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The importance of language and culture in pediatric care: Case studies from the Latino community

Glenn Flores, MD, Milagros Abreu, MD, Ilan Schwartz, MD, and Maria Hill, MD

Background: Few studies have examined culture's effect on pediatric care.

Objectives: To analyze 3 cases illustrating the importance of culture in pediatrics.

Methods: Case analysis with a cultural competency model.

Results: No interpreter was available for the parents of a 3-year-old brought to the emergency department because of abdominal pain; she was discharged twice, returned with an acute abdomen, and was hospitalized for treatment of appendiceal rupture and peritonitis. A 2-year-old fractured her clavicle in a fall but was placed in social services' custody because of a pediatrician's misinterpretation. Parents of a ventilation-dependent 2-week-old with encephalopathy, seizures, and renal failure were unaware of the infant's poor prognosis, despite use of an interpreter.

Conclusions: Culture can have a significant impact on pediatric care; use of a simple model can ensure that pediatricians provide culturally competent care. (*J Pediatr* 2000;137:842-8)

Language barriers and culture have a major impact on the health care of children. Studies have shown that culture (including language issues) can affect access to pediatric care,¹⁻³ adherence,⁴ health status,^{5,6} continuity of care,⁴

preventive screening,^{7,8} doctor-patient communication,^{9,10} the adequacy of analgesia,¹¹ the likelihood of having a regular source of care,^{5,6} use of harmful remedies,¹²⁻¹⁶ immunization rates,¹⁷ and prescription practices.^{18,19} In a re-

cent review of the literature on culture and pediatric care, however, we were concerned by the dearth of illustrative case studies, health services research analyses of the role of culture, and practical models for providing culturally effective care.

DSS Department of Social Services
ED Emergency department

The Committee on Pediatric Workforce of the American Academy of Pediatrics²⁰ recently stated: "To promote the provision of culturally effective health care to pediatric patients, the Academy recognizes the need to develop education and training materials and courses." One of the most effective educational tools in medicine is case-based learning. Written summaries of actual cases can be used to stimulate the development of clinical reasoning and problem-solving skills. Case studies also graphically demonstrate the major management issues for a particular medical problem and the effects of specific clinical decisions on outcomes, satisfaction with care, and costs. Nevertheless, few case studies on culture in pediatric care have been published.

Three of the most dramatic cases encountered in our clinical practices are presented to illustrate the importance of culture in pediatric care. Our objectives in sharing these cases are to (1) provide an educational resource for training and course development; (2) illustrate the significant impact that language issues and culture can have on pediatric care, including health care processes and outcomes, satisfaction with care, and the costs of care; and

From the Divisions of General Pediatrics and Pediatric Emergency Medicine and the Department of Pediatrics, Boston Medical Center and Boston University School of Medicine; and the Division of Epidemiology and Biostatistics, Boston University School of Public Health, Boston, Massachusetts.

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Reprint requests: Glenn Flores, MD, Division of General Pediatrics, Boston Medical Center, 91 E Concord St, Maternity 419, Boston, MA 02118.

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(3) present a practical model for culturally competent pediatric care.

METHODS

We identified the 3 most striking and informative cases from our clinical practices to illustrate the importance of language and culture in pediatric care. Case data were derived from personal observations of the participating pediatrician. To ensure confidentiality, all personal identifiers have been removed from the case reports. All 3 cases occurred at an inner-city hospital that primarily serves poor children who are covered by Medicaid or lack health insurance.

Analysis of the language and cultural issues and optimal approaches follow each case presentation. The intent of analyses is to provide systematic examples of how to evaluate and approach clinical encounters in the most culturally competent manner. Our analytic framework is a 5-component model of cultural competency in health care (Table), which has been presented elsewhere in detail.²¹ For clarity, we divide analyses into primary and secondary issues.

CASE REPORTS

Case 1

A 3-year-old Latino girl was brought to the emergency department at 12:00 AM, complaining of abdominal pain. No interpreter was available, and because the mother spoke no English, she was unable to adequately describe her daughter's condition. The attending pediatrician examined the child and discharged her with what the mother understood to be a diagnosis of "colic." One hour later, both parents returned to the ED with their daughter, whose pain now involved the entire abdomen. The same pediatrician examined her, and the mother found the physician to be quite angry. The patient's father was extremely upset be-

Table. A model for cultural competency in health care*

1. Normative cultural values
• Identify those that affect care
• Accommodate for these values in clinical encounter
2. Language issues
• Use interpreter services unless fluent in patient's primary language
• Follow guidelines for effective interpreter use
• Encourage efforts to increase foreign language skills of staff and English skills of patients with limited English proficiency
3. Folk illnesses
• Recognize those that may affect clinical care
• Suggest alternatives to harmful folk remedies
• Accommodate in nonjudgmental manner into clinical encounter
• Integrate into biomedical treatment plan whenever possible
4. Parent/patient beliefs
• Identify those that may affect clinical care
• Suggest alternatives to harmful home remedies
• Carefully explain etiology and treatment rationale for given biomedical condition
5. Provider practices
• Maintain vigilance for ethnic disparities in screening, prescriptions, procedures, and outcomes
• When disparities occur, determine source of problems and address practices that might be responsible

*Data from Flores.²¹

cause no interpreter was available, and he felt that his daughter was treated poorly because they were Latinos. The pediatrician sent her home again, this time with a medication, the name of which the mother did not recall.

Several hours later, the family returned to the ED. Their daughter's condition had deteriorated. She now had a rigid abdomen, rebound, guarding, tenderness, and fever. She was admitted on an emergent basis.

In the operating room, the child was found to have a perforated appendix and peritonitis. She was hospitalized for 30 days because of complications including 2 wound site infections. Her parents had no medical insurance.

Analysis of Case 1

PRIMARY ISSUE

Language Issues. Because of language differences, the parents were unable to communicate the severity of their

child's illness. For the same reason, the physician could not appreciate the severity of the child's symptoms. Clearly, a major problem was the absence of an interpreter. It is possible that if an interpreter had been present when this child initially was seen, the nature and severity of the symptoms might have been recognized immediately. The outcome with an interpreter, indeed, could potentially have been prompt diagnosis of appendicitis, a routine short hospital stay for an appendectomy, and a satisfied family. This outcome is in stark contrast to the costly, complicated 30-day hospital stay that actually occurred and most likely left the family dissatisfied and embittered. This case graphically demonstrates that an interpreter should always be requested when the parent does not speak English, even if the symptoms seem to be benign, because not doing so can produce a disastrous denouement.

SECONDARY ISSUES

Normative Cultural Values. It might have been helpful for the clinician in this case to recognize and respect the normative cultural values of Latino families. Attention in particular to *simpatía*, *personalismo*, and *respeto* probably would have been warmly welcomed by this family. In *simpatía* ("kindness" in Spanish), a value is placed on politeness, pleasantness in the face of stress, and avoidance of hostile confrontation.²² In this case, the family felt that the pediatrician was not polite, was unpleasant in this stressful situation, and confronted them with hostility. These perceptions probably contributed to this family's dissatisfaction with care. The pediatrician can ensure *simpatía* by emphasizing courtesy, a positive attitude, and social amenities.

In *personalismo* ("formal friendliness"), a warm, personal relationship with the pediatrician is expected.²³ The child's family in this case probably did not feel that the physician established a warm, personal relationship. *Personalismo* can be achieved by reducing physical distances during interactions, using socially appropriate physical contact, and conversing about the parent's and patient's life at each visit.

In *respeto* ("respect"), appropriate deferential behavior is expected on the basis of positions of authority, age, gender, social position, and economic status.²³ Pediatricians are considered authority figures who must be shown *respeto*; Latino parents, in turn, expect reciprocal *respeto* from the provider. The family in this case undoubtedly felt that they were not shown appropriate *respeto*. Not only can absence of *respeto* lead to an inaccurate history and dissatisfaction with care (as it did in this case), but it may also cause non-adherence to important therapeutic interventions, medication errors because of lack of communication, and inadequate follow-up. The pediatrician in this case could have achieved *respeto* (as well as *simpatía* and *personalismo*) by demonstrating more interest in and

attention to the parents' concerns, involving the parents in medical decisions, and using verbal and nonverbal signs of respect (such as use of the titles *señor* and *señora* and facial expressions of attentiveness and concern).

Folk Illnesses. Although no folk illness was mentioned during this encounter, the culturally competent physician should view a complaint of abdominal pain in a Latino child as an opportunity to determine whether it is believed that the child has *empacho*. This condition is believed to occur when a substance gets "stuck" to the walls of the stomach or intestines, causing obstruction and symptoms such as vomiting, diarrhea, anorexia, bloating, cramps, and a stomachache.²⁴⁻²⁶ As with all folk illnesses, it is important to recognize and inquire about *empacho*, because treatment at home can include use of certain harmful or fatal folk remedies,^{12-16,27} the first clinical contact may not be with a pediatrician,²⁶ and the symptoms overlap with important biomedical conditions.²⁶

In Case 1, the pediatrician could have sensitively determined whether the parents believed that their child had a folk illness by explaining that he or she is aware that *empacho* exists and that doctors may not know about it and by asking whether the parents have ever heard of it, and if so, whether their child now has it. Practical information about inquiring about folk illnesses is described in greater detail elsewhere.^{24,28}

Parent/Patient Beliefs. Flores²¹ has described how parent and patient health beliefs can sometimes impede preventive efforts, delay or complicate medical care, and result in the use of neutral or harmful remedies. In Case 1, the family might have held non-biomedical beliefs about the cause of their child's abdominal pain. The pediatrician did not inquire about such beliefs, but doing so probably would have enhanced the rapport; helped to achieve

simpatía, *personalismo*, and *respeto*; and determined whether any home remedies or over-the-counter preparations were given to the child. The relevance of these beliefs for other gastrointestinal symptoms was revealed in a study of Latino mothers at a California clinic.²⁹ The mothers believed that their child's diarrhea and vomiting were more frequently due to noninfectious causes (most often food not settling well in the stomach, decomposed food, or dentition) than infectious causes.

Provider Practices. Studies have shown that clinicians sometimes provide a lower quality of care to certain minority groups, including fewer procedures, less preventive screening, less analgesia, and fewer prescriptions.²¹ The pediatrician's attitude in Case 1 may have affected the quality of care. The provider expressed anger, rather than appropriate recognition of the parents' distress and the possibility that their distress might reflect the severity and acuity of the child's condition. Such attitudes can be perceived by parents as barriers to care for their children. In one study of children with asthma, 31% of Latino mothers said that attitudes of pediatricians and nurses are a major barrier to managing their child's condition.³⁰ Among Latino mothers in a primary care clinic, 11% said that they had deferred a medical visit for their child because pediatricians and nurses did not understand Latino culture.³ Lack of confidence in the health care staff was cited by 31% of Latino mothers in a pediatric ED as a major barrier to obtaining care for their child in the past year.¹

Another possible cause for some of the problems that occurred in Case 1 might be clinician difficulties in assessing pain and its severity in patients from other cultures. Todd et al¹¹ found that among adults presenting to the ED with long-bone fractures, Latinos were 7 times more likely than whites to receive no pain medication. The authors hypothesized that this striking

difference might be due to failure of physicians to recognize pain in other ethnic groups or divergent estimates of pain severity when patients are from a different ethnic group than the physician.

To practically address such culturally based problems in clinician behaviors, one should always reexamine such "incidents" when they occur and ask: "Could provider attitude be responsible, and if so, what could be done differently to avoid an adverse outcome in the future?"

Case 2

A 2-year-old Latino girl was brought to the pediatric ED because of right shoulder pain. Radiographs revealed a right clavicle fracture. The patient's mother spoke Spanish almost exclusively. When her mother was asked what happened, she responded, "*Se pegó, se pegó.*" The resident interpreted this to mean, "She was hit." The mother then showed the nurse a discharge summary from a previous ED visit to another institution 2 months before the first visit, when the patient was also given a diagnosis of right clavicle fracture after a fall from her bed.

Child abuse was suspected by the ED staff, and the Department of Social Services was contacted. A DSS caseworker came to evaluate the patient and her sibling. Without a Spanish interpreter, the caseworker spoke with the patient's mother, then asked her to sign over voluntary custody of the children. The patient and her 4-year-old sibling were immediately taken from their mother and placed in DSS custody.

When the Spanish interpreter arrived, the children's mother was interviewed again, and she reported that the patient had fallen from her tricycle and struck ("*se pegó*") her right shoulder. The primary care physician was contacted and denied any history of abuse or neglect in the family and any concerns about the potential for abuse or neglect. The mother regained custody

after 48 hours. An orthopedist emphasized that it is not uncommon to sustain a clavicle fracture with minimal trauma at the site of a previous fracture.

Analysis of Case 2

Because folk illnesses, parent and patient beliefs, and provider practices did not appear to play major roles in this case, we focus on normative cultural values and language issues.

PRIMARY ISSUE

Language Issues. Language problems were clearly central in Case 2. The pediatric resident was guilty of false fluency, which led to a disastrous outcome. In a recent study of pediatric encounters in which an interpreter was used, Flores et al⁵¹ found that false fluency was one of the most common errors, representing 16% of the 381 errors committed during the 13 encounters. Many false fluency errors occurred when the pediatrician attempted to speak the parent's language before the trained interpreter had arrived or while the interpreter was temporarily out of the room. Flores et al⁵¹ found that many false fluency errors had definite or potential clinical consequences.

Another major problem in Case 2 was that "informed consent" to relinquish custody of the children was supposedly obtained from the mother, but in reality, she was completely uninformed, because she did not understand the meaning of the document placed before her. Because of medical terminology and scientific complexities, it is fairly difficult even for an English-speaking mother to fully understand an informed consent document in English. The absence of an interpreter makes it practically impossible for the patient or parent with limited English proficiency to have any understanding of an informed consent document.

A critical lesson to be learned from Case 2 is to never assume fluency; if in doubt, always confirm information with a trained interpreter, especially

when such major medical and social decisions are being made. Furthermore, interpreters are crucial in obtaining informed consent; as this case illustrates, obtaining consent from a patient who is not proficient in English without an interpreter is tantamount to not obtaining consent at all.

SECONDARY ISSUE

Normative Cultural Values. When they obtained consent for voluntary custody of the children, the pediatric resident and DSS caseworker in Case 2 overlooked an important Latino normative cultural value. *Familismo* is a collective loyalty to the extended family that outranks the needs of the individual.^{52,53} The extended family, rather than the individual alone, makes important decisions. Because of *familismo*, crucial medical decisions may be delayed or deferred to permit consultation with the extended family. *Familismo* can thus have an impact on a variety of clinical issues, including informed consent, intensive care unit choices such as intubation and extubation, and end-of-life decisions. In Case 2, the pediatric resident and DSS caseworker could have demonstrated appropriate respect for *familismo* and probably avoided the adverse outcome by providing ample time and opportunity for the child's extended family to gather to discuss the reason for which informed consent was required.

Case 3

A male infant was born at term to a 28-year-old Dominican woman; an emergency cesarean section was performed because of placental abruption. After the delivery, full resuscitative measures were performed. The patient had no heart rate until 25 minutes of life, after administration of multiple doses of epinephrine, intubation, and bilateral chest tube placement for pneumothoraces. The patient was transferred to the neonatal intensive care unit.

When the patient was 2 weeks old, his care was taken over by a Spanish-

speaking resident. The patient's problem list at that point was extensive. He had sustained severe hypoxic-ischemic encephalopathy, and on physical examination, demonstrated pupils that were poorly reactive to light, decerebrate posturing, and flaccid tone. He was dependent on mechanical ventilation, and an extubation trial had failed. Blood cultures had just grown *Flavimonas* species. He had anemia, seizures, and was recovering from acute renal failure.

When the resident first met the family, they knew little about their baby's prognosis. The staff had reported thorough interpreter-assisted communication. However, the family believed that their baby would soon recover and be released. The staff claimed that the family was in denial, when in fact they had no idea of the neurologic devastation the infant had sustained.

The next weeks in the NICU were quite difficult for the family because of having to deal with the reality of the new prognosis. Multiple meetings were arranged to discuss the code status (after repeated extubation failures), a tracheostomy, and gastrostomy tube placement.

Analysis of Case 3

PRIMARY ISSUE

Language Issues. Language problems were central in this case. Even with interpreters, miscommunication can occur that results in disastrous outcomes. Depending on the type of medical interpreter used, errors can be quite common. In a study of interpretation by family members,³⁴ mistranslation or no translation was noted in 23% to 44% of the questions asked by physicians. In a pediatric primary care clinic, an average of 29 interpreter errors were made per encounter, and 63% of errors had definite or potential clinical consequences.³¹ Although untrained interpreters made significantly more errors of clinical consequence, 53% of errors by trained interpreters had clinical consequences. In Case 3, what was

viewed by the staff as "denial" on the family's part was probably a combination of interpreter errors and the staff's failure to communicate.

To avoid such miscommunication when interpreters are employed, important information should always be repeated several times. The parent should also repeat the information back through the interpreter to ensure understanding. Cultural differences that may impede information exchange, such as *respeto*, should be kept in mind. Written information about the child's condition in the parents' language is invaluable, either in the form of standardized preprinted handouts or a summary translated by the interpreter. Supplementing such written information with non-linguistic aids, such as pictures and diagrams, is particularly helpful and effective.

SECONDARY ISSUE

Normative Cultural Values. Demonstrating appropriate *respeto* may include a hesitancy to ask questions, because posing a question to an authority figure may be construed as disrespectful. The family in Case 3 may have had several questions about their child's condition but did not ask them for fear of being disrespectful. The "nod of the head" in response to a physician's instructions or comments may also have misled the NICU staff, because for some Latinos, it is a socially required gesture of *respeto*, and not necessarily a sign of understanding or agreement.²⁵ This may also have led the medical team to falsely conclude that the family had an adequate understanding of their child's condition and were in denial.

DISCUSSION

These 3 cases demonstrate the profound impact that linguistic issues and culture can have in pediatrics. In all 3 cases, failure to address language and cultural issues resulted in inferior quality of care, adverse outcomes, in-

creased health care costs, and parental dissatisfaction.

Cases such as these can be effective learning tools. One of our primary aims was to present dramatic examples of how language and culture can affect pediatric care. It is our belief that it is not enough to emphasize cultural sensitivity, because most people in health care professions believe that they are sufficiently sensitive to a variety of issues. In this era of cost containment and managed care, clinicians, payers, and policy makers are most likely to act on an issue that affects quality, outcomes, cost, and patient satisfaction. It is within this framework that we have selected and analyzed the cases. Such cases might prove useful in courses on cultural competence and pediatrics for medical students, in resident conferences, and in continuing medical education courses. The cases and the analytic approach can serve as a model for accumulating a larger institutional educational resource base on cultural competence. Educators might consider actively soliciting and analyzing such cases from clinicians within their institution, thereby providing a library of cases that is relevant to the care of local ethnic groups and that resonates with providers' clinical experiences.

The 5-component model of cultural competence was used to analyze cases that involve Latino children, but we believe the model can be useful in addressing the cultural issues of any group encountered in practice. Normative cultural values, language problems, folk illnesses, parent beliefs, and relevant provider practices have not been adequately studied for many ethnic groups. Nevertheless, by using the relatively brief set of model questions summarized in the Table, pediatricians can provide culturally competent care by obtaining the necessary information from patients and colleagues belonging to a given ethnic group.

Informed consent issues can be particularly difficult when the pediatrician and the patient's family are from different cultures, as was demonstrated in

Case 2. The following 4 guidelines (based on our clinical experience) should assist the pediatrician in ensuring that informed consent is properly obtained. (1) *Always have a trained interpreter present.* This ensures that the clinician can thoroughly communicate the risks and benefits of the procedure and that the parents or patient achieve a clear understanding and can ask questions. (2) *Ask the parents or patient to repeat to you, through the interpreter, all essential items about the procedure and consent.* This provides crucial accuracy and comprehension checks to guarantee that no information has been lost because of interpreter error or misunderstanding. (3) *The signed consent document should be written in the parents' or patient's primary language (whenever possible).* Ideally, the institution should consider preprinting standardized consent forms in the major languages spoken in surrounding communities. Alternatively, the interpreter can translate all or essential parts of the consent form on a case-by-case basis. (4) *Ask the parents, patient, and/or interpreter whether there are any cultural or personal beliefs relevant to the procedure that you and the staff should know.* If you are already aware of such beliefs (such as *familismo*, as described in Case 2), it would be helpful to specifically ask about such issues.

The cases highlight the serious health care consequences of inadequate interpreter services. In each case the absence of adequately trained interpreters resulted in compromised quality, adverse outcomes, avoidable expenses, and dissatisfied families. The lack of adequate interpreter services can also have medicolegal ramifications: a \$71 million malpractice claim settlement originated from misinterpretation of a single Spanish word, *intoxicado*, by ED physicians and paramedics.³⁵ The few studies that have been done on the adequacy of interpreter availability suggest that many patients with limited English proficiency do not get needed interpreter services. Baker et al³⁶ found that among

Spanish-speaking patients with limited English proficiency who were seen by ED providers with limited or no Spanish proficiency, 87% of patients who did not have an interpreter thought that one should have been used. The authors also found that interpreters are underutilized despite the expressed needs of patients, most interpreters lack formal training, and patients' understanding of their conditions and therapy was poorest among those who desired but did not have access to interpreters. A national survey showed that among EDs serving large Latino populations, only 41% always have an interpreter within the department, and 14% rarely do.³⁷ Only 2 states (Washington and Minnesota) in the United States currently have Medicaid reimbursement for interpreter services. The data indicate that in health care systems with many patients who are limited in English proficiency, providing adequate interpreter services will result in higher quality of care, fewer adverse outcomes, lower expenses, fewer malpractice claims, and more satisfied families.

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