CERLIS Series

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CERLIS Series
Volume 5

Maurizio Gotti, Stefania M. Maci, Michele Sala (eds)

The Language of Medicine: Science, Practice and Academia

CELSB
Bergamo

CERLIS SERIES Vol. 5

CERLIS
Centro di Ricerca sui Linguaggi Specialistici
Research Centre on Languages for Specific Purposes
University of Bergamo
www.unibg.it/cerlis

THE LANGUAGE OF MEDICINE:
SCIENCE, PRACTICE AND ACADEMIA
Maurizio Gotti, Stefania Maci, Michele Sala (eds)
ISBN 978-88-89804-28-5
URL: http://hdl.handle.net/10446/35418

Published in Italy by CELSB Libreria Universitaria
Via Pignolo, 113 - 24121, Bergamo, Italy

Contents

Focus on medical communication

ASHLEY BENNINK

Dialect Variation and its Consequences on In-Clinic Communication

1. Introduction

In the past two decades, the United States has experienced a rapid growth in the Hispanic population – increasing 233% since 1980 to reach a total of 37 million Spanish-speakers by 2012. For some regions, such as North Carolina, Arkansas and Tennessee, this growth rate has reached almost 1000% (US Census Bureau). A logical effect of this increase in population has been an increase in the use of Spanish in every service industry, of which health and human services is no exception. This has led to a surge in demand for medical Spanish courses in order to effectively communicate with the rising number of Latino patients.

However, despite the significant diversity found inherent to this incoming population – which represents various countries, regions and backgrounds – many of the medical Spanish courses treat these immigrants as a homogeneous group. Indeed, oftentimes in these courses, and in much of the learning and reference materials, the colloquial register, which is not only the most common language register but also the one that takes into account this diversity, is absent. In contrast to the abundant information available on both standard and technical Spanish in the medical setting, it is quite difficult to find any materials that include or describe Latin American dialect variants. Nonetheless, these variants have an important presence in the clinic setting and can have a negative impact on doctor-patient communication.

In this chapter, the variants that arise in the clinic setting and the impact that these can have on doctor-patient communication will

be described. Then, the communicative competence necessary to converse effectively in the medical interview given the appearance of these terms will be outlined along with a discussion of the challenges that they present to the attainment of this quality communication. However, it should be noted that the intention in this chapter is not to offer solutions to these problems but instead to create awareness around the issue of Spanish lexical variants in the United States medical setting.

2. Spanish lexical variants in the United States medical setting

In 2013, a preliminary study was conducted by Bennink (2013a) to research the presence and frequency of Spanish lexical variants in the medical setting in southeastern United States. The study was inspired, on one side, by her previous work with Latinos and with other bilingual professionals in healthcare clinics within that region and, on the other, by the fact that, prior to that study, there were no lists of frequent variants in the field of health and wellness. With the goal of starting to fill that gap, questionnaires were sent to clinics and medical interpreter organizations in order to collect data on which variants were encountered and at what frequency. It should be noted that in that study the denomination *lexical variant* was used to refer to words or phrases used by patients that were neither the technical term nor the 'standard'.

The responses received not only confirmed the extent to which lexical variants are employed in the healthcare setting, recovering a list of around 242 distinct variants, but also demonstrated a surprising diversity in terms of origin. The variants recorded in the survey by respondents as 'lexical variants' included ones with origins in other languages, including indigenous languages – such as *cuate* from the Nahua *cóatl*, meaning 'twin' – or the English language – for example, *raite* to mean 'a ride as a form of transportation and *rifill* to mean a

'medication refill'. Other origins can be traced to the archaic peninsular Spanish – e.g. *sopapo* for a 'slap', pronunciation variations – for example, *salpullido* from the Cuban pronunciation of the term *sarpullido* ('rash'), the influence of the cultural beliefs – such as *mal de ojo*, euphemisms – *mis partes* ('private parts'), vulgarisms – *pito* ('penis') – and regionalism – *ándale* (which can equate, at times, to an exclamation or affirmation similar to 'exactly', 'that's it' or 'you've got it right').

However, it should be noted that most diatopic variants were found to be from Mexico, with high numbers also from El Salvador, Guatemala and parts of South America (Colombia and Peru). This concentration of variants from a handful of countries seems to reflect the composition of the non-English speaking Latino population in that region, which seems to logically imply that the variants most frequently employed are determined, in part, by the most common countries of origin for the Hispanic population in that region, leading us to hypothesize that care should be taken in generalizing these results to other sectors of the United States.

3. Impact on care

Given the presence and diversity of these variants in the clinic setting, the question is then raised as to if they have any impact on care. In early 2014, I met with groups of Spanish for healthcare professors, Spanish-speaking medical professionals and medical interpreters while conducting part of a larger study. Almost all of them affirmed medically related dialect variants as a key aspect in the promotion of good communication and care. Nevertheless, in terms of specific studies, there is no known research that looks specifically at Latin American variants in cross-lingual communication in the medical context. However, there are studies showing ample evidence of the noxious effect of dialect variation between medical professionals and patients who share a common maternal tongue (Wolfram/Cavendar

1992, for example) as well as from anecdotal evidence (Bennink 2013b) and other related studies on the language barrier (including Yeo 2004 and Timmins 2002, among others), which both reveal the considerable impact dialect can have on doctor-patient interaction in terms of misunderstandings, patient dissatisfaction, physician frustration and loss of time dedicated to patient care. Below, these studies and how they relate to the topic at hand will be further explained.

In terms of studies regarding same language communication in the medical context, it has been well-confirmed by researchers such as Mishler (1984) and Woods (2006), to name two, that differences in language usage between doctors and patients who share a native tongue can result in miscommunications. For example, Mishler (1984), describes two main categories of language in medical discourse: the voice of medicine and the voice of the *lifeworld*. This *lifeworld* language is the everyday language used by those unfamiliar or uncomfortable with medical terminology and includes aspects such as dialect variants, and euphemisms and even different definitions for technical medical terms (such as the difference between the lay definition of *depression* and the technical one). Though in this case, while the doctor is likely to understand the patient, the patient may not always be familiar with the medical language of the doctor. Woods describes this as a problematic gap between technical language and common language in which much information can be lost. As a result, Mishler (1984) explains the need for the doctor to act as a translator between the *lifeworld* and the medical language.

However monolingual English-speakers may also encounter communication difficulties on top of those arising from the lifeworld-medical language dichotomy. In conversations with medical professionals, many have cited their difficulties in understanding certain regional dialects or the African American vernacular. Wolfram and Cavendar (1992) discuss the substantial range of variants produced in the Appalachian region. Hoejke (2011: 11) affirms: “Monolingual English speakers from one geographic area of the United States also may not understand the local expressions and pronunciation of the patient population where they do their residencies”. For that reason, there are, as she mentions, some residency programs that offer acculturation

courses to their first year residents even though they are native to the United States. The language taught in the course includes words and phrases used by the local patient community regarding various topics such as parts of the body, symptoms, sicknesses, etc.

In this case, as opposed to the first monolingual scenario described, the physician's role as an interpreter would no longer be sufficient to attain understanding, as he or she is now the one confronted with an unfamiliar language use. Nevertheless, since they still share the same base language and similar cultural backgrounds (at least in comparison with foreigners and speakers of another language), it is still not quite the same as the situation that we are confronting. Instead, dialect variants can represent an even more crucial factor when considering the communication between speakers who do *not* share a native language and thus have fewer resources available to them to resolve misunderstandings. An example of a cultural difference that can complicate the process would be the value of *respeto*, which can lead patients to show agreement with the medical professional even if they do not agree or do not understand. For example, one Latino patient at the clinic where I previously worked who spoke no English nodded "yes" to the medical professional when asked "do you speak English?". It was only after speaking with the patient another five minutes in English that the physician realized that the patient was constantly nodding along to what the medical professional said or asked but actually had no idea what the physician was saying.[1]

Other cultural factors that can impede linguistic communication may include differing beliefs on origins of illness, how care should be carried out, effective treatments, etc. Additionally, the stress of not knowing how to act in a setting that is not their own as well as being ill can make it harder for patients to think through their word choice and also can lead them to revert back to their native language or dialect (Marcos Marín/Gómez 2008). Thus some *patients* who are unable to reword what they wish to say, instead may respond to the

1 This tendency is also noted by other researchers such as Calzada *et al*. (2010) and Carteret (2011).

question "what do you mean by that?" or "please say that in another way" by repeating the same response again and again.[2]

Aggravating this, in the case of the United States, is that courses and manuals have focused on teaching doctors and interpreters the technical and standard terminology required to communicate with Latino patients while maintaining the formal register characteristic of the medical setting. Nevertheless, these terms may not be known nor familiar to the Spanish-speaking patients whose *lifeworld* language may differ greatly from the standard. Additionally, these patients may use language and terminology from their *lifeworld* language or linguistic repertoire that is likely to be unfamiliar to a Spanish as a second language learner. The resulting effect is an increase in misunderstandings and frustration, and decreased patient satisfaction and compliance – all of which impact quality of care and outcomes and all of which are further exacerbated by time constraints placed on patient care (Bennink 2014).

An anecdotal example of how misunderstandings arising from differences between lifeworld and technical language can impact care would be the phrase commonly used in the city where I worked as a medical interpreter in North Carolina: *mi esposo me cuida*. Latino patients often employed this phrase when asked what form of birth control method they use. Many times they were unwilling (or unable) to further clarify when asked what they meant by this expression. For professionals unfamiliar with the phrase, it was generally taken to mean that her husband uses a condom. However, it actually refers to the use of the withdrawal method (that is, when the man cares to). In contrast, the phrase *mi esposo se cuida* is the one used to refer to condom use. This knowledge changed, in some cases, the doctor-patient communication, inciting a conversation regarding more reliable forms of birth control in the first case rather than assuming an adequate method was being used. Thus it can be seen how, in some cases, variants can have a direct impact on care.

Up to this point, the focus has been on the impact lexical variants have on care in terms of misunderstandings. Nevertheless, in

2 For more information on factors that give rise to higher variant use in the clinic setting, see Bennink (2014).

addition to misunderstandings, lexical variants can have other possible consequences, including physician frustration and loss of patient satisfaction. In the previous example, it was mentioned that some Latino patients are reticent (or at times unable) to offer an explanation for a term they used when it is not understood and, instead, tend to simply repeat the term or phrase.[3] This repetition and difficulty to resolve what the patient wishes to express can be frustrating for the medical professional who does not always understand the difficulty in explaining something in another way and also feels the pressure of limited patient care time. Additionally other studies, such as those by Timmins (2002), Yeo (2004) and David/Rhee (1998) note that when a patient feels misunderstood their levels of satisfaction and trust in their provider decrease and, in turn, this often results in poor patient compliance and, consequently, less positive health outcomes.

Lastly, patient care time is a scarce resource in the clinic setting and these variants can lead to a significant loss of that commodity. A recent study published in the *Journal of Internal Medicine* affirmed that doctors in the United States have only about eight minutes per patient (Block *et al.* 2013). Also, given that medical interviews with speakers of another language generally take longer than a standard interview, providers often feel pressured from the start. Thus, the use of dialect variants and the time required to come to an understanding is all the more problematic. Moreover, the relative lack of these terms in bilingual dictionaries and reference materials (Bennink 2013a) exacerbates the situation and leaves the doctor without the needed support to help him/her quickly resolve the situation. An additional concern regarding the loss of patient care time is that, if the doctor has to spend more time resolving an unfamiliar term, he/she may feel rushed, which could give rise to more errors and/or a decrease in quality of care.

3 Studies show that those with a lower education level and socioeconomic status have more difficulties resolving misunderstandings than their more educated, higher socioeconomic level counterparts (Washington/Craig 1998, Wieling *et al.* 2013, Williams/Kerswill 1999).

4. Necessary communicative competence

Given the appearance of dialect variants in clinic and their impact on communication and care, the communicative competence necessary for this setting will now be examined. Effective communicative competence on the part of the medical professional would, first, imply not only a knowledge of technical terminology but also an ability to communicate with the patient on a more *human* level that reduces the social distance as well as using language that allows the patient to understand the information the doctor wishes to explain. This would allow for more patient centered care (Mishler 1984). This is the *productive* element of the communicative competence, that is, the linguistic ability to produce certain lexicon during the medical interview and to carry out an effective and appropriate dialog. Second, medical professionals would need the *receptive* capacity to understand variants used by patients as well as a practical knowledge of techniques that could be implemented to resolve a misunderstanding in the case that one should occur. Thus, specifically in terms of lexicon, the medical professional needs to produce the appropriate standard and technical terminology while at the same time understand the variants used by patients or at least be equipped with the skills to help attain a level of understanding with the patient (Bennink 2013a). Unfortunately, though in theory this concept is fairly basic, there are various challenges to its practical implementation that arise from diverse factors including the patient himself/herself, the inherent characteristics of the variants and the availability of materials and education.

In the above description of communicative competence, the onus of fostering adequate communication is placed solely on the medical provider, a considerable burden for a single person who interacts with people of various backgrounds on a daily basis. However, when considering the patient's ability to take on that burden, the difficulties are clear. Firstly, the patient typically uses a given variant as opposed to a more standard term because that is the one he/she has within his/her language repertoire. Secondly, the

patient, in most cases, will have a lower ability to resolve misunderstandings than the medical professsional due to a couple of factors. For one, it has been demonstrated that people with a low educational level and socioeconomic status tend to have more difficulties in resolving misunderstandings or finding other ways to explain a word or a phrase. Within the Spanish-speaking population in the United States, many of those who are Spanish-only speakers fall within this category. Another is the fact that patients typically visit the clinic when they are ill. Illness, tiredness and stress greatly impair one´s ability to reason, making it difficult to find another way to explain something. This may result in the patient's inability to play an active role in the resolution of misunderstandings leaving the responsibility on the medical provider, who then has to learn to effectively resolve these situations with each patient from diverse backgrounds and countries of origin. This is no simple feat.[4]

Compounding the difficulty of this task is the quantity and diversity of the variants that occur in clinic, as briefly alluded to in the description of the variants. For that reason, it is extremely difficult, if not impossible, to learn all of them. Nonetheless, even if it could be done, the nature of the variants themselves complicates their use. First, variants change over time, moving into disuse or becoming part of standard language, requiring continuous learning to stay current. Second, due to the fact that many variants are region specific and informal in nature, though it would be useful to learn them in order to understand the patient, they are not as readily useful in terms of productive language. Many times, the patient's country of origin is unknown and, additionally, it is nearly impossible to know which terms are familiar to that particular patient. Inserting dialect variants with the hope of making the patient feel more comfortable and more likely to understand the medical professional without knowing more about them could actually result in the opposite effect – a distancing of the patient or even an offense. Finally, given that some variants are due to pronunciation differences or interferences from English, the

4 For more information on factors which give rise to higher variant use among patients and which inhibit the patient's participation in the resolution of misunderstandings, please see Bennink (2014).

provider would also need an understanding of phonetic variations between different countries and regions as well as an understanding of language interference. This represents a linguistic understanding that is far too demanding for most physicians who are already setting aside part of their all too scarce time to learn Spanish.

Lastly, even if the medical professional had the desire to learn some of the dialect variants or turn to reference materials such as dictionaries when they do not understand a term or phrase, they may be surprised to discover a great absence of variants in both of these resources. During the aforementioned study carried out by Bennink in 2013, there was also an analysis of the inclusion of dialect variants in Spanish for medical professionals courses and manuals used within the studied region as well as in some dictionaries used as reference. The results obtained revealed a severe dearth of variants in all three areas. It was found that many courses do not teach any variants or only teach those familiar to teachers. The manuals, for the most part, only include technical terminology and, those that do include variants, offer very few.[5] Finally, in terms of the dictionaries, the analysis of the *Diccionario de la Lengua Española* from the Real Academia Española (2001), the *Diccionario del Español Usual de México* (Fernando Lara 2000), the *Southwestern Medical* (Artschwager Kay 2001), and a later comparison with the *Diccionario de Americanismos* (Asociación de Academias de la Lengua Española 2010) confirmed that each one is missing some of the variants found to be frequent in the medical setting. Furthermore, some frequent variants were not included in any of these. This absence leaves the medical professionals without the education or reference materials to deal with unfamiliar variants when they arise.

5 For a list of courses and manuals analyzed, see Bennink (2013a).

5. Conclusion

As has been illustrated, dialect variants in cross-lingual medical communication are not only prevalent but also, when unfamiliar to the medical professional, can potentially have a negative impact on care. However, when seeking to integrate them into the communicative competence of the healthcare professionals, various challenges are confronted, including the patient's communication skills, the quantity and diversity of variants and the lack of educational and resource materials that incorporate dialectal terms. Though the intention in this chapter is not to give an answer for each of these challenges, it should be mentioned that Bennink and those at the Universidad de Oviedo are currently conducting research that aspires to address this need. The hope is to create a repertoire of Spanish dialect variants that arise frequently in the medical setting. The final goal of this repertoire will be its use as a resource in clinic and as the basis for the creation of material for Spanish for medical professionals courses. It is hoped that this research will be a first step in the search for solutions to the challenges that have been presented in this chapter.

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