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Editor's Introduction

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Editor's introduction

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Introduction

A few weeks ago, I was at a networking event in my home city of San Angelo, Texas. Because I research issues involving healthcare and culture, I often find myself talking to physicians or nurses at these sorts of get-togethers. I find that I get many of my best ideas from chance comments made by others. This event was no exception. I was discussing my research with a nurse who, like me, originated from Michigan.

"I was just so unprepared," she said. "When I was hired for this nursing job in Texas, they said Spanish was helpful, but no one was said it was *necessary.* I mean, I had some training in medical Spanish but that just doesn't cut it. For months I was walking around saying, '¿Quieres dolor?' to my Spanish-speaking patients. Can you believe that? I was going around asking them if they wanted pain! What I meant to ask was 'are you in pain.' Something needs to be done. We just can't help people effectively this way."

I have heard similar sentiments over and over again from nurses, physicians, home health aides, paramedics, and others working in the vast array of job titles and positions in healthcare. The professionals working in this field are well aware of the fact that most of them do not have the skills to work effectively with patients from other cultures. They do not speak the language or understand the special health challenges that the culture encounters.

This is not to blame the medical community. Far from it. Universities and hospitals spend millions annually trying to teach their students and staff the basics of the language skills and the cultural nuances that affect how they should treat their patients. The healthcare community wants to serve these populations, they just do not have the resources or they don't know the best ways to go about doing it.

This is where research can be so valuable. Busy physicians, nurses, and hospital administrators do not have the time to conduct focus groups or in-depth interviews with patients. Researchers in the communication fields, such as the authors whose work is featured in this edition of *Rhetoric, Professional Communication, and Globalization,* can help fill in these gaps of

knowledge and provide insight into some of the best practices and issues that our healthcare professionals need to address to serve these populations more effectively.

The Importance of Addressing Issues of Culture in Healthcare

When I first began researching issues of culture and healthcare as a graduate student, I found that I had to write a lengthy justification in every article about why we have to address this healthcare issue, this population, this topic. The big issue at stake was the cost of translating and localizing the materials. Researchers in this area continually had to justify the expense to the healthcare organizations and hospitals that would provide the translated or localized materials.

In the past ten years, however, the tide has begun to shift, and although the cost of translation and localization is still an issue, it is more a given that we have to make our healthcare information more culturally appropriate. Several events precipitated this sea change.

Executive Order 13166

One of the most significant events that precipitated a greater awareness of the role of culture and language in healthcare was Executive Order 13166. Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency," sets forth guidelines that hospitals, clinics, and practices must follow to receive federal funds. The guiding idea behind this EO is to prevent discrimination against those with limited English proficiency, which would violate Title IV of the Civil Rights Act of 1964. Title IV prohibits discrimination on the basis of national origin. This EO was signed into law by President Clinton in August of 2000 (USDOJ, 2012).

The mandate of this order caused sweeping changes in healthcare, so much so that ten years later many healthcare organizations are still struggling to become fully compliant (St. Germaine, 2010). According to the Department of Justice Federal Register (2002), the order mandates that "Recipients of Federal financial assistance have an obligation to reduce language barriers that can preclude meaningful access by LEP [Limited English Proficiency] persons to important government services." This can be interpreted rather broadly. At the very least, hospitals and other healthcare organizations that receive federal assistance, including federal grants or accepting Medicaid or Medicare, must offer language assistance programs for patients with limited English proficiency, such as offering the use of an interpreter over the telephone (Schroeder, 2002). However, the order also contains instructions for providing translations of written materials, notices for the availability of services in languages other than English, staff training, and monitoring services to ensure compliance (2002, p. 2).

Many hospitals, practices, and other healthcare organizations already provided the services of a telephone interpreter (St. Germaine, 2010). The part of the order that triggered a tidal wave of translation and localization work was the mandate for providing written materials. To clarify, these hospitals and clinics do not have to offer written translations of all healthcare materials. The EO states that translation should be available for "vital documents" (Health Consumer Alliance, 2004, p. 3). However, the EO does not define which documents are "vital." This has left healthcare organizations to determine for themselves what constitutes a "vital" document. In most cases, written consent forms, prescription information forms, and overviews of medical procedures are the documents that are most often translated (St. Germaine, 2010).

In a similar vein, healthcare organizations do not have to offer translations into every possible language or dialect. To do so would be prohibitively expensive and virtually impossible. Instead, the EO mandates that the organization should provide written translations for "each LEP language group that constitutes five percent or 1,000, whichever is less, of the population of persons served or likely to be served" (Health Consumer Alliance, 2004, p. 3). In other cases, a telephone interpreter can be offered to provide an oral translation of the document or information (2002, p. 3).

Some larger healthcare organizations, such as the American College of Obstetricians and Gynecologists (ACOG), have gone further and offered translated and even localized versions of patient information pamphlets (St. Germaine, 2007). Hospitals, private practices, and even individual physicians can purchase the pamphlets for the use of the patients.

If a hospital, clinic, or practice that receives any form of federal aid is found to be non-compliant with EO 13166, they lose access to funding. This is enough to put a large financial burden on most of these organizations, forcing them to choose between spending a few thousand on translated and often localized materials, or to no longer be able to accept federal funding from grants or accept payment from patients on government programs (Schroeder, 2002).

The Growing LEP Population

Another change that has fueled a greater awareness for the need for translated and localized materials is the rapid shift in demographics. According to the United States Census Bureau (2010), the portion of the population that speaks a language other than English at home has risen by 140 percent in the past 30 years. This figure amounts to 55.4 million people, or 20 percent of the population. The number of Americans who do not speak English at home is growing faster than the general population. The 140 percent growth of Americans who speak a language other than English at home far outstrips the 34 percent growth of the nation's population during that time period (2010).

These figures indicate that healthcare organizations as well as professional communicators can no longer assume that the dominant English-speaking model will always hold true for the United States. As other languages and populations grow in number and exert more influence over public policy, the stakes for addressing these populations in the healthcare setting will become even higher.

The language groups experiencing the largest growth were Spanish and Vietnamese. The Spanish-speaking population has grown by 23.4 million people from 1980 to 2007, according to the U.S. Census Bureau (2010). This represents an increase of 211 percent. The Vietnamese population has grown by over 1 million people, which represents a 511 percent increase (2010).

However, the growth of populations that speak a particular language has a large regional impact as well. While the growth of the Spanish-speaking population has been felt in virtually every corner of the nation, its largest impact has been on Texas, New Mexico, and California, according to the U.S. Census Bureau. Louisiana and Maine have been impacted by a growing French-speaking population. The highest concentration of people who speak German at home is in North and South Dakota. Illinois, New York, New Jersey, and Connecticut have a growing

Slavic language-speaking population. California, New York, Hawaii, and Massachusetts are experiencing a growth in the population of speakers of the various Chinese dialects. Hawaii, California, and New Jersey have the largest proportion of speakers of Korean (2010). The regional growth of specific languages and language groups necessitates that each hospital, clinic, and healthcare organization examines its patient population to determine which language groups represent critical populations for them.

While not every person who speaks a language other than English at home is limited English proficient, it is safe to assume that many of them do fall into the LEP category. According to Ku and Flores (2005), the LEP population has grown by 1/3 from 1990 to 2000, rising from 6.3 percent of the U.S. population to 8.1 percent. This percentage may continue to grow as long as the United States depends on immigration to grow its workforce.

The Effect of Language Barriers

Language barriers have a significant impact on the quality of healthcare that a patient receives. Imagine having severe pain and stumbling into an emergency room. Neither the physician nor the rest of the staff speak English. After 30 minutes, you finally are handed a telephone and an interpreter, who speaks a variety of English that you can barely understand, tells you that you have a rare disorder. You have many questions, but the answers come slowly and in the end, you still aren't clear about what your condition is and what will happen next. Frustrated, you take your prescription and head home.

This scenario is a reality in emergency rooms across the country. Even those who speak widely-spoken languages, such as Spanish or Mandarin Chinese often report having problems with obtaining reliable interpretations and translations of their healthcare information. According to a survey, one-quarter of the Spanish-speaking Hispanic parents surveyed reported that the language difference was the "single greatest barrier to access to health care with their children" (Ku & Flores, 2005). In the same survey, 6 percent of parents reported that they did not bring their child to a physician on at least one instance because of the language barrier (2005).

LEP patients have some of the lowest satisfaction levels with healthcare of any group, and research shows that the language barrier compromised the level of care they receive (Ku & Flores, 2005). In some cases, this problem can lead to costly lawsuits for the hospital. In one case, the Spanish-speaking parents told the paramedic that their son was "intoxicado" as meaning "intoxicated" rather than "nauseated," which was its intended meaning. The boy was treated for drug abuse rather than the brain aneurism that he was suffering from. The aneurism ruptured and the boy ended up a quadriplegic. The family sued the hospital for $71 million and won their malpractice case (2005).

Certainly, EO 13166 has played a pivotal role in ensuring that LEP patients have at least minimal access to interpretation and translation services, but the system is not perfect. Ideally, trained interpreters should be offered at larger hospitals and clinics, and an effort should be made to hire bilingual staff in areas with a high LEP population. According to Ku & Flores (2005),

> Patients with limited English proficiency who are provided with such interpreters make more outpatient visits, receive and fill more prescriptions, do not differ from English-

> proficient patients in test costs or receipt of intravenous hydration, have outcomes among those with diabetes that are superior or equivalent to those of English-proficient patients, and have high satisfaction with care. LEP patients with bilingual providers ask more questions, have better overall information recall, and are more comfortable discussing sensitive or embarrassing issues; those with hypertension or diabetes have less pain and better physical functioning, psychological well-being, and health perceptions and have high patient satisfaction.

In the end, interpretation and translation services are a key component to preventative care. When patients understand their conditions and the instructions for taking their medications, accidents related to the language barrier can be prevented. This is likely to result in fewer trips to the emergency room and fewer lawsuits.

Cultural Views of Wellness and Illness

Language is important, but it is not the only thing that affects the quality of healthcare and health information. How a culture views wellness and illness also influences their level of care. In fact, the very concept of health and the wellness/illness dichotomy differs widely among cultures. What one group might consider as well-being, another might consider being illness (Kreps & Kunimoto, 1994; Forslund, 1996). Forslund (1996, p. 48) offers the example of a sub-tropical culture where dysentery and malaria are common, and as a result are not expressed in terms of "illness" but rather as a normal, though perhaps unfortunate, state. Brigitte Jordan (1997) refers to this as "cultural authority," or the probability that particular definitions of illness and wellness will be judged to be valid by a particular culture. In the Mexican culture, pregnancy has been traditionally treated as a normal condition that most women go through once or more in their lives. It is not seen as an atypical condition that must be monitored, as the dominant-culture Anglo-Americans view it. As a result, pregnant women of Mexican descent or from Mexico are less likely to seek prenatal care unless they suspect that something is wrong with themselves or their unborn child (Committee on Health, Education, Labor, and Pensions, 2002).

Culture determines what constitutes illness and wellness, as well as how these states of being are treated and by whom (Forslund, 1996). Gary Kreps and Elizabeth Kunimoto add, "No matter how 'rational' the goals of a health care campaign are, from family planning to organ donation, cultural roots run deep and will influence audience member interpretation" (1994, p. 97). For instance, many Spanish-speaking Hispanic women in the United States consider social aspects as well as personal health before they decide to follow the advice of the physician. If the advice seems difficult to follow in light of one's social obligations, the individual would be unlikely to comply (Browner & Press, 1997, p. 126-7). A pregnant woman who was advised to avoid smoke for the health of her baby might not comply if doing so would mean that family members would have to quit smoking in order to accommodate her needs (Committee on Health, Education, Labor, and Pensions, 2002).

Localizing Healthcare Information

With the push for translations came a growing awareness of the need to provide culturally-appropriate versions of medical documentation. There is no such thing as communication that is free from culture. We often think of our communication as "culture-free" because we are so

immersed in our own cultural preferences and biases that we fail to see how our culture impacts the communication. The "plain English," liner style that we have adopted for our technical communication has its historical roots in the birth of the military-industrial complex during World War II (Longo, 1998). Although we tend to think of this no-frills style as "neutral" and free from culture, it is itself a cultural artifact.

This is why we must take care to localize information. Michael Cronin defines localization as "taking a product that is already designed and adapting it to a local market" (2001, p. 13). Each culture has its own rhetorical preferences and communication style. Simply translating the document is not enough to make the document understandable for a particular culture. Localization moves beyond simple translation. Localization considers other issues such as how the readers will use the document, the content that they prefer and need to know, graphics, layout, and other stylistic issues must also be considered (Yunker, 2003, p. 128-129; Esselink, 1999).

The preferred communication patterns among cultures can differ in several ways. Although researchers in communications, particularly in technical communication, have begun to shy away from the use of broad cultural models such as those developed by Geert Hofstede and Edward T. Hall, they are still useful as a general basis for discussing differences in communication patterns between cultures.

Direct or Indirect Communication

Dominant culture, Anglo-American culture tends to use a very direct pattern of discourse. Low-context cultures, such as the United States, tend to prefer direct, linear discourse (Condon, 1985). Anglo Americans, for example, tend to assume that "technical information naturally flows in a linear fashion, such as from summary to background information, methods, results, interpretations, and recommendations. In contrastive rhetoric, this standard is assumed to be based upon Western thinking patterns" (Panetta, 2001; Cook, 1996, p. 19). Medical information in low-context cultures often contains bulleted lists of facts and figures and follows a prescribed format, such as a definition of the disease, signs and symptoms of the disease, how the disease is contracted, methods of diagnosis, treatments for the disease, and information about coping with the disease and where to find other resources.

People from high-context cultures, on the other hand, such as dominant-culture Mexicans or dominant-culture Chinese, prefer to include all of the information that is needed to understand a message and no more (Driskill, 1996, p. 29). These high-context cultures prefer digressive, non-linear rhetorical styles over direct styles (Condon, 1985; Hall, 1976; Uljin & St. Amant, 2000). Rae Gorrin Cook (1996) attributes this rhetorical style to the differences in how these cultures think, noting that "in many other cultures, thinking is either associative or circular" (p. 19). In medical writing meant for high context cultures, readers tend to prefer a more conversational discussion of the condition that is personal in nature and covers aspects of how the illness and treatment may affect their lives and that of their family rather than a statement of facts. Instead of a linear format, a question and answer format may be preferred with an organization that flows naturally with the discussion rather than a prescribed order of topics (St. Germaine, 2009).

Formality

Cultures can also differ in terms of how formal the tone of the communication is expected to be. Hofstede's cultural dimension of power distance is related to the degree of formality that the communication is expected to have. Power distance is defined as "a culture's willingness to accept differences in social levels" (Hofstede 2001, p. 46). This factor of power distance means that when there is a status difference between the individuals who are interacting, the individual with the lower status gives great deference to the individual with the higher status. Some manifestations of power distance in communication include the use of formal titles, the great show of respect to higher status individuals even outside of the work context, and an attitude of obedience toward individuals with higher status (Noble, 1991; Kenna 1994; Thatcher, 1999).

Sometimes, the expected tone can even differ depending on the type of communication. For example, Mexican business communication tends to be very formal and uses long sentences to build ethos (Tebeaux, 1998). However, medical communication for a Mexican and Mexican-American audience is expected to be more personal and conversational (St. Germaine, 2009). As a result, it is important to move beyond cultural dimensions and conduct focus group tests and usability tests to determine if the tone and other rhetorical aspects of the medical communication are appropriate.

Affect

Affect refers to the amount of personalization the culture prefers in their communication. Cultures that are collective in nature, meaning that a great deal of value is placed on relationships with family and friends, and an emphasis on the welfare of the group or of society as a whole over the individual (Arreola, 2002). This desire to be personal and to relate to the reader can be interpreted as concern for the other. To write a less personal communication is seen as a failure to recognize the individuality of the reader. Further, according to Barry Thatcher (1999, p. 187) the personal narrative aspect can be viewed as a desire to provide adequate context for the reader: "high-context cultures call for *more* context in unfamiliar situations whereas low context cultures tend to always write in a low-context manner."

This desire for personal communication can extend to medical information, where the personal communication pattern is reinforced by the desire for a personal working relationship with the physician. In Mexican culture, this personal, affective communication, known as *personalismo*, can be seen as one vital way to achieve the goal of establishing relationships and providing the needed background information about the individual (Lafayette de Mente 1996; Ortiz, 2005; Driskill, 1996; Tebeaux, 1999, p. 58; Thatcher, 1999, p. 187).

US and other low-context medical, business, and technical communication tend to be very specific and to the point, as well as neutral in tone (Uljin & St. Amant, 2000). Professional communication in the United States and other low-context countries and cultures tends to focus on the interpretation aspect of the message rather than the alternative role of building a relationship (Uljin, 1996; Longo, 1998).

This is not to say that Americans and other members of low-context cultures do not seek a personal relationship with their physician or that general medical advice is seen as acceptable. To the contrary, members of low-context cultures also seek personal medical advice, but they

seek this advice from their physician. In contrast, medical information is expected to be general in nature and impersonal (St. Germaine, 2009).

Fatalism and Uncertainty Avoidance

Cultural preferences for medical communication are strongly influenced by their comfort with ambiguity. Hofstede defines uncertainty avoidance as "The extent to which the members of a culture feel threatened by uncertain or ambiguous situations" (1991, p. 167). High uncertainty avoidance cultures have a low tolerance for uncertainty or for situations in which the outcome is unknown. According to this idea, the future is seen as unknowable, and for this reason, only the present situation is suitable for discussion (Kenna, 1994; Tebeaux, 1999, p. 59).

A related dimension, specific vs. diffuse culture, can be found in Trompenaars and Hamden-Turner (1997). In a specific culture, such as the dominant Anglo-American United States, people and events are judged on their own merit and easily integrated into a particular context, such as a business relationship. People and concepts are easily contextualized. In a diffuse culture, such as many Latin American and Asian cultures, it is difficult to integrate new people and new events into any sphere of life, public or private, where established standards for behavior already exist. This system means that new people or events are not accepted into the schema of "work" or "personal life" until they are well-known. As a result, until the person or idea becomes accepted, or part of the "standard" events within a particular context, a tone of uncertainty prevails ("Specific vs. Diffuse," n.d.).

Tied to these ideas is the concept of fatalism. Some cultures are fatalistic, which means that there is a "belief in the role of fate and the lack of control that humans have over their own destiny" (Kenna, 1994, p. 13). This tendency toward fatalism affects the types of assertions medical writers can make in medical documentation. For instance, speaking very broadly, Hispanic cultures tend to be fatalistic, a concept that is known as *fatalismo* in Spanish. In focus groups conducted by Ogilvy, a localization firm contracted by the CDC, Spanish-speaking Hispanic Americans preferred concrete facts in their medical information to get a better handle on their risks and health outcomes. When specific information was available, Spanish-speaking Hispanics preferred to know it rather than read ambiguous information such as statements like "Most people recover" (St. Germaine, 2009).

In contrast, the rhetorical patterns of communication for most low context cultures, such as the dominant-culture English-speaking United States population, communication tends to be very certain in tone. The concept of fatalism is generally not a feature of the US's Anglo culture or for most other low-context and specific cultures. Therefore, speaking in generalities and providing loose estimates is considered to be more acceptable for physician-patient communication and other forms of medical writing meant for the patient (St. Germaine, 2009).

Preferences for Graphics

Graphics are a key aspect for the localization of a document because they can cover for a problematic or faulty translation, or make a translation more useful because simple graphics can appeal to a wider audience than text can (Horton, 1993, p. 683). Graphics, however, must be used with caution, particularly when the document is meant to convey medical information (Forslund, 1996, p. 48). In patient information pamphlets as well as other medical documents,

several factors come into play. As Flint et al. (1999) state, "If you need to depict people in documentation, the most sensitive areas to be aware of include: race, gender, nudity, body language, and hand gestures" (1999, p. 241; Andrews, 1996; Forslund, 1996). Several of these "sensitive areas" must be covered in medical pamphlets that treat the topic of issues in women's health, meaning that each time a graphic is introduced it could have the potential of alienating some audiences. Further, in populations that subscribe to a more holistic model of medicine, cut-aways of women's bodies and other graphics that only show an organ or part of the body might be considered to be disempowering or inappropriate (see Martin, 1994).

Not only must we consider which graphics and types of graphics are culturally appropriate, but we also need to consider cultural understanding of illness and wellness, as well as how the culture views particular illnesses. For instance, as I stated previously, in the Mexican culture, pregnancy is not considered to be an "illness" or a pathological state, and perhaps many Mexicans, therefore, may find that the over-use of graphics depicting women in a clinical setting to be inappropriate for their understanding of pregnancy as a normal, healthy state. These issues can affect both the text and the graphics that are selected.

Many technical communicators, such as Charles Kostelnick (1995) argue that graphics for technical documents must move beyond simple sketches of people (or "flatman") and should adhere to the particular culture's preferences for graphics. These cultural preferences can vary widely from detailed line drawings (such as those preferred by English-speaking North Americans) to not using graphics that involve people, as is the case in many Muslim cultures (Kostelnick, 1995). Forslund (1996) found that many Mexican women preferred to see photographs in their health care information. In cases such as these, knowing a particular culture's standards for graphical representation can be key to the success of the document.

Researching Localization

It is important to conduct focus group tests and/or usability tests on medical information meant for other cultures before it is disseminated. Wide differences in cultural preferences exist, even among cultures with similar characteristics in Hofstede or Hall's cultural dimension measurements. Although these cultural dimensions provide useful insights into cultural preferences for general communication, they do not cover specific preferences for health communication, cultural models of wellness or illness, or preferences for the types and numbers of graphics in medical information. Subtle nuances in meaning, preferences for graphics, tone, and format can have a significant effect on the success of the medical documentation. As a result, cultural dimensions and other broad measurements of culture should only be used as a starting point for developing a localized document.

Looking Forward

In most countries, healthcare is rapidly changing and it is almost impossible to keep up with all of the trends that could have implications for translation and localization. The digitization of health information is one important topic that will increasingly become an issue as the years go by. Patient records are increasingly being digitized. In my city of San Angelo, Texas, patients at my children's pediatrician's office are asked to subscribe to Imutrac, a database that is managed by the state to track children's immunizations. Patients that do not speak English or who do not

have access to the Internet, as is the case for many LEP people, are at a distinct disadvantage when it comes to tracking their children's vaccination and medical records. In addition to patient records, most up-to-date health information is being kept online in large medical websites such as Web MD and the Mayo Clinic websites, as well as their social media sites. This has implications for translation and localization as well as raises questions about access to the information.

Grassroots movements, fueled by the Internet, are also affecting how we view healthcare. The public no longer finds out about illness solely through the media. They can learn about and track the spread of illnesses online through social media, privately-owned websites, and message boards. This not only affects how the public deals with illness and the prevention of illness, but it also has implications for culture because it can lead to stigmatization of certain populations as well as restrict international travel.

Another development to watch is the widespread reconsideration of what is considered "wellness" or "illness." This is not a new movement; the deaf culture began the discussion of "abled" versus "disabled" decades ago. However, with the growing recognition of problems such as autism, mental illnesses, and even addictions, advocates for those with these conditions are leading the discussion of how to accommodate people with the conditions and whether or not those with the condition are disabled.

These three trends are just a few of the emerging patterns that we can expect to continue developing over the next decade. Professional communicators working in the health fields are working on the front lines, helping to determine what the "best practices" for dealing with these changes are as well as putting those best practices for communication in place. It is a weighty responsibility, but a rewarding one.

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