

Babel, Justice, and Democracy:

Reflections on a Shortage of Interpreters at a Public Hospital

by JAMES DWYER

When a doctor sees a patient, answers to a few questions can be crucial. So what to do when no one at the hospital speaks the patient's language? Doctors can often devise creative, makeshift ways of communicating with their patients, but the problem calls ultimately for a creative organizational response.

The public hospital where I work never seems to have enough. It never seems to have enough doctors, nurses, technicians, interpreters, and janitors. It never seems to have enough clinic hours, follow-up visits, and social services. Of all these shortages I want to focus on one in particular: the shortage of interpreters for patients who don't speak English. I want to consider, in a philosophical way, how the hospital should address this problem. But first I need to say more about the problem.

Many of the people who use this hospital and its clinics are working class immigrants. This is not a new development. The hospital has a long tradition of serving immigrants, and it has a mission to serve people without regard to their ability to pay. What has changed at the hospital is the countries that immigrants come from and the languages they speak. Two generations ago, German, Yiddish, Polish, and Italian were common at the hospital. Today, Spanish, Cantonese, Mandarin, and Bengali are much more common.

What has also changed is the number of languages spoken. During an eight-week period, the emergency department saw immigrant patients who spoke over thirty-five languages.¹ I suppose that more languages are spoken at the United Nations, but at the UN people can reliably assume that someone they want to converse with will have a working knowledge of English or French, and they can call on an extensive staff of interpreters. At the hospital,

that's not the case. More than one-third of the immigrants have a poor command of English, and the hospital doesn't have enough interpreters.

So how do patients and staff deal with this problem? Some staff members are bilingual. They themselves are immigrants or are children of immigrants. Other staff members have learned to function in a second language, usually Spanish, and keep a bilingual dictionary close at hand. The hospital has hired some interpreters and trained a few volunteers to act as interpreters. And, finally, some patients show up with a family member—a spouse, child, or cousin—who knows enough English to help with the medical encounter.

Although the patients and staff muddle through each day, and the hospital never quite turns into a tower of Babel, problems do arise. Here are three examples:

■ **A Depressed Patient.** Mrs. Chen was waiting to be seen in the primary care clinic. She was sitting quietly with her daughter, who looked to be about ten years old. It was almost six o'clock when Dr. Marsh called Mrs. Chen's name and introduced himself. Mrs. Chen didn't speak a word of English, but her daughter was fluent. Although Dr. Marsh didn't like to use family members as interpreters, he didn't know what else to do. The Cantonese speaking receptionist had gone home at five, and so had the hospital interpreters. He didn't want to send the patient away, so he began the interview through the daughter. He asked a few open-ended questions and took in the responses, all with the help of his ten-year-old interpreter. As the story unfolded, Dr. Marsh real-

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ized that Mrs. Chen was seriously depressed. He wanted to ask some pointed questions to assess the risk of suicide, but he felt bad about posing these questions through the daughter.²

■ **The Yellow Pages.** The patient spoke Cambodian, two words of English, and one of French. He kept coughing and pointing at his chest. The attending physician was worried about tuberculosis. The answers to a few questions would help to clarify the matter, but none of the staff spoke Cambodian. The attending physician took the whole matter in stride. He asked the resident to get him the yellow pages. The resident looked puzzled, but did as he was asked. When the res-

ident came back with the phone book, the attending physician flipped it open to restaurants, found a Cambodian restaurant, called the number, and explained the problem. He then posed a question to someone at the restaurant, and handed the phone to the patient. The patient spoke Cambodian into the phone and then handed it back to the physician. That's how the interview took place.

■ **About 60 Percent Effective.** Dr. Gold says that she is better at physics and philosophy than at foreign languages. Although she has learned a lot of Spanish by studying on her own, she estimates that when she does an interview in Spanish she is functioning at 60 percent effectiveness. Every time a patient comes in who speaks only Spanish, she wonders whether to do the interview herself or to call

for an interpreter. It often takes more than a hour for an interpreter to arrive, at a clinic where a patient is scheduled every twenty minutes. In each case, Dr. Gold must decide whether to call for an interpreter, make the patient wait, and introduce more chaos into an already chaotic schedule; or to muddle through at 60 percent effectiveness, get a little more practice at Spanish, and hope she doesn't miss something crucial.

As part of my work at the hospital, I discussed these cases with medical students and hospital staff. The students, staff, and I tried to address both the particular ethical problems that the clinicians face and the general ethical problem that the hospital

faces. I like to think that philosophers like me can help people to address problems like these. But I'm not sure that's true. All my life I wanted to be helpful and philosophical, an engaged citizen and a real philosopher at the same time, but this twofold aim has proved more difficult than I ever imagined.

Part of the difficulty is finding the most appropriate perspectives, discourses, and categories for the problem at hand. To be helpful, the perspectives, discourses, and categories must be useful and accessible to the people engaged in the actual situation. But philosophical perspectives, discourses, and categories tend to be rather abstract, reflective, and critical. Given my desire to be both helpful and philosophical, I came to view the shortage of interpreters as a kind of test case, and the rest of this essay is both a discussion of the ethical problems and a reflection on the role of practical philosophy.

Clinical Ethics

To begin, I want to say something about the ethical issues that the clinicians face. The first case is the most dramatic and the most typical of the traditional conflicts in medical ethics. To grasp the full meaning of the conflict it presents, we need a feeling for the situation of the mother. She is a working class immigrant trying to get medical care in a strange land where she doesn't know the language. She is dependent on her daughter to help her navigate a sinking ship in a strange ocean.

We also need a feeling for the situation of the daughter. Children of immigrants are often deeply attached to their parents but also somewhat embarrassed by them. Although these children often have to interpret for their parents and grandparents, rarely do they have to interpret while doctors ask: "Have you ever thought of harming yourself?" We need to try to imagine what this experience would be like for this ten-year-old girl, what it would be like to learn that your mother is thinking of killing herself.

A sensitive understanding helps us to grasp the particular problem. This problem arises because Dr. Marsh is concerned to help the patient, avoid harm to the daughter, get accurate information, protect confidentiality, and proceed in an efficient way. These are important and legitimate concerns, but in the present case they come into conflict. Dr. Marsh made a judgment about the balance of these concerns when he began the interview, but now that he realizes that the patient is depressed, he needs to reconsider what he is doing.

Although some philosophers like to formulate conflicts as air-tight dilemmas so that people must choose one side, I think that much of the real work in moral life involves attending properly to the various concerns, finding satisfactory ways to reconcile those concerns, and developing responsive institutional structures. An important part of the work is to find a way that responds to the concerns but

avoids the conflict. No one I discussed the case with felt good about sending Mrs. Chen home without assessing the risk of suicide, and no one felt good about conducting the rest of the interview through her daughter. Everyone looked for some way out.

Here is a list of suggestions that people made, along with a few comments from the discussion:

- Page a medical student who speaks Cantonese. ("There's probably a student running errands in the hospital who speaks Cantonese.")
- Page any hospital employee who speaks Cantonese. ("Why isn't this information on the computer, in a kind of language bank?")
- Find a bilingual patient in one of the waiting areas. ("Patients spend a lot of time waiting, and another patient would be better than the daughter.")
- Call one of the hospital interpreters at home. ("Wouldn't we page a doctor at home if we needed her?")
- Call the International Buddhist Progress Society. ("Buddhists practice compassion, and there is a temple right in the city.")
- Call the AT&T interpretation service. ("If the clinic doesn't have an account, charge the call to your own credit card.")
- Ask the patient if she will agree to be hospitalized for an important evaluation. ("But what will she do with her daughter, and what if she has other children at home?")

I do not want to contend that this list is exhaustive. Indeed, I hope that other people can come up with other suggestions. Nor do I want to contend that all the suggestions are equally good. Part of the work of the discussion was to evaluate the relative merits of the various suggestions.

Some suggestions seemed better than others, and some seemed much better than making the daughter interpret the rest of the interview.

In the process of discussing the problematic cases, a real education took place. The students, staff, and I all became more aware of the need to get accurate information, protect against harm, maintain confidentiality, act efficiently, consider family life, and attend to the situation of immigrants. When we discussed a case in a group, the group was often able to come up with more alternatives than a single person could. And when the discussion went well, we were able to evaluate the relative merits of the alternatives. The better alternatives entered into people's stock of ideas—the hospital's human and social capital—to be called on when needed.

Although the discussions proved educational, they also proved frustrating. We all found it frustrating to discuss problems in clinical ethics that could be avoided altogether with a bit more money, effort, planning, and organization. We all wanted to shift the discussion from clinical ethics to organizational ethics. So we did.

Organizational Ethics

Some people began to discuss organizational ethics in a way that would have bypassed most of the ethical problems. They claimed that patients who are not proficient in English have a right to an interpreter. I cautioned against this approach. I argued that simple claims about rights tend to ignore difficult ethical problems about assigning responsibilities, setting priorities, allocating resources, and resolving conflicts between different rights. Claims about rights tend, unwittingly, to imply that all these ethical problems can be replaced by administrative problems about monitoring and enforcing rights. But ethical life is not so simple.

I wanted to pause to discuss the forces behind global migration, the meaning of national borders, the effects of political responses, the mis-

sion of the public hospital, and the allocation of resources at the hospital. But these matters were seen as too abstract, too distant from the problem at hand. Perhaps they were, at least at the time. Because the shortage of interpreters was so immediate, people (including me) were quick to make suggestions and propose solutions. Here is a list of suggestions that people made:

- Hire more interpreters, and place some of them on call.
- Hire more bilingual staff. In employment decisions, consider competence in a second language as a relevant skill.
- Contract with a telephone interpretation service like AT&T. Make sure everyone knows how to access the service, and that the equipment complements the service (speaker phones compromise confidentiality, and single phones have to be handed back and forth).
- Encourage staff members to learn a second language. Offer free classes, and give people time off to attend the classes.
- Start and maintain a language bank on the computer. List all students and staff who speak a second language. List where they work and how to contact them.
- Recruit and train more volunteers. Establish relationships with associations from the different language communities.
- Encourage premedical students to learn a second language. Competence in a second language could become a de facto requirement for medical school, just as volunteer service and research have become de facto requirements.

These suggestions are quite diverse. They embody different views about the availability of resources, the locus of responsibility, and the urgency of

the problem. Some suggestions would require substantial and ongoing funding, whereas others would require only a modest grant to pay for start-up costs and administration. Some suggestions focus on society's or the staff's responsibility, others look to the community or the immigrants themselves. Some suggestions aim at an immediate solution, other focus on the long term. Some suggestions might work well for common languages but prove impractical for rare languages. Of course, these suggestions are not mutually exclusive, and the list is not exhaustive. Administrators may find good ways of combining suggestions or good ideas that are not on the list at all. Part of the work of administrators is to formulate and evaluate alternative modes of organization that respond to the problem.

The hospital must try to encourage and empower people to meet together, deliberate about, and address the problems of their public hospital.

But how—in what categories and from what perspectives—should administrators think about the various suggestions? Some useful categories emerged in the discussion of clinical ethics. Administrators need to consider cost-effective ways to help the staff get accurate information, respect confidentiality, attend to families, care for immigrants, and so on. But are there broader categories that might guide administrators in their work? I think it would be helpful to focus attention on three ethical ideals: the good, the just, and participatory democracy.

The Good and the Just

It is unrealistic and simpleminded to evaluate organizational suggestions without taking into account the cost of those suggestions. After all, the problem arises because the hospital has limited resources. Every administrator would like to have more resources—more money, people, and equipment. More would often be bet-

ter, at least for the hospital, if not for society as a whole. But given the hospital's limited resources, administrators should try to increase the good done with those resources. This may seem like an obvious idea, but I don't think people attend to it carefully enough. People don't usually think and respond in terms of increasing the good. Let me try to illustrate this point.

Physicians often tell me, and teach their students, that 90 percent of the information needed to make a diagnosis comes from the patient interview. Yet language barriers are blocking the flow of information. In Dr. Gold's case, for example, she estimates that she is only 60 percent effective when conducting an interview in Spanish. If physicians had to order a diagnostic test that was only 60 per-

cent as effective as another test on the market, they would demand that the hospital get the more effective test. Likewise, if they had to prescribe a drug that was only 60 percent as effective as another drug, they would seek immediate changes.

When better outcomes can be achieved with tests, medication, or equipment, people are concerned and take action. Clinicians voice their concerns, and administrators work to increase resources or to reallocate the given resources so as to achieve better outcomes. But when the limitations are a matter of language, time, or organization, people tend to accept these limitations as a fact of life. There is no good reason to adopt this double standard.

Maybe hiring another interpreter would do more good than hiring another lab technician. Maybe adding a telephone interpretation service would do more good than adding another MRI scanner. I don't know, of course, but neither do most adminis-

trators and clinicians. They should try to find out. They should consider how to allocate the financial and human resources in ways that increase the good. After all, part of the art and science of management is to do better with the same resources, and "better" is the comparative of "good." It might be possible to get better outcomes, to do more good, if the given resources were allocated in a way that addressed the language problem.

In addition to trying to increase the good, administrators and clinicians need to attend to how the good is distributed. Justice may not be adequately expressed simply by maximizing the good. In discussing questions of social justice with the staff, I started to articulate some philosophical critiques of the way power, wealth, opportunity, and health care are distributed in American society. The problem I encountered was not that people disputed the critiques. For the most part, they agreed that there is something cruelly unjust about a health care system that fails to provide basic care for so many poor and working-class patients. And they found that philosophical critiques based on social justice were useful in making a case that public hospitals are underfunded in comparison to the rest of the health care system.

The problem, rather, was that most philosophical views of social justice seemed to them too distant and abstract to provide much guidance about the distribution of goods at an underfunded hospital where the patients come from the most disadvantaged classes in the larger society. What the staff wanted was more guidance about distributing goods among their patient population. About this problem I had much less to say.

I did suggest that the hospital needs a process that is fair, reasonable, and transparent. I also suggested the need to avoid invidious distinctions. Because the hospital was having difficulties meeting the basic needs of all the patients, some staff suggested distinctions based on the idea of desert. A few people suggested that immi-

grants who have been in the country for many years but have not learned English are less deserving than others. A few people thought that illegal immigrants are less deserving than legal immigrants. And a few people suggested that hearing-impaired patients who use sign language are more deserving of interpreters than speakers of foreign tongues.

In one sense, there is no getting away from the idea of desert. After all, justice is giving people their due—what they deserve. But I am skeptical about appealing to a narrow conception of desert. First of all, in this context it is very difficult to determine who is more deserving. It is easier to judge who is more deserving of an award in a piano competition than who is more deserving of an interpreter at a public hospital. Furthermore, a narrow conception of desert does not seem appropriate for dealing with the problem of distributing health care across a diverse patient population. A narrow conception of desert is most at home in allocating particular goods that go beyond basic needs, in situations where the criteria of effort and achievement are very clear.

Participatory Democracy

I expect the hospital to increase the good and attend to justice. But that's not all. I also expect the hospital to foster democracy. To do that, the hospital must do more than provide patients with individual rights—like those listed in a patient's bill of rights. The hospital must try to encourage and empower people to meet together, deliberate about, and address the problems of their public hospital. It must foster participatory democracy. Such a change is a very significant but not unreasonable expansion of a hospital's mission, and it generates some practical suggestions.

A robust democracy requires more than an occasional act of voting. It requires forms of life where people meet frequently to deliberate about issues

and are empowered to address problems. But this kind of civic life does not happen by itself, especially in egalitarian societies that encourage people to act as consumers and clients. Civic engagement has to be fostered by social institutions. Of course, one public hospital cannot transform the economic inequalities and civic withdrawal that characterize American democracy, but it can do its part.

One practical suggestion is for the hospital to work with community groups to recruit and train volunteers who can serve as interpreters. If such a measure is to realize its full potential, however, we need to consider carefully how and why the use of volunteers should be connected to the idea of participatory democracy. At its worst, the use of volunteers may serve as a palliation for a lack of justice in the larger society. It may just be an expensive and private way to do something that should be funded and done in a public way. But at its best, the use of volunteers could increase people's understanding, provide a service in a culturally sensitive way, encourage further civic engagement, and develop habits of citizenship. In short, it could foster civil society and the social ideal of democracy.

The shortage of interpreters is a community problem. Because it affects members of linguistic communities and the hospital that serves them, it is an occasion for the hospital staff to work with these community members to address the problem. As a first step, people need to come to a better understanding of the problem. For example, community members need to understand that one of the current practices—the use of family members as interpreters—does not insure a high standard of coverage, accuracy, and confidentiality. And staff members need to understand how to interpret terms in those languages that are quite distant from American English, and how to interpret elements in those cultural beliefs that are quite different from American medicine's view of illness. Only when people un-

derstand the scope and depth of the problem can they helpfully discuss what might and should be done. Recruiting and training volunteers from community groups can help.

In thinking about social problems, people often focus on what governments or markets can do and neglect the important role of civil society—all those associations that are neither commercial nor governmental. Robert Fullinwider has described some of these associations and their effects:

civil society extends from churches to soccer leagues to reading circles to social movements. It encompasses highly organized national federations as well as informal neighborhood crime watches; it includes associations as large as the AARP and as small as the family. Its activities produce an amazing array of goods—from community safety to companionship to medical care to spiritual guidance. And in producing these goods, it generates such valuable byproducts as social trust, political competence, and civic spirit.³

Thinkers from Alexis de Tocqueville to Vaclav Havel and Robert Putnam have also stressed how important these byproducts are to the realization of a meaningful democracy.⁴

Democracy needs people who perceive social problems, discuss the causes and remedies of these problems, listen to other people in an attentive way, and deliberate about what should be done. Democracy needs people who are concerned, engaged, and public-spirited. People tend to develop these habits and attitudes in associations that embody democratic spirit. John Stuart Mill refers to such development as "the peculiar training of a citizen, the practical part of the political education of a free people."⁵ According to Mill, this education involves taking people

out of the narrow circle of personal and family selfishness and accustoming them to the comprehen-

sion of joint interests, the management of joint concerns—habituating them to act from public or semi-public motives and to guide their conduct by aims that unite instead of isolating them from one another. Without these habits and powers, a free constitution can neither be worked nor preserved, as is exemplified by the too-often transitory nature of political freedom in countries where it does not rest upon a sufficient basis of local liberties. (p. 108)

At the local level, the hospital has a role to play in democratic education.

Does an approach that depends on civil society presuppose the existence of robust democratic communities? Yes and no. It presupposes that there are groups, associations, and organizations with members who are willing to help with the problem. But that seems realistic. There are associations of Latino medical students, Buddhist

temples with Chinese speaking members, Christian churches with Korean speaking members, organizations of Bengali business people, and so on. There is the potential to solve the problem and to make society a little more democratic if we look for solutions that come from and contribute to more participatory forms of democracy.

Does this approach shift a burden onto the very groups that are already burdened with involvement? Yes and no. It does, of course, depend on the civic involvement of everyone who is able and willing to help. But we need not think of civic involvement as an onerous and extra burden. We need to remind ourselves that civic involvement is not only a social duty, but also an important mode of self-realization. And we need to remind ourselves that the most just and fortunate societies are societies that develop democratic forms of life where self-real-

ization and civic involvement reinforce each other.

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1. Unpublished study by Lewis Goldfrank and colleagues.
2. Christopher Taurani and Damara Gurnick deserve credit for this case.
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4. See A. de Tocqueville, *Democracy in America* (New York: Doubleday & Company, 1969); V. Havel, *Summer Meditations* (New York: Knopf, 1992) and R. Putnam, *Bowling Alone* (New York: Simon & Schuster, 2000).
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Decisionmaking Issues in the Rehabilitation Process

by MARILYN MARTONE

Family members are widely believed to be the best decisionmakers for those with brain injuries, but the rehabilitation process does not in fact give them that authority.

I have been teaching health care ethics at St. John's University in Jamaica, New York, since 1984. Although I have researched and written a great deal in the field of

health care ethics, I had done no work in the area of traumatic brain injury, nor do I remember ever attending a professional conference where that topic was examined. I had never thought about traumatic brain injury as a distinct topic of medical ethics and certainly had not studied the topic in depth. All of that changed, however, as a re-

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