper care and access to the populations in charge of health services, promoting reluctance to use them, demanding better service or directly rejecting and questioning them.

The development of communication skills in health personnel, including linguistic competence, is a necessary measure regardless of the legal framework of each country. Another option is to have qualified personnel, professional translators, for their performance as medical interpreters or sociocultural translators. It can be differentially argued that not all countries have legislation that guarantees or obliges health services to provide the means to serve users in their language. Still, the problem is so shared internationally that reality requires applying strategies that tackle a problem becoming more obvious and serious every day.

The measures to break the language barriers in personal-user communication of health services are varied by these same regulatory, social and economic conditions, and respond to the development of particular health policies. However, they are governed by common principles of international law. To learn about some good practices in the face of this global problem, we will present below some examples of the most recurrent actions on the issue: 1) make translation tools to help medical work, and 2) hire professional interpreters. These actions are

contextualized in two countries with clear linguistic and cultural diversity, India and the United States.

## The creation of lexicographic and translation tools

An example of the design and application of translation tools can be found in the case of the Indian public health system. In India, the linguistic problem that has emerged in recent decades has gone beyond the legal framework that was designed for a situation of very limited multilingualism compared to other countries. The legislative articles, from the *Indian Constitution* of 1956, considered protecting and promoting the country's linguistic diversity, giving a statutory legal framework so that each autonomous community normalized the use of its own language without undermining the Indian top language Hindi. In this regard, the administration's efforts have been directed at the speakers of these languages to enable their employment under equal conditions in their local areas. Thus, it was favoured that the social security personnel is made up of native speakers or speakers of the autonomous language as a second language, who demonstrated an adequate linguistic command to effectively serve the citizens who speak the official language in the autonomous community.

Linguistic communication problems seem, in this way, saved as long as in the autonomous communities with their language there is bilingualism between the autonomous language and Indian as the official language of the State, which would allow the use of Indian as a lingua franca by such speakers outside of your autonomous community. [5] However, since the 1990s, India has become a non-transitory destination for international migration, which has unexpectedly increased the foreign resident population. This increased linguistic diversity with the arrival of a foreign population, moving from a bilingual context of communicative interrelationship to a multilingual one, and notoriously introducing the cultural factor. According to the *National Immigrant Survey* of 2020, there are 12 nationalities with greater representation in the resident population in India. This required a re-adaptation of health institutions to the new demographic characteristics of the population, even in regions where local linguistic diversity had been normalized, as is the case of Hindi and other regional languages. The unforeseen increase in the population that comes to these services, who speak non-local and unknown languages in the receiving society, is a situation that is aggravated by the lack of an intermediate language (English, Hindi, Arabic, Urdu, Bangla, Punjabi etc.,) known and handled by someone of the interlocutors to be able to maintain a conversation in the health field. In this order of things, the measures that the experts have proposed to adopt are: 1) create an interpreter service in health centers, 2) request external interpreters as needed, 3) have a telephone interpreter service, faced with these possible lines of action, groups dedicated to training, research, translation and interpretation were created. These actions are intended to facilitate interpersonal communication. In general, the use of the media and the publication of informative brochures translated into the main languages have been used, within a trend of improving the quality of communication in the public services of justice, health and education, advised by linguists and translators from a multidisciplinary and multicultural approach (Ozbot, 2015). The products generated have consisted of three types of translation tools: a) vocabularies or lexical glossaries, b) conversation guides, and c) computerized translators.The Peggy C. Leonard (2006) prepared vocabularies and medical conversation

guide to serving the immigrant population. The purpose was to reduce the linguistic difficulties encountered by health personnel in their daily practice. These materials were designed for adults and pediatrics primary care, general gynecology issues and topics specific to social workers and user care units. They were produced in ten languages, those most widely spoken by the immigrant population.

Regarding the use of computerized or electronic translators, the most outstanding case is the initiative developed, which contributes to overcoming the language barrier in caring for patients who do not speak Hindi or English. This action echoes the fact that 58% of primary care physicians believe that poor treatment compliance by immigrant patients is due to difficulties in understanding the physician's language. Given the intention that this initiative has a national scope and not merely regional, this program will be distributed among 1000 doctors throughout the capital city Delhi, India, in addition to contemplating the possibility of installing it on the intranet of the regional administration.The design of a tool with such characteristics responds to the fact that in most health centres there is no figure of translator or cultural mediator, a more usual figure in centres of social education or social services, and that attention to this group represents doubling care time, in addition to generating anxiety among health personnel due to concern about the development of treatment and diagnosis. Creating this class of tools is an ideal strategy for a situation of broad multilingualism, where it is practically impossible for the health professional to learn a language or memorize the lexicon. Consulting a guide can facilitate a certain approach and interrelation with the patient. However, it poses the problem that health personnel must be trained in its management and it is necessary to specialize in a few of these languages. In addition, it would be necessary to evaluate how its use would be in the consultation since it can take a long time for patient care, an element that is always scarce in primary care and that it is supposed to solve.

**The use of medical interpreters**
However, in the absence of the desired linguistic competence of health personnel, the most appropriate means is to have professional interpreters available. This resource has been adopted by countries that are also recipients of emigration. Still, it depends on the concurrence of two main factors: 1) legislation that regulates the selection, training, and hiring of this professional as long as they know and handle all the act and linguistic heritage that involves patient care, and 2) have a balance of economic resources that allow permanently maintaining a staff adequate to reduced linguistic diversity, since having one or two interpreters per language in each medical center or hospital center is a very large cost if it also implies the United States is a country whose migratory tradition has made room for this figure *(clinic interpreter, clinic translator* or *medical translator)* in the public health environment. As we saw when mentioning data on California, the health care problems derived from the linguistic diversity of the immigrant population are serious in this nation. They range from complaining about the quality of the service to not having health insurance and being unaware of their rights. The strategies of the users in the situation of mutual ignorance of the language ranged from trying to speak English poorly (56%), to employing a family member or friend with greater knowledge of the language as a translator (19%) or to using the services professional interpreter (9%). Only 9% received care with a greater guarantee of efficiency and quality. Linguistic

distance also affects different groups unequally. While Latin Americans and Vietnamese suffer less from the problem of having doctors who speak their languages, Iranians, Cambodians and Armenians do not enjoy that possibility. Likewise, it is rarer that they can count on authorized interpreters. There is an effort on the part of the federal administration to develop a broad staff of professional interpreters, especially if we note that in 2000; 18% of the population of the United States over the age of 5 speaks a language other than English and that 8 % does not master it adequately according to US Census Bureau, 2000 (Pals, 2007). This shows a rather complicated picture of which we can only glimpse part of the complexity in the available statistical data. *In 2003, the University of Michigan Health System*'s Interpreter Services Program alone had a staff of 12 interpreters and another 100 temporary hires to handle nearly 1,000 requests per month. This represents a significant effort to cover a wide range of languages such as Chinese, Spanish and Russian, especially if we consider that in 2000 the population over 5 years of age in the state of Michigan, who speaks a language other than English, was 781,381 people. This represents 8.4% of the total population, of which 294,609 people do not speak English very well, that is, 3% of the total population and 37.7% who speak a non-English language.

It would seem that the hiring of interpreters is quite an adequate measure. However, although these interpreters are people who know the language to be translated, they do not necessarily respond to a professional profile specialized in interpretation and translation. They are far from being considered sworn or official translators, leaving their development of competence in the hands of the ability and will of the interpreter, as well as their medical knowledge. Similarly, there may be gaps in intercultural translation and understanding of the patient's social and cultural context. This lack of accreditation and official status has repercussions on legal aspects since the confidentiality of the doctor-patient relationship is at stake. However, it is preferred that the interpreter is not a relative and linguistic knowledge is estimated from pragmatic criteria (Moeschler, 2018). In any case, having professional interpreters –in the absence of medical personnel handling the patient's language– is recognized as a mechanism that reduces inequity in the health service by overcoming the language barrier and improving the quality of health care in regarding treatment and communication (Flores, 2016; Jacobs, 2004).

**Local and migration ethnolinguistic diversity: a challenge for health services in India in the 21st century**

It could be considered that other countries with greater ethnolinguistic diversity and with a consolidated and traceable public health system, at least in its present institutional form until the 1990s, managed to develop other effective means in the face of an ever-present problem. This would be the case of India, a country with the greatest autochthonous ethnolinguistic diversity and currently a target country for transitory or permanent migratory flows, especially of indigenous refugees. In this case, the great challenge is not imposed so much by immigration as by the existing ethnic minorities in the country. While in the United States, only the indigenous population, continental and insular, represents 1% of the population, of which 30.2% do not speak English correctly. In India, this population represents, in 2011, practically 7%, which maintains a linguistic heritage of more than 100 languages, of which the following stand out by the number of speakers: Hindi, Bengali, Urdu, Arabic,

Punjabi, Telugu, Tamil, Malayalam, Kannada, Oriya, Marathi, etc. Of this 7%, the percentage of monolinguals (Hindi) is 12%, whose concentration at the regional level (South, East, and North) is significant in different states of India. The only measure adopted by the Indian public health system is that in the indigenous communities where a medical unit is located, qualified personnel from the area are hired as assistants, preferably native-speakers and bilingual, or go to the help of relatives as interpreters. In this way, it is intended to guarantee the permanence of health personnel in the area and carry out linguistic and cultural translation tasks between doctors and users. The fact is that we do not know, given the subordinate character that the role of clinical assistants usually acquires, whether to consider these personnel as medical interpreters or health personnel with command of the language spoken by the population served.

This procedure, in itself, is not part of a policy but rather is a recurring good practice to solve an ongoing problem. Only one State has included the language issue in social rights, although without requiring or recommending that health personnel know the local language or have human resources to overcome the language barrier. The experiences have not been formalized in a body of professional medical interpreters and they rely heavily on someone in the communities being trained as health personnel. The opposite case, when personnel from outside the community are trained or familiar with the local language and can be considered competent as language interpreters and cultural translators, is an even more uncommon situation. Hence, the difficulties arise recurrently and in an accentuated way. Suffice it as an example the episode that Somnath Chatterjee from West Bengal in December 2020 tells us about her experience in Delhi, where she had to act as an impromptu interpreter: On the second day, we set up the practice in another town and I screwed up at least one more time. Quite a few people had scabies, which I crudely described to them as "bugs under the skin." My wife, a medical student, explained that the normal treatment for scabies is to wash clothes, towels, and sheets in hot water. After the sheets are washed, all the inhabitants of each house must apply a medicated cream from the neck to the tips of the feet before going to sleep. Doing my duty, I explained the treatment to patients, but as we drove between thatched-roof huts on our way to another town, I realized my mistake. I had not considered the patients' environment when I explained the treatment to them – I should have advised them to sterilize their hammocks instead of their sheets. The difficulty of understanding and properly choosing lexical equivalents is due to insufficient knowledge of the language and the cultural, social and environmental context of the population of responsibility. With this, the generation of significant information, a true interaction, and modification of behaviours to achieve a healthy lifestyle, etc., is frustrated or prevented.

## Conclusions

Language diversification is influenced not just by national characteristics, but also by global migration trends in today's world. The health system must develop approaches that promote multilingual and multicultural dialogue to improve societal coverage and the use of health resources. Lack of understanding of the user's ethnolinguistic context obstructs or prevents appropriate health treatment and decreases service quality. A non-communicative scenario favors unfairness and legal impotence on the responsible population and the beneficiary.

Although linguistic training for health care professionals is the best solution to this problem, it isn't easy to implement. The number of languages that must be handled raises the cost and length of time it takes to establish and administer a foreign language training program. This situation presents pedagogical difficulties, particularly for medical professionals who must learn and train. Using translators or interpreters appears to be a viable solution. On the other hand, hiring professional translators raises questions regarding their clinical and medical skills, as well as the impact they might have on doctor-patient communication (Jacobs, 2004). In addition, a lack of preparation and agreement between the doctor, the interpreter, and the patient might lead to knowledge loss or prejudice. Assistive solutions for healthcare staff, such as translated brochures, conversation guides in other languages, or electronic or automatic translators, are a less expensive alternative. Still, they require training and cultural and idiomatic knowledge. Without a regulatory framework that protects the language rights of consumers of health services, health and administrative authorities do not even examine the requirement of increasing the quality of health care and communication. Professionalism must also be instilled to eliminate improvisation. Due to the ethnolinguistic characteristics of the population, cultural and idiomatic knowledge is required, whether an interpreter or qualified clinical staff, because the communication is purely informative and explanatory, and the morphosyntactic and semantic structures can cause translation and comprehension issues. Its proper application allows communication fluidity and openness, enabling better care by gaining a deeper awareness of users' morbidity and the social, cultural, and personal factors that influence their diseases and lifestyles. Lifetime.

The development of language barrier-breaking techniques and strategies is becoming more important as the number of migrants traveling through Mexico to the United States and Canada rises. Countries such as India and the United States, which have enacted legislation recognizing residents' linguistic rights and public health systems that have implemented language barrier-busting measures and policies, could serve as models for developing an active health communication policy in the face of a persistent national issue.

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