

Barriers and Bridges



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WHEN YOU MOVE to another country, you soon realize what you have taken for granted and how different things can be in a new place. In 2013, I moved from Germany to Boston, Massachusetts, for a 2-year research fellowship, leaving the place where I had lived, studied, and worked as a pediatrician for over a decade. It was a big and exciting step for me and my family. We left our old lives behind, including all the familiar places and faces, as well as the vast network of friends, colleagues, neighbors, and teachers we had built over the years—a community in which we were securely embedded.

Although I had traveled a lot on my own during medical school to places such as England, Southern Africa, and the United States, a move with my wife and our 3 little kids felt different and more foreign than what I had experienced before. Even our luggage showed how having a family makes life more complex over time: during medical school I only used a backpack, which I could easily throw onto a pickup truck to hitchhike wherever I wanted to go. This time, we had 10 suitcases filled with only basic clothing and some essential toys. It felt like the difference between a surfboard and a freight ship.

Before our departure, friends who had been to the United States told us that New England was very much like Europe, especially when compared to the West Coast or the Southern states. Therefore, they argued, our transition would surely be smooth. However, upon our arrival in Boston, we were impressed by many differences in daily life. We explored our new apartment with its huge refrigerator, were amazed to see wild turkeys in the street, and wondered about the busy people working the whole day in Starbucks (did they not have offices? homes?). I couldn't figure out which mobile phone plan best fit my needs. I got lost on the way to the supermarket.

Professionally, I was excited to move from patient care into research. After years of squeezing in research after call and during weekends, I looked forward to working more continuously on research projects. A scholarship allowed me to focus on my area of interest: provider–patient

communication in difficult circumstances, such as in the presence of medical errors or language barriers. At the same time, I knew it would not take long before I started missing seeing patients. Instead, I spent my time observing the practice of my colleagues, as well as analyzing and interpreting interview data for my research. I had hung up my stethoscope for transcripts and databases.

Some things were not so different, like the need for pediatric care. One of the first things I did after our arrival was to register my kids in a pediatric practice. Part of the enrollment procedure was a telephone conversation with an administrator who asked me standardized questions about my kids' health and past conditions—things that felt familiar from my own practice. I was also asked whether I had any guns at home, which surprised me and seemed strange, as I come from a country with restrictive gun laws. (Even seeing a gun scares me.) At the end of our conversation, she asked a few questions that impressed me and upon which I continue to reflect even now, years later. “What language do you speak at home?” she asked. “German,” I replied. She continued, “In what language would you like to be treated in our practice?” She asked the question in a way that told me it was okay if my answer was not English. I paused and replied, “English.” In that moment, I did not say “German” because I thought my English was pretty good but also—and more importantly—because I did not want to ask for any extra effort. After all, I was the parent of a new patient who was not familiar with how things were handled here.

Looking back, this simple question—and the openness with which it was asked—marked a transformative moment in my understanding of language barriers and how they affect parent–provider communication. Back home, I was accustomed to working with patients with language barriers; I was usually the one calling the interpreter to help me and my patients communicate. Almost a third of the families in the Dortmund area, where I practiced in Germany, are migrants and speak Turkish or Arabic as their first languages, with limited proficiency in German. I routinely collaborated with medical interpreters to get an accurate history and provide care. Despite the frequency of language barriers in Dortmund (which recently

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increased even more by the wave of refugees from Syria), medical interpreters were not available everywhere, and quality standards regarding their use are not in place. In addition, I often heard parents with obviously limited German proficiency claiming to have good German skills. As a result, I often called for an interpreter to help me communicate better as a physician. But now, when I am the migrant parent? Suddenly I found myself in the same situation, taking the line of least resistance, trying to be an unproblematic parent.

In addition to this role change, I also came up against the “subject-specific” limits of my English proficiency. Buying a used car, for example, was challenging. I had never been an expert on cars to begin with, but now I suddenly lacked important terms, like “shock absorber” or “wheel bearing.” I seemed unable to ask even basic questions. My limited vocabulary weakened my bargaining position and made me anxious the seller would take advantage of me. When we finally closed the deal, my neighbor, Mitch, a tall, American-born, ex-football player, came along to help me with the language and to rebalance my position in terms of both information and power.

But would I really need an interpreter for the medical treatment of my kids? Was it similar to buying a car in terms of an imbalance of knowledge and power? I am, after all, proficient in the medical field and confident enough to represent myself appropriately as a responsible parent. However, there might be occasions when my proficiency might not be at its best. A medical emergency might make me nervous and prevent me from being able to access my stored vocabulary. Being sleep deprived or emotionally strained might impair my ability to connect to the people caring for my child and to build a trusting relationship

with them. And perhaps my friends and colleagues might not be available at those particular moments to help me, as Mitch had. As a consequence, I might have a less-than-optimal relationship with my kids’ clinicians; my abilities as a parent could be limited by such boundaries, and most importantly, communication errors could occur that could in turn harm my child.

In the moment the administrator asked about my language preferences and I answered “English,” I had none of these thoughts. They came much later, and remembering that moment, I still feel friendly surprise—and respect. Being asked this question right at the beginning, before anything serious happened, gave me the comforting message that it was okay to have limited language skills. And although I denied the need for an interpreter in that instant, I was hopeful that I would be able to ask for help through an interpreter if I needed one in the future.

Since then, we have returned to Germany and everything turned out fine. My kids stayed healthy, I did not need an interpreter, and the used car worked reasonably well. Those 2 years were as exciting and adventurous as we had hoped. I also got a glimpse of how vulnerable some parents may feel because of limited language proficiency. Yet the simple questions the administrator asked me helped make it safe for patients and families to request an interpreter when they need one.

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