Role of language in dermatologist-patient relationship: "He who speaks well, treats well!"

Sir,

In countries like India, USA and Europe, several languages are spoken due to a composite culture, tradition and migration. In India, 325 languages and more than a thousand dialects are spoken.[1] Platt recently described history taking as "two ... artists" producing a "collaborative work", a mutual understanding of the biomedical and psychosocial circumstances of the patient.[2] For the highest quality of health care, the case history must be comprehensible in both biomedical and human terms. Language has been documented as a barrier to the physician–patient relationship in USA.[3] Dermatology is a visual specialty where most diseases can be diagnosed with the eyes. But does good communication still play an essential part in dermatological care?

I was posted as a teacher in the dermatology departments in government medical college hospitals at Bambolim, Goa from November 1997 to December 1998 and at Bellary, Karnataka from January 1999 onwards. These are two different linguistic regions with different culture and traditions. I did not understand the languages spoken at Goa, but I spoke and understood the languages spoken at Bellary, Karnataka being my native state. A translator's assistance was needed for patients who were unable to speak the languages that I did (English and Kannada), in 93 (74%) out of 125 patients in Goa, and in 21 (12%) out of 175 patients in Bellary. This difference was statistically significant ($p < 0.05$) (Chi square = 121.74).

Previous studies have confirmed that patients are less satisfied with a physician when an interpreter is used for a medical interview.[4] The results of interpretation using family members, children and nurses are discouraging.[4] A study by Laws et al has demonstrated language interpretation by inadequately trained interpreters fails to establish the physician-patient communication.[5]

A significant problem that I have noticed with house surgeons as translators was that they are new to dermatology and are unable to determine how relevant the history is. I observed that interpretation was tiring in poor-health literacy patients (described by the Council on Scientific Affairs for the American Medical Association[6] as patients unable to "obtain, process and understand basic health information and services needed to make appropriate health decisions[6]"). I noticed that history taking was further complicated because poor-health literacy patients spoke irrelevantly and raised unconnected issues, making it a time consuming effort.

Dealing with chronic cases in dermatology involves three phases of the negotiation model: the content phase (discussion of problems), the relationship phase (phase of trust and attachment), and the problem solving phase.[7] I noticed that in all the phases a translator's assistance had to be taken. In the relationship phase, the patient gave more importance to the translator than to the dermatologist, as the translator knew the patient's language. This was reflected in the follow-up visits, when the patient was more attached to the translator than to the dermatologist.[7] It may be due to the emotional support of the translator towards the patient as the translator could understand the patient's emotions through communication. The attachment theory by Bruni et al[8] states that a patient completely relays his/her emotions upon the doctor. Therefore dermatologist's duty goes beyond prescription and he/she has to heal the patient's emotions through effective communication. A patient's emotional attachment to a doctor and the doctor's support to the patient are strong binders in the physician–patient relationship.

I noticed that patients for whom I was taking a translator's assistance were hesitant to discuss confidential problems. In communicating with a patient, especially about sexually transmitted infections, HIV, and leprosy, there can be awkward moments. A recent thematic and sequential analysis of videotaped physician–patient discussions on HIV risk showed that communicating with patients, even in their own language, about these topics could be

embarrassing to them.[9] Taking a translator's assistance would be further embarrassing, resulting in poor communication.

Language has a vital role in capturing the patient's perspective and in the information-sharing phase of a medical interview. Patients feel comfortable and secure with a dermatologist speaking their language. History taking with a translator's assistance is time consuming and can result in misinterpretation.[10] Misinterpretation and delay in communication through a translator's assistance lead to patient dissatisfaction, non-compliance, non-adherence to therapy and a poorer clinical outcome.

A dermatologist taking a translator's assistance might not be able to share information during the medical interview. However, a dermatologist who speaks the patient's language will win the patient's trust, satisfaction, achieve a better outcome and improve adherence to long-term treatment protocols (e.g. phototherapy, pulse therapy for pemphigus and treatment of collagen vascular diseases) that require good communication and convincing ability.

Dermatologists from the same linguistic area should be recruited or posted in clinics. The appointing authorities for dermatologists posted outside their linguistic region should consider language training and periodic language evaluation for them.

Even in a visual specialty like dermatology, language plays a vital role in cementing a successful dermatologist–patient relationship. It may be worthwhile to undertake research to determine the convincing ability of a dermatologist, a key denominator in the physician-patient relationship, and measures to overcome linguistic barriers.

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ACKNOWLEDGEMENT

I acknowledge Dr. Bart Laws. Ph.D., M A. Senior Investigator in Social Science and Policy, Latin American Health Institute, 95 Berkley St., Boston MA 02116, U.S.A. for his constructive review and suggestions on this manuscript

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