HEALTH-CARE ACCESS IN A RURAL AREA: PERSPECTIVES FROM
RUSSIAN-SPEAKING IMMIGRANTS, ENGLISH-SPEAKING DOCTORS,
AND VOLUNTEER INTERPRETERS

A Dissertation in
Applied Linguistics

by
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Health-care access for immigrants in the United States is often problematic because of language barriers, lack of health insurance, or differing expectations based on divergent medical systems in the U.S. and the immigrants’ home countries. Such difficulties are exacerbated when a linguistic-minority population lives in a rural community that has limited health-care-access resources for non-English-speakers. In the current project, I investigate an immigrant community in an area of Pennsylvania that has recently become a destination for Russian-speaking immigrants. Their numbers have been estimated at 2,000 people. Some have strong proficiency in English, but many do not, especially the elderly. In the study context, there are very few medical personnel with language skills in both English and Russian, few intermediaries trained in medical interpretation for those languages, and a scarcity of Russian-language print materials.

Using a directed approach to content analysis, I analyze data from semi-structured interviews with three groups who have a significant stake in the issue of health-care access: recent Russian-speaking immigrants from the former Soviet Union (n=12); English-speaking staff members at a medical and social services facility where many of the immigrants seek help (n=5); and volunteer interpreters who act as go-betweens for Russian-speaking patients and English-speaking personnel (n=3).

Based on the coding and analysis of the data, particularly salient issues included: 1) the role of language as an entry point or impediment to health-care access (language and language accommodation) and 2) the impact of immigrant and U.S. health-care beliefs on medical behavior (health-care socialization). Regarding language and language accommodation, I consider the following questions using data from the stakeholders’ interviews:

- What kind of language accommodation is portrayed as desirable?
- Who is responsible for providing the interpreter?
• What roles do non-professional/non-naïve interpreters take on?

In regard to *health-care socialization*, I address the following issues using data from the stakeholders’ interviews:

• How are “good doctors” portrayed?
• How are “good patients” portrayed?
• How is use of medications portrayed?
• What effects are associated with divergent logistics of the medical systems?
• What attitudes surround prices, payments, and quality of care?

In the three participant groups’ discussion of these issues, there are areas of convergence. For instance, all share the sense that medical costs in the U.S. present a barrier to access, and all recognize the need for medical bilingualism in interpreters. There are also a number of potentially significant divergences, especially around attitudes toward medical compliance and use of medications, and the logistics of approach to medical care.

In the conclusion, I synthesize the research literature and my own empirical findings to suggest ways of increasing the health-care access of the Russian-speaking community in the study context and, by extension, of other linguistic-minority groups in areas far from the resources available in large cities.
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Chapter 1

Introduction

Three Vignettes

(1) “They [U.S. doctors] begins with the strongest treatment, is antibiotics, it’s a lot of antibiotics. And I don’t know, maybe for Americans it’s good, but they came from Russia. In Russia, the doctors they begin with the mild treatment, and so for many Russians it’s like a shock.”

—Immigrant from the former Soviet Union

(2) “They [immigrants from the former Soviet Union] feel ... if you’re on medication for any extended period of time, you’re doing some— you’re doing harm to your body, and I’ve told them many times that we have blood tests for that, to make sure your liver’s OK....”

—American ally of the Russian-speaking community

(3) “This lady’s delightful— but she doesn’t take her medicines.... When she’s here, she says she will. Her ((relative)) understands English, she interprets right at the time, and you think everything’s great, gives you a hug goodbye, we’re wonderful, but she doesn’t take them. She doesn’t take them.”

—Clinician, speaking of an immigrant from the former Soviet Union

Introduction

Health-care access for immigrants in the United States is often problematic because of language barriers, lack of health insurance, or differing expectations based on divergent medical systems in the U.S. and the immigrants’ home countries. Such difficulties are exacerbated when a linguistic-minority population lives in a rural community that has limited health-care-access resources for non-English-speakers. In the current project, I investigate an immigrant community in an area of Pennsylvania that has recently become a destination for Russian-speaking
immigrants. Their numbers have been estimated at 2,000 people. Some have strong proficiency in English; many do not, especially those who are elderly. The area has few linguistic resources for accommodating their needs: There are extremely few medical personnel with English-Russian bilingualism, few intermediaries trained in medical interpretation for those languages, and a scarcity of Russian-language paperwork.

The study explores factors that affect the health-care access of this immigrant community and, conversely, the ability of the medical community to provide care to the immigrants. Particularly salient issues include the role of language as an entry point or impediment to health-care access; the activities of unofficial social support networks such as volunteer interpreters who emerge from the lay community; and the impact of health-care beliefs (of both the immigrant and U.S. medical communities) on medical behavior. We can see each of these factors at work in the three vignettes with which I began this chapter, and we will encounter them many times in the chapters that follow.

In the study, I analyze data from interviews with three groups who have a significant stake in the issue of health-care access: recent Russian-speaking immigrants from the former Soviet Union (n=12); English-speaking staff members at a medical and social services facility where many of the immigrants seek help (n=5); and volunteer interpreters who act as go-betweens for Russian-speaking patients and English-speaking medical personnel (n=3). Analyzing data from these three groups provides a multifaceted lens on the complex questions around health-care access. It is my hope that this approach will allow us to better understand both the convergences and the divergences between the three groups in terms of the beliefs and behaviors they describe, since those areas of overlap and tension are likely to significantly affect health-care access.
Organization of This Chapter

This introductory chapter begins with a brief discussion of two prior studies I conducted that provided background information and initial conceptual foundations for the current study. Following that section is a statement of the central research question and the significance of this investigation. The chapter concludes with an overview of the organization of the dissertation as a whole.

Related Prior Projects

I conducted two prior studies exploring the intersection of health-care access and communication in a community of immigrants from the former Soviet Union, and these have informed the design and analysis of the current study.

Prior Study 1: I analyzed the health-care attitudes and behaviors of a Russian/Ukrainian immigrant couple, who described challenges they encountered while seeking medical care in the United States (Brua, unpublished M.A. paper). In 2001 and 2002, I conducted a series of interviews with Tatyana and Ivan (pseudonyms), a couple who had immigrated to the United States from Ukraine in the mid-1990s. The study was intended to describe their perceptions about health-care access in the United States, as well as the role of language in that access. I transcribed the interviews, which were conducted in English, and analyzed them using discourse analysis and a grounded theory approach (Glaser & Strauss, 1967).

While the role of language was a primary concern of mine as an applied linguist, I was somewhat surprised to find that Tatyana and Ivan portrayed other factors as bigger issues. They reported being generally satisfied with U.S. doctors’ attempts to use understandable English during medical visits. However, barriers related to logistics of access to the U.S. system (and thus
to the divergent health-care experiences of people growing up in the former Soviet Union and the United States) were very salient for the couple.

For instance, they prominently discussed their lack of medical insurance, which prompted them to seek medical care only in serious situations. A related concern was the high cost of medical care, which they were obligated to pay themselves when they did seek treatment. Tatyana noted that some medications that would have been available over the counter in the former Soviet Union were only available with a prescription in the United States, a situation she experienced as a barrier:

Tatyana: Here I has uh ... high blood pressure ... and comes to the drugstore and say "I have ... high blood pressure, do you have a medicine you can give me medicine." But she [the pharmacist] says, “I can’t, you need to go to the doctor.” I can’t go [LAUGH QUAVER] to the doctor because I don’t have medical insurance.

In addition, Tatyana and Ivan discussed what they considered to be a lack of fairness in the U.S. health-care system: They felt that even if dissatisfied with treatment, they had no recourse but to pay their bills, which they considered to be far more expensive than the services warranted. These two themes—frustration with financial constraints on health-care access, and skepticism about the fairness of the U.S. system—are not unique to immigrants. Indeed, they are widespread in domestic discourse about health-care in the United States. However, immigrants from the former Soviet Union also are likely to be influenced by their experiences under the medical system there, and thus, health-care socialization—the way in which our past experiences shape our expectations regarding medical interactions—will come into play.

Tatyana and Ivan also talked about ways they used unofficial resources to “work around” perceived impediments. So, for example, when one of their children became ill and they felt that their U.S. doctor was unable to cure the problem, Tatyana telephoned specialists in the former Soviet Union for advice. She additionally procured medicine from the former Soviet Union to treat the child, and she attributed his recovery to these measures. (She remarked with a laugh: “I
understand that here doctor knows only ones [sic] medicine—it's Tylenol. That’s all.”) In the current study, we will similarly see several instances of immigrants’ attempts to provide alternative resources when they are dissatisfied with either the treatment or access available through medical facilities in the U.S. In addition, we will see numerous instances of skepticism about the quality of U.S. health care, often couched in statements about U.S. medical staff members’ training, pharmaceutical choices, or level of concern about their patients. Of course, in examining such skepticism on the part of patients, it will be important to look deeper for underlying factors that might be motivating their views.

Thus, even before the current project commenced, I was alerted to the probable importance of several themes—concern about financial constraints on health-care access; perceptions of unfairness; willingness to use unofficial medical channels when dissatisfied; and skepticism about quality of care—and wished to explore them with a larger sample of participants from the Russian-speaking immigrant community.

*Prior Study 2: As part of my comprehensive exams process, I located and interviewed two key informants from the former-Soviet immigrant community in the autumn of 2004. During this pilot study, I investigated the following themes:*

- Ways in which unofficial systems of help emerged within the immigrant community (e.g., via religious groups, via help from friends and neighbors, etc.);
- How immigrants found their way to good doctors;
- The perceived role of communication between patients and doctor when they did not share similar degrees of proficiency in their available languages;
- Perceptions about where barriers to health-care access resided (e.g., in knowledge, language skills, attitudes, or other factors);
- Ways to disseminate medical information to the Russian community;
• Ways to share useful information about health-care access between the immigrant and medical communities (Cameron, Frazer, Harvey, Rampton, & Richardson, 1992; Kemmis & Wilkinson, 1998; Rose & Garwick, 2003; Stringer, 1999; Wallace, 1998);

• Narratives about experiences when helping other immigrants as interpreters (questions inspired by Goodnow, Lawrence, Ryan, Karantzas, & King, 2002).

For the pilot test of the semi-structured interview questions, I was seeking two to three former-Soviet immigrants who now live in the study community. Specifically, I was seeking immigrants who speak Russian or another Slavic language as their first language and who have moved to the study community since the late 1980s. While many of this population came under refugee status, for simplicity I will generally refer to the population en masse using the general term “immigrants.”

Additionally, I was seeking participants from the study context’s Russian Baptist congregation or other evangelical Christian movements, because evangelical affiliation is a defining factor for many people in the local Russian-speaking immigrant population. A number of the original members of the community were evangelical pastors who fled the Soviet Union and its successor states because of persecution (Dr. Catherine Wanner, Penn State Department of History, personal communication, April 15, 2002). I eventually found that my understanding of the Russian immigrant community was oversimplified—one of my informants turned out to be a Russian immigrant who had extensive ties to the Baptist community but who was herself not a member of that religious group.

Because of external constraints, I needed to conduct and process the pilot interviews within a two-month period. This led to an additional selection criterion: that the interviewees be able to understand English well enough to answer the questions in English. While I have a low-level knowledge of Russian, my fluency is much too limited to conduct interviews on health-care
topics, and there was no time to hire Russian-speaking co-investigators to conduct, transcribe, and translate interviews.

My attempts to locate potential interviewees took three paths, all using snowball sampling. I asked: a) people I knew in the former-Soviet community to recruit relatives, friends, or acquaintances; b) a graduate student from the former Soviet Union to make contact with leaders of the local Russian Baptist congregation; c) and an ESL teacher with Russian clients whether any might be interested in an interview.

All three of the approaches yielded the names of potential interviewees. In the interest of IRB compliance, I preferred that the potential interviewees call me to express interest, rather than my “cold-calling” the person based on a third-party referral. In this way, I received a call from Masha (pseudonym), who had been contacted by the graduate student from the former Soviet Union. After I received human-subjects approval for the pilot study from Penn State’s Institutional Review Board, Masha and I scheduled an interview at her home on Oct. 25, 2004. During this initial interview, her friend Oksana (pseudonym) stopped by. Masha and I explained the purpose of the interview to Oksana, who agreed to be interviewed the following night.

Both Masha and Oksana agreed to take part in follow-up interviews one week later. However, a severe emergency arose for Masha’s family, and she was unable to do the follow-up at that time. I decided not to re-interview her, in order not to burden her in light of her ongoing family emergency and because of my own time constraints. Thus, my pilot data included one 45-minute interview with Masha and two 45-minute interviews with Oksana, whose follow-up was held on Nov. 2, 2004. I then transcribed the interviews.

Both participants were women between the ages of 30 and 40. Both were married and were mothers. Both told me they knew little English before arriving in the United States, but in the years since, both had become highly proficient in English. Both reported serving many times as volunteer intermediaries between Russian-speaking patients and English-speaking medical
personnel, and both demonstrated knowledge of English medical vocabulary during the interviews. As noted above, I conducted these pilot interviews in English because of the narrow window for transcribing and analyzing the data. The choice of English also seems justifiable on theoretical grounds: Both of the pilot participants were serving as volunteer intermediaries between the Russian-speaking community and the English-speaking medical community, so their proficiency in English was a salient issue.

Masha had lived in the United States for several years, although her arrival in the study community was much more recent. She was a member of the Russian-speaking Baptist congregation that is attended by many of the refugees and immigrants.

Oksana had been in the United States for several years and had become a U.S. citizen. She was not a member of the Baptist congregation, although many of her interpreting clients were Baptists. She said she came here as an immigrant, not a refugee, and she emphasized the importance of entry status, which affects access to public assistance as well as how soon newcomers may bring other members of their family to live in this country.

I asked these volunteer interpreters about various types of informational, emotional, and instrumental social support that was available within the immigrant community. Their interviews, which were reanalyzed for the current project using the coding procedures described in Chapter 3, will be considered in detail in the volunteer intermediary data chapter (Chapter 6), but in general, they indicated that:

- There is a pressing need for interpreters who have a command of medical terminology in both Russian and English. Many immigrants with low English proficiency enlist more proficient relatives as intermediaries when dealing with medical personnel. Masha and Oksana cautioned that such naïve interpreters have serious drawbacks, as when a child is asked to translate medical terminology that he/she does not understand.
• The degree of coordination of community-internal social support does not appear high. Information about community members’ health needs and illnesses seems to be passed mostly via word of mouth. Masha also said that congregants’ health problems are sometimes announced at the Russian Baptist church.

• Differing cultural expectations related to medical care can cause confusion and frustration for the immigrants (and by extension, the medical personnel treating them). Thus, the preliminary studies suggested to me that the local health-care context had a considerable distance to go before it could achieve alignment with the federal Culturally and Linguistically Appropriate Services in Health Care (Office of Minority Health, 2001), at least as regards the “mandates” in standards 4-6:

  **Standard 4.** Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation….

  **Standard 5.** Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services….

  **Standard 6.** Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer). (pp. 8-10)

Another theme that emerged from initial analysis of the interviews with Masha and Oksana was the importance of considering intra-community variation such as differences in immigration status, since these might affect access to resources such as government-supplied health-care access cards. In addition, the pilot study allowed me to refine my study goals. For instance, while I maintained an interest in the social-support networks to be found in the immigrant community, I discarded the communal-coping theories of Lyons, Mickelson, Sullivan, and Coyne (1998) as not germane to my research objectives.
Central Question and Significance of the Study

As will be detailed in the methodology chapter (Chapter 3), the central research question evolved from the prior studies and my lengthy engagement with the data in the current study. The research question can be stated as follows: In this health-care context—which involves Russian-speaking doctors, English-speaking medical staff, and bilinguals serving as intermediaries for the other two stakeholder groups—how do factors related to language resources and health-care socialization enhance or impede access to quality health care?

In exploring this question, my study makes a contribution to the literature on social support, health-care use, and language accommodation in linguistic-minority contexts, especially in areas distant from big cities. It is also my hope that information from the study will prove valuable to medical providers and immigrant communities as they work to achieve better health-care access for linguistic-minority residents of the United States.

Organization of the Dissertation

Chapter 2 presents a review of the literature surrounding two topics of central interest in the current study:

1) Interpreting in cross-linguistic/cross-cultural medical interactions, with particular focus on U.S. policy toward language accommodation; studies discussing the efficacy of various types of interpreters; and taxonomies of medical interpreting.

2) The divergent health-care socializations that have been experienced by residents of the former Soviet Union and residents of the United States. Significant differences between the health-care systems in those two geographic/cultural regions are likely to affect the attitudes and
behaviors of immigrant patients, U.S. doctors, and the volunteers who act as intermediaries for the other two groups.

Chapter 3 presents the methodology used in the study, with details about participant recruitment, data collection, and the transcription and coding of interviews.

Chapter 4 presents data from interviews with eight recent immigrants from the former Soviet Union. Salient issues include participants’ comparisons of the U.S. and former-Soviet medical systems; language skills; cost factors; the roles taken on in the U.S. by immigrant medical personnel; and portrayals of medical personnel.

Chapter 5 presents data from interviews with five staff members at a medical facility that serves many immigrants from the Russian-speaking community. Salient issues include patient-supplied intermediaries who serve as interpreters; language proficiency; the role of volunteers; and narratives about patient compliance.

Chapter 6 presents data from interviews with three people who function as “volunteer intermediaries” in interactions between Russian-speaking patients and English-speaking doctors. Their language proficiency and knowledge of the health-care system make them more skilled than so-called “ad hoc” interpreters such as naïve family members of patients. At the same time, while these volunteers do function as interpreters, they take on additional roles outside the purview of professional, institutionally based interpreters, and their lack of professional training may sometimes lead them into ethical gray zones. Salient issues include interpreter identity, language proficiency, and participants’ portrayals of the U.S. health-care system.

Chapter 7, the conclusion, integrates the findings from the data chapters to show major themes across participant groups, as well as areas of implicit or explicit thematic conflict between the stakeholders. The chapter concludes with recommendations that might serve to improve medical communication between the three stakeholder groups and increase the Russian-speaking community’s access to quality health care.
Chapter 2

Review of the Literature: Medical Interpreting and Health-Care Socialization

Introduction

In order to provide explanatory support for the data and discussion chapters that follow, this chapter explores the literature relating to two major areas of concern in this dissertation: 1) Medical interpreting and 2) health-care socialization (i.e., the ways in which members of a culture learn to navigate the health-care systems in their culture).

In regard to medical interpretation, the following topics are most salient:

a) Government policies regarding the obligation of medical facilities to provide medical interpreters for patients;

b) Research findings concerning the efficacy of various types of medical interpreters, as well as issues unresolved in the literature;

c) Two major approaches to categorizing medical interpreters: first, a taxonomy based on training and identity, which I will critique and adapt in order to structure my discussion of the interpreters in my study, and secondly, a family of taxonomies based primarily on role during the appointment, from which I will take terminology for describing interpreters in action.

In regard to health-care socialization, the following topics are most salient:

a) The socioeconomic and health-related conditions historically experienced by Soviet and post-Soviet citizens, and thus by the immigrant participants in my study;

b) Particular health-care beliefs and behaviors that are influenced by such conditions and experiences;
c) Ways in which the health-care socialization in the American system may run counter to the expectations of immigrants from the former Soviet Union.

**Medical Interpretation**

**Federal Policy around Medical Interpreting**

Clear communication is important in many areas of human social life, and medical encounters are surely among the areas where it is most crucial. Health-care communication even in what is ostensibly a single language can be a form of intercultural communication, at least when a medical professional and a layperson are involved, because of differences in register, jargon, explanatory models, and preferred healing practices (Candlin & Candlin, 2003; Davidson, 2001; Good, 1994; Greenhalgh, Robb, & Scambler, 2006; Loustaunau & Sobo, 1997). In situations where the provider and patient are not fluent in each other’s available languages, the situation seems likely to become even more difficult, since one “channel” for negotiation of meaning is either impaired or missing completely.

In the United States, several policies at the federal level have taken up the issue of providing language accommodation to patients with Low English Proficiency (LEP). For instance, federal adoption of Title VI of the Civil Rights Act of 1964 began a series of far-reaching changes in American society, as the Johnson Administration made attempts to mitigate or reverse longstanding structures that promoted discrimination against African-Americans and other groups on the basis of “race, color, or national origin” (U.S. Department of Health and Human Services, 2003: pp. 47311-47312). The law regarding national-origin discrimination was found to protect people with Low English Proficiency in a 1974 U.S. Supreme Court ruling, and subsequent “policy guidance” documents from various federal departments have affirmed this protection, as did Executive Order 13166, issued in 2000 (U.S. Department of Health and Human
Services, 2003). However, in addition to protecting LEP residents’ access to federally funded programs (including health care), the guidance documents also stress the need to minimize financial burdens that such protection imposes “on small businesses, small local governments, or small non-profits that receive federal financial assistance” (U.S. Department of Health and Human Services, 2003: p. 47313). In order to achieve both the protection of LEP patients from denial of access and the protection of providers from excessive financial burdens, the U.S. Department of Health and Human Services suggests that recipients of federal funds weigh the following factors: proportionally how many of their clients have Low English Proficiency; how often LEP clients seek services; how important the service provided is (in the case of health care, very important); and how costly it will be to accommodate LEP clients in light of available resources (U.S. Department of Health and Human Services, 2003). The department adds:

Resource and cost issues, however, can often be reduced by technological advances; the sharing of language assistance materials and services among and between recipients, advocacy groups, and Federal grant agencies; and reasonable business practices. Where appropriate, training bilingual staff to act as interpreters and translators, information sharing through industry groups, telephonic and video conferencing interpretation services, pooling resources and standardizing documents to reduce translation needs, using qualified translators and interpreters to ensure that documents need not be “fixed” later and that inaccurate interpretations do not cause delay or other costs, centralizing interpreter and translator services to achieve economies of scale, or the formalized use of qualified community volunteers, for example, may help reduce costs. (p. 47315)

In regard to community volunteers, the guidance document notes:

To the extent the recipient [i.e., the medical provider] relies on community volunteers, it is often best to use volunteers who are trained in the information or services of the program and can communicate directly with LEP persons in their language. Just as with all interpreters, community volunteers used to interpret between English speakers and LEP persons, or to orally translate documents, should be competent in the skill of interpreting and knowledgeable about applicable confidentiality and impartiality rules. (p. 47317)

The guidance document elsewhere states: “Competency to interpret, however, does not necessarily mean formal certification as an interpreter, although certification is helpful” (p. 47316). The document also advises that family members and especially minor children not be
used in medical interpreting, although the patient’s wishes should be followed in most instances; in any case, the provider is required to offer the patient the opportunity to use a free interpreter provided by the facility. If the provider determines that a family member is insufficiently skilled to interpret (or that the family member is suspected of abusing the patient for whom he/she is interpreting), the provider is instructed to bring in a skilled interpreter as a supplement or replacement. The 2003 guidance document thus gives providers rather wide latitude in selecting the kinds of interpretation accommodation they provide, as well as the difficult responsibility to weigh many competing factors.

The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care (Office of Minority Health, 2001), another widely cited group of federal guidelines, are at first glance more specific in terms of what they require. The CLAS document contains the following “mandates” for any medical provider receiving federal funds, such as reimbursements from Medicare or Medicaid (Office of Minority Health, 2001):

**Standard 4:** Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.…

**Standard 5:** Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.…

**Standard 6:** Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).…

**Standard 7:** Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area. (pp. 8-11)

However, in the case of these mandates as with the guidance document discussed above, a certain degree of “wiggle room” is built in. The CLAS document notes:
[I]t is important to view the CLAS standards as a framework that describes the types of cultural competence activities that an organization should undertake in the context of its size, location, organizational type, and available resources. In the final version, some standards (related to language access services) are described as mandates. These standards simply reflect current Federal requirements for recipients of Federal funds. However, these Federal requirements are also intended by HHS to be implemented flexibly in relation to the individual characteristics of the organization. (p. xiv)

The political force behind Title VI and outgrowths such as the CLAS Standards has not been sufficient to actually make language accommodation a reality across the board in the United States. Lack of funding, and the extreme diversity of languages spoken in the U.S., are among the reasons often noted for the distance between ideal and reality (Ku & Flores, 2005; U.S. Department of Health and Human Services, 2003).

Efficacy of Interpreting

Many studies have addressed problems that can occur when patient and medical provider cannot achieve mutual comprehension because of divergent language resources (see, for example, Chan, Alagappan, Rella, Bentley, Soto-Greene, & Martin, 2008; Derose, 2000; Flores, Torres, Holmes, Salas-Lopez, Youdelman, & Tomany-Korman, 2008; Ginde, Clark, & Camargo, 2008; Ku & Flores, 2005; Leanza, 2005; Ngo-Metzler, Sorkin, Phillips, Greenfield, Massagli, Clarride, & Kaplan, 2007; Regenstein, Mead, Muessig, & Huang, 2008). Without a language-based channel of communication, both the patient and physician would seem to be in increased danger—the patient in terms of adverse health outcomes, including death, and the physician in terms of malpractice lawsuits and psychological distress when patients suffer needlessly.

As we have seen above, health-care providers who receive federal funds are required to provide language accommodation for patients who have Low English Proficiency. In the realm of medical interpretation, the policies establishing the accommodation suggest that various kinds of interpreters might be used—with trained interpreters preferred, but with situational constraints
also allowing the use of family members, bilingual medical staff, trained interpreters, telephone services, or other resources. In this section, I will briefly review the research literature on the efficacy of medical interpreting by various types of interpreters in terms of effects on patient outcomes and costs.

Flores (2005), in a review of 36 research articles, reports that lack of trained interpreters—a condition that Flores defines as having no interpreter at all or relying on ad hoc interpreters such as family members or medical staff who were not trained in interpretation—was associated with many problems, including decreased patient understanding. Flores adds that “ad hoc interpreters misinterpret or omit up to half of all physicians’ questions, are more likely to commit errors with potential clinical consequences, have a higher risk of not mentioning medication side effects, and ignore embarrassing issues when children are ad hoc interpreters” (p. 273). In terms of outcomes and costs, Flores adds that “trained interpreters generally result in better health processes, outcomes, and use of services, but additional research in this area is warranted, and greater insight is needed on the effect of interpreter services on visit duration” (p. 292). Flores concludes by saying that additional research is needed but that “optimal communication, the highest patient satisfaction, the best outcomes, and the fewest errors of potential clinical consequence occur when LEP patients have access to trained professional interpreters or bilingual health care providers” (p. 296).

Goode, Dunne, and Bronheim (2006) surveyed 25 studies to explore whether “cultural and linguistic competence” on the part of medical providers led to better health outcomes for patients and/or reduced costs for the health-care system (p. vii). They found that the concept of cultural and linguistic competence has not been consistently defined in much of the research literature and that much of the literature is methodologically flawed. They suggest that the literature shows “great promise” of eventually demonstrating a trend toward better health outcomes for patients when providers have cultural and linguistic competence, but they also note
that better research is necessary to confirm this possibility (p. viii). They write:

The current evidence provides information about intermediate outcomes of short-term interventions, but none directly address the ultimate outcome of decreased incidence of a disease for a population, or a decrease in morbidity or mortality as a result of the intervention used. Instead, intermediate outcomes such as increased rates of cancer screening or improved HbA1c levels were measured. (p. vii)

In terms of the business case, they report that the current literature has shown mixed results and has not conclusively established whether culturally and linguistically competent care reduces or raises costs. Again they call for better-designed, more long-term research to explore this question.

Karliner, Jacobs, Hm Chen, and Mutha (2007) focus their review of 28 studies somewhat more narrowly by including only those that deal with the effects of medical interpreters. Karliner et al. categorize the interpreters mentioned in the studies they review as either professional (hired to interpret by a health-care facility, although they note that levels of training differ from site to site) or ad hoc (family, staff, or volunteers who lack training in interpreting). They note that some past reviews, including Flores (2005), described above, were based on studies that did not differentiate between professionals and ad hoc helpers. In evaluating the results of the studies in their review, Karliner et al. look at four areas: “communication errors and patient comprehension, utilization, clinical outcomes, and satisfaction” (p. 729). They conclude:

Taken as a whole, the findings of this review suggest that professional interpreters are associated with an overall improvement of care for LEP patients. They appear to decrease communication errors, increase patient comprehension, equalize health care utilization, improve clinical outcomes, and increase satisfaction with communication and clinical services for limited English proficient patients. (p. 748)

They add that the improvement is greater when the interpreter is a professional rather than an ad hoc interpreter, and they also suggest that the use of professionals can help LEP patients to attain care that is comparable to that experienced by proficient speakers of English.

As might be gathered by this brief overview of literature on efficacy of medical interpreting, and as suggested in Goode et al. (2006), much research remains to be done in order
to clarify the effects of interpreting in general and of particular kinds of interpreters. In order to lay the groundwork for the data on the interpreters in my study, I will now turn to two medical-interpreting taxonomies from which I will draw conceptual support.

**Taxonomies of interpreting**

This section will explore two main approaches to categorizing medical interpreters. The first comes from a study that focuses on the interpreter’s identity or degree of training in linguistic/cultural mediation and medical concepts/terminology. The second comes from a group of studies that focus on the roles taken by the interpreter while acting as a linguistic or cultural mediator.

1) **Categorization on the basis of identity or training**

Whereas much of the literature focuses on interpreters with some official institutional affiliation, Hsieh (2006) expands her discussion to include interpreters who have little or no training but who nonetheless are often pressed into service by families or medical facilities. Additionally, rather than discussing interpreters in terms of operational role (e.g., clarifier, broker, etc.), she categorizes them in terms of training/preparedness for medical interpreting. She proposes the following taxonomy as valuable:

- **Chance interpreters:** Family or friends of patients, or simply available strangers who are bilingual to some degree in the languages used by the medical providers and the patient. While this type of interpreter has the potential advantage of being a person known and trusted by the patient, chance interpreters do not necessarily have command of medical terminology in either language, and almost certainly do not have training in
interpretation.¹

- **Untrained interpreters:** The distinction here is that the interpreter has a paid role but does not have training as an interpreter. Examples would include “support staff” at the medical facility (p. 179) such as a radiology technician, dietitian, or nurse pressed into service because he/she speaks (to some degree) the languages of the medical provider and the patient. Medical knowledge is more likely in this category than in the “chance interpreter” category.

- **Bilingual physicians:** These are doctors who have some degree of bilingual ability, including some command of medical terminology, in both languages. People in this category are medical providers first, rather than language intermediaries, and they have not been trained in interpreting. Hsieh stresses that bilingual physicians often evaluate their own proficiency in the patient’s language too highly, and she additionally emphasizes that having lexico-grammatical knowledge is not the same as having deep understanding of the culturally influenced beliefs and practices of the patient.

- **On-site interpreters:** In Hsieh’s taxonomy, these are trained interpreters, with strong medical bilingualism and bicultural understanding, stationed at the medical facility. The disadvantage Hsieh notes with this kind of interpreter is that they often are not available (i.e., they are too few or do not exist at all at many facilities) for reasons that include employment costs.

- **Telephone interpreters:** These are also trained interpreters with high levels of medical bilingualism and cultural knowledge. Hsieh notes that their inability to see the patient and provider can be a major disadvantage (although I would note that increasing use of

¹Nonetheless, a number of researchers have found a patient preference for trusted family members and friends, as opposed to institutionally affiliated interpreters, for reasons of privacy and a sense that known interpreters will care more than strangers, as well as availability to help at home (Edwards, Temple, & Alexander, 2005; Morales & Hanson, 2005; Rhodes & Nocon, 2003; Robinson & Gilmartin, 2002).
videoconferencing might mitigate that problem).

Hsieh argues that adopting this taxonomy would allow researchers to better understand medical interpreting. She notes that past studies have found mixed results about whether medical interpreters lead to improved or worsened patient outcomes, and she suggests that these mixed results stem in part from researchers’ lumping all kinds of interpreters into a single category despite their substantial differences (a criticism also made by Karliner, Jacobs, Hm Chen, & Mutha [2007], as noted above). Hsieh also argues that use of nonprofessional interpreters might be a valid option in some circumstances, if findings of communication research are used to guide the process. For instance, she cites research recommending that chance and untrained interpreters be required to back-translate physicians’ instructions to enhance quality control. In other words, after the interpreter has relayed information from the physician to the patient, the patient is asked to repeat what the interpreter said; the interpreter then tells the physician what the patient said. However, it seems to me important to wonder whether the information would not still be vulnerable to distortion, since the physician only has the interpreter’s word for what the patient said/understood.

2) Categorization on the basis of role

A number of researchers have categorized interpreters on the basis of the functions they carry out before, during, or after the medical interaction, and those categorizations will be considered in this section.

Beltran-Avery (2001) chronicles the arguments weighed by a working group of stakeholders in the medical interpreting field. An early emphasis on the conduit role (machine-like transfer of information, word-for-word from one language to the other) was later expanded, she writes, to consider other potential roles:
• A communication manager who helps patient and provider understand one another’s words, concepts, and culturally influenced worldviews, and who regulates the give-and-take of the conversation to preserve accuracy\(^2\) (p. 7);

• An incremental interventionist who is knowledgeable about the provider and the patient’s respective communities and who takes whatever action is necessary to assure high-quality communication—including interpretation, culture brokering, and advocacy (p. 9);

• And finally an embedded interpreter who, having an identity as part of the patient’s community, observes community norms such as gender and age taboos concerning the topics that can be discussed (p. 10). Beltran-Avery notes: “In these situations, as in the incremental intervention approach, transparency is again of utmost importance in order to maintain trust among the members of the triad. Each party in the triad needs to be aware of the responsibilities the interpreter is prepared to assume through training and experience” (p. 11).

Beltran-Avery writes that each of the four stances detailed by the working groups has its place:

“Without the conduit perspective, the profession runs the danger of losing its focus. Without the embeddedness perspective, it runs the danger of losing the heart and spirit of those for whom the survival of their communities is paramount” (p. 15). She adds:

In the middle are the perspectives of the interpreter as manager of the communication process and of the incremental intervention model. These two perspectives focus primarily on the functions and tasks that the interpreter performs in the interest of making possible the communication between the two parties and the development of shared meaning. These two perspectives move in either direction—sometimes closer to the conduit approach and sometimes closer to the embeddedness approach—depending on the context of the interpreter-mediated encounter. (p. 15)

\(^2\)Roy (1992), however, in a study of interpreting between a professor and student, notes that an interpreter might defer to the relative social power of the interlocutors in allocating turns. As we will see below, Angelelli (2004) makes similar observations about interpreter allegiance in medical settings.
Questions about flexibility of interpreting roles also loom large for Dysart-Gale (2005), whose argument derives in part from Beltran-Avery’s article. In order to examine interpreters’ confusion about their expected roles, Dysart-Gale first discusses interpreting literature that describes the following roles: a) a message conduit, a word-for-word converter of information from one language to another (a role she cites from the Cross Cultural Health Care Program’s code of ethics for medical interpreters); and b) a clarifier, an intermediary who can paraphrase and expand on information when the languages contain no word-for-word correspondence for a particular concept; c) a culture broker, who provides additional background information to help the patient and doctor understand each other’s worldviews; and d) a patient advocate, who can work with the patient even when no doctor is present to make sure the patient’s holistic needs are met by the health-care system (the latter three being roles that she attributes to Beltran-Avery, 2001).

In conducting interviews with 17 medical interpreters, however, Dysart-Gale found that they often faced dilemmas about which role was appropriate to adopt at any given moment. One of Dysart-Gale’s interpreters, for instance, told an anecdote about a pregnant woman who had just had a miscarriage; once the doctors left the room, the interpreter was unsure whether she was allowed to offer her own sympathies to the mother (since this would be an independent action rather than message transmission). The interpreter was doubly troubled because she knew the patient in the outside world and was uncertain whether talking about the death with the mother there would be an ethical violation. Other interpreters mentioned being burdened by doctors who handed them patients’ paperwork and medicines and then left, expecting the interpreter to shepherd the patient through discharge and answer any medical questions the patient might have.

Dysart-Gale discusses communication theory to shed light on interpreter practice, noting a distinction in the literature between “technical” or “transmission” models and “therapeutic” or “ritual” models (p. 99). She writes:
Thus, rather than viewing communication as the transmission of information between individuals, the ritual conceptualization views individuals as creating, affirming, negotiating, and maintaining their environment through communication. The ritual view has great descriptive power in modeling clinical interactions as, for example, in the case of the interpreter whose acquaintance had suffered a miscarriage. When the doctors and nurses left the room, there was no information remaining to be transmitted. There was, however, much more to say: The interpreter felt the need to join in the woman’s life world, to affirm her loss and express her condolences. (p. 99)

Like Beltran-Avery (2001), Dysart-Gale ends by arguing for interpreting standards that allow interpreters to shift as needed between conduit-style work and the more “ritual” styles (which would include the aforementioned clarifier, culture broker, and patient advocate roles). She suggests that additional research is needed in order to provide workable guidelines to interpreters as they navigate challenging situations.

A sustained critique of the notion of the conduit metaphor of interpreting and the idea of interpreter “invisibility” is found in the work of Claudia Angelelli. In her 2004 book *Medical Interpreting and Cross-Cultural Communication*, Angelelli strongly criticizes depictions in which the ideal interpreter is portrayed as transparent relay station/conduit rather than as a human being with identities that might affect the interaction with medical provider and patient (i.e., gender, race, age, religious affiliation, etc.). Such stripping away of identity is not possible, she argues—a perspective in accord with the embedded interpreter role discussed in Beltran-Avery (2001). Angelelli portrays the *conduit* role as focused on decontextualized information that does not provide a full sense of an utterance’s meaning. Citing the research of Davidson (2001), she also notes the *gatekeeper* role, in which the interpreter acts to block the patient from full participation.

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3As an example, emphasis on a conduit view of interpreting can be found in the Language Line telephone interpreting service code of ethics (2009): “The Interpreter shall render, to the best of his/her ability, a complete and accurate interpretation without altering or omitting anything that is stated. Interpreter shall not add to what is said nor provide unsolicited explanation” (Interpreter Code of Ethics online document, “Accuracy & Completeness” section). Similarly, many of the physicians in Singy and Guex (2005) wanted an interpreter who would be nothing more than a “walking bilingual dictionary” (p. 48).
in the conversation or from general empowerment within the medical system (p. 7). Angelelli argues that only if invisibility is not assumed can the interpreter act as a broker/opportunity channel, who makes the patient aware of all information necessary for health-care access.

In a 2006 article, Angelelli delves into the ways in which internal contradictions in guidelines can snare interpreters in difficult situations. She conducted focus groups with hospital interpreters, who like those in Dysart-Gale (2005) reported many dilemmas as they attempted to integrate the new standards into their practice. Angelelli writes:

As indicated, the role of patient advocate, which is the policy for interpreters at many institutions/hospitals, contradicts Ethical Principal 2: Impartiality. Other interpreters, especially those who are staff members, employed directly by a hospital, align themselves more with the institution than with the patients. Impartiality is therefore a problematic topic in these situations. (p. 184)

Angelelli also makes an important observation about simplistic or internally contradictory interpreter guidelines when she writes:

It is not always possible to choose between performing as a message converter, a culture clarifier or an advocate and the distinctions between the roles are not that clear. Most often, an interpreter will assume part of two or more roles depending on the course of the conversation. For example, s/he might start by rendering the conversation between a provider and a patient faithfultly, in the role of a message converter. In the following turn, the interpreter stumbles upon a problem resulting from cultural differences and immediately switches to culture clarifier. Later in the same turn, after the interpreter has returned to the role of message converter, the provider makes a discriminatory remark and the interpreter becomes the patient's advocate. (p. 185)

Angelelli additionally critiques interpreter guidelines that imply that interpreters, in their roles as cultural explicators, can be an expert on each client’s culture at an individual level (i.e., each client’s cultural idiolect).

While Angelelli discusses role-shifting by interpreters, White and Laws (2008) look at a slightly different phenomenon: role-blurring by interpreters, especially bilingual physicians or other health-care workers. For instance, a nurse who is interpreting might not tell the patient exactly what the doctor said because the nurse disagrees with the doctor’s advice. Or the interpreter/clinician might independently conduct a medical evaluation of the patient through
questions, without the knowledge of the attending doctor. In instances of role-blurring, White and Laws see transparency on the part of the interpreter—that is, keeping all parties informed about what is being done by the interpreter—as the best option for avoiding potential harm or unethical behavior. The National Council on Interpreting in Health Care’s ethical guidelines (2005) also address this issue: “The interpreter with an additional role adheres to all interpreting standards of practice while interpreting. For example, an interpreter who is also a nurse does not confer with another provider in the patient’s presence, without reporting what is said” (p. 8).

Leanza (2005) explores two categorizations of interpreter roles: Leanza’s own, and that of Jalbert, whose model Leanza modifies. Based on Leanza’s summary, Jalbert (whose work appeared in the francophone literature) portrays interpreters as inhabiting the following roles: 

- **translator**—a conduit-style link between the doctor and patient; 
- **cultural informant**—as a one-way conveyor of knowledge, the interpreter informs the doctor about immigrant beliefs and practices; 
- **culture broker/mediator**—in which both the doctor and the patient are informed about the other’s beliefs, practices, and culturally influenced motivations via the interpreter; 
- **advocate**—in which the interpreter works against the health-care system or other locus of authority in order to protect the patient from ill treatment; and 
- **bilingual professional**—a medically trained interpreter (or one very familiar with the workings of the health-care bureaucracy) who conducts the medical interview without step-by-step guidance from the doctor and then informs the doctor about the results (p. 170). Jalbert’s categorization is valuable because it takes a less idealized view of the workings of power during three-party medical communication.

Leanza modified Jalbert as a result of an empirical study in which Leanza videotaped pediatric appointments with medical providers, patients, and interpreters affiliated with a hospital. Leanza conducted stimulated-recall interviews with the providers and interpreters as well as analyzing transcripts of the actual appointments. He found that the providers valued the interpreters as “a neutral ‘translating machine’ or neutral ally” (p. 177). However, the providers
also felt frustrated because interpretation slowed down the appointments and lessened the physicians’ control of the proceedings (p. 176). Leanza adds: “These physicians found it very hard to get the information needed to do their work properly and manage time appropriately (according to institution rules)” when the communication was mediated by interpreters (p. 176). Leanza notes that the interpreters he interviewed added two roles to those postulated by Jalbert: a) *welcomers*—interlocutors whose presence caused the patients to feel at ease, because of shared language and cultural background (a finding similar to that in Simich, Beiser, and Mawani [2003], where new immigrants experienced relief when they saw the successes of previous immigrants from their own background); and b) *family support*—sources of informational help, outside the hospital, as immigrant families coped with life in their new homeland (p. 178). Leanza notes: “The two new roles indicate that community interpreters work toward social integration also before and after the consultation” (p. 178). However, Leanza takes pains to point out that the interpreters and providers generally worked together in such a way that biomedical information was funneled toward pediatric patients and their parents while restricting the patients’/parents’ ability to gain the floor or establish their own expertise.

Based on his findings, Leanza reformulates Jalbert’s categorizations into the following roles, which I list verbatim:

—As a *system agent*, the interpreter transmits the dominant discourse, norms and values to the patient. Cultural difference is denied in favor of the dominant culture. Cultural difference tends to be elided or assimilated.

—As a *community agent*, the interpreter plays the reverse role: the minority (migrant) norms and values are presented as potentially equally valid. Cultural difference is acknowledged. This role can be played in various ways, more or less nuanced.

—When acting as an *integration agent*, the interpreter finds resources to help migrants (and people from the receiving society) to make sense, negotiate meanings and find an “in-between” way of behaving. These roles take place outside consultations in everyday life.

—As a *linguistic agent*, the interpreter attempts to maintain an impartial position (to the extent that this is possible). The relationship with cultural difference is more technical, in that the interpreter has to find the proper translation on the fly. The cognitive and symbolic process does not require her to intervene on any level other than that of language (in other words, she does not intervene about the object of the interaction). (pp.
Although still based on the roles performed by the interpreter, Leanza’s formulation is more expansive than many of the role-based categorizations seen above: Leanza emphasizes the interpreter’s role not just during the appointment, but also at the interface with the larger community outside the medical facility.

Synthesizing elements of both the role-based and training-based taxonomies, we can make the categorizations of interpreters shown in Table 2-1:
<table>
<thead>
<tr>
<th>Type of interpreter</th>
<th>Example</th>
<th>Primary alliance (speculative)</th>
<th>Bilingual / bicultural skills</th>
<th>Role during appt.</th>
<th>Role outside appt.</th>
<th>Who trusts this person?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chance</td>
<td>Another patient; family or friend of patient</td>
<td>Patient</td>
<td>Generally low</td>
<td>Conduit / linguistic agent; broker / community agent; emotional support; second set of ears; may speak instead of patient or restrict info</td>
<td>Emotional support; integration agent; provide explanation, reminders, transportation; do daily caretaking; or (in case of stranger in waiting room) none</td>
<td>Patient; maybe the provider</td>
</tr>
<tr>
<td>Untrained</td>
<td>Hospital janitor; receptionist; bilingual member of community</td>
<td>Patient or facility</td>
<td>May have some medical knowledge but is not trained in interpretation</td>
<td>Conduit / linguistic agent; broker / community agent; system agent; may speak instead of patient; may mix interp. with clinical role</td>
<td>Provide explanation, reminders, transportation; act as integration agent; or in case of hospital staff, none</td>
<td>Maybe the patient; maybe the provider</td>
</tr>
<tr>
<td>Bilingual provider</td>
<td>Doctor or nurse</td>
<td>Patient or facility</td>
<td>Medical knowledge; not trained in interpretation; may overestimate language proficiency or cultural knowledge</td>
<td>Mixture of information transmission, language accommodation, and clinical diagnosis and treatment; system agent</td>
<td>None</td>
<td>Provider (self); maybe the patient</td>
</tr>
<tr>
<td>On-site</td>
<td>Staff member trained in interpretation</td>
<td>Facility</td>
<td>Generally high</td>
<td>Conduit / linguistic agent; broker / community agent; gatekeeper who blocks access; system agent</td>
<td>None</td>
<td>Provider; maybe the patient</td>
</tr>
<tr>
<td>Telephone (or video)</td>
<td>Language Line</td>
<td>Employer</td>
<td>Generally high</td>
<td>Conduit / linguistic agent; broker / community agent; system agent</td>
<td>None</td>
<td>Provider; maybe the patient</td>
</tr>
</tbody>
</table>
A few additional notes are in order. First, I divide two of the categories slightly differently than was done in Hsieh (2006). She places nurses in the “untrained interpreter” category (which includes “bilingual support staff (e.g., nurse, technician, or receptionist)” (p. 179) and seems to devote the “bilingual medical providers” category solely to physicians. However, because of their medical expertise and their potential to mix clinical and interpreter roles just as physicians might (as in White & Laws, 2008), I place nurses in the “bilingual provider” category.

Secondly, although Hsieh notes differences in skill levels and training, her taxonomy assumes that on-site hospital interpreters have a minimum level of expertise and training in interpreting of medical concepts. Pöchhacker and Shlesinger (2005), however, note that it is somewhat dangerous to equate “paid” with “trained” or skilled (p. 161).

Thirdly, following Hsieh, I am defining telephone interpreters as those employed by a party other than the medical facility, as is the case with the Language Line or similar services. The telephone interpreters in Angelelli (2004), who were employees of a hospital, would be an exception to this definition.

Health-Care Socialization

There is a well-established literature regarding health-care socialization as a general construct (see for instance, Good, 1994; Loustaunau & Sobo, 1997). Health-care socialization refers to learning what is normal or expected behavior in a particular culture when interacting with people or systems intended to accomplish healing. Such norms and expectations will vary, sometimes drastically, from one place to another and from one era to another. For instance, during my childhood in a small Pennsylvania town, it was expected (based on the accumulated experience of people in the town) that a family doctor would come to a patient’s house under
certain circumstances, such as if the patient were too sick to travel to the doctor’s office. In the larger community where I now live some 40 years later, it would be considered quite unusual for a doctor to make such house calls.

Another aspect of health-care socialization is the learning of “scripts” (Quinn & Holland, 1987; Schank, 1986; Schank & Abelson, 1977), that is, what to do and the sequence in which the actions should be done. A typical script for making a medical appointment in the present-day United States, for example, would include calling the office; perhaps navigating a voicemail menu or talking with a receptionist or both; being told a specific day and time to arrive at the office; going to the office on that day and at that time; signing in with the receptionist and possibly filling out paperwork regarding insurance or personal information; waiting a few minutes to a few hours; being admitted to an examination room; etc. This script would not be universally applicable: A person seeking a Traditional Navajo Blessingway service to help cope with an illness would follow different steps in interacting with the healer than would the same person interacting with a biomedical clinician or a healer from the Native American Church (Csordas, 2000; Storck, Csordas, and Strauss, 2000). Even between two highly advanced biomedical systems—such as the ones found in the former Soviet Union and in the United States—there can be many differences in expectations because of differences in scripts, attitudes, or other aspects of health-care socialization.

My study context involves the interaction of three populations—immigrants, medical and social services personnel, and volunteer interpreters who act as intermediaries. While there may be considerable individual variation in participants’ health-care behaviors and attitudes (as will become evident in the data chapters), members of each population have been influenced by the health-care socialization occurring in communities where they have lived, as well as by the operational roles they inhabit. For instance, the immigrants will have been medically socialized to varying degrees in the former Soviet Union (F.S.U.) as well as in the United States; the medical
personnel in my study have for the most part been socialized in the United States health-care system and are additionally influenced by their roles as clinicians or social workers; and the interpreters likewise will have been influenced by the places where they have lived, as well as their roles as brokers or intermediaries. In the review that follows, I focus mainly on literature related to health-care socialization in the former Soviet Union and the United States (including socialization of medical providers). After providing a brief overview of Soviet and post-Soviet health care, I explore some attitudes typically associated in the literature with immigrants from the F.S.U. Finally, I explore ways in which the immigrants’ attitudes and those of the present-day U.S. medical system may come into conflict.

Overview of Health Care in the Soviet Union and Its Successor States

The Russian-speaking participants in my study ranged in age from their 30s to their 50s as of 2005. Thus, all of them grew up in the medical system of the Soviet Union. After the dissolution of the Soviet government in 1991, and until their respective immigration dates (mid-1990s to mid-2000s), the participants would also have experienced the post-Soviet medical system as it underwent changes and severe strains because of economic, organizational, and infrastructure conditions (Tulchinsky & Varavikova, 1996). In order to understand the health-care attitudes and behaviors expressed by the immigrant participants, it will be valuable to briefly examine health-care conditions in the Soviet Union and its successor states.

The Soviet Union was the first nation to guarantee universal access to health-care to all citizens (Field, 1995). By the 1930s, the Soviets developed an extensive system of neighborhood clinics and hospitals in an effort to achieve this, and one outgrowth of their policies was an epidemiological shift in which infectious diseases were sharply reduced (Tulchinsky & Varavikova, 1996). As Tulchinsky and Varavikova note, even during World War II, when many
millions of Soviet citizens were killed (either during direct fighting or from indirect causes such as starvation in besieged areas), there were no widespread resurgences of infectious disease. However, around 1960, a negative change in health trends began to gather strength, as life expectancies started to decline and infant mortality started to rise (Barr & Field, 1996; Field, 1995; Tulchinsky & Varavikova, 1996). Major factors in the shift included cardiovascular problems, cancer, nutritional deficiencies and other socioeconomic stressors, widespread alcohol abuse, and environmental degradation via industrial pollution (Barr & Field, 1996; Duncan & Simmons, 1996; Field, 1995; Tulchinsky & Varavikova, 1996). By the mid-1980s, the health-care system was heavily burdened with problems, as noted by Barr and Field (1996):

Corruption, including bribery in the admission and graduation of physicians (a shocking proportion of whom could not perform the simplest medical procedures), had permeated the entire system. Largely as a result of the very low salaries they drew, some health personnel demanded large sums of money from patients to provide services they were supposed to provide for free. A shortage of pharmaceuticals and other medical supplies intensified, leading often to gray or black markets. And on top of all this, the system was paralyzed by a suffocating bureaucracy and a command mentality. (p. 308)

Worsening conditions and insufficient health funding during the last years of the Soviet system (Barr & Field, 1996; Field, 1995) were exacerbated by economic and governmental uncertainties during the transition to the post-Soviet systems, including the implementation of some private insurance systems, which many citizens could not afford (Barr & Field, 1996; Tulchinsky & Varavikova, 1996). Field (1995), for instance, noted the following worrisome problems:

There are new cases of hepatitis, cholera (three times as many cases as in 1991), typhoid, tuberculosis (three times more than in 1991), whooping cough, bubonic plague, anthrax, measles (number of cases in 1993 quadrupled compared to the previous year), salmonellosis…. The rate of vaccination among children is on the decrease, both because of the shortage of such vaccines, and the fear that parents have in taking their children to be vaccinated or inoculated because of dirty needles and unsanitary conditions. (p. 1473)

Tulchinsky and Varavikova (1996) additionally note: “In 1990, the State Statistical Committee of the Soviet Union reported that 24% of hospitals lacked plumbing, 19% lacked central heating, 45% lacked bathrooms and showers, 29% lacked hot water, and 15% operated without any water...
at all” (p. 316).

By 1993, two years after the Soviet Union dissolved, life expectancy for a newborn male in the Russian Federation had dropped to 59 years (from 61 years in 1979), and life expectancy for a newborn female was 71 years (Tulchinsky & Varavikova, 1996).

**Attitudes of Immigrants from the Former Soviet Union**

The Soviet and post-Soviet conditions noted above—nominally universal access to health care, erratic quality of health care, and challenging socioeconomic conditions—would have been experienced by the immigrant participants in my study and would have shaped their medical socialization. Studies about former-Soviet citizens—both in their country of origin and as immigrants to the United States—have investigated a number of behaviors and attitudes related to medical socialization, which I will now briefly discuss.

*Access to health-care services.* Although quality of service and infrastructure may have been lacking in many instances in the F.S.U., access to health care was in some ways much easier than in my study participants’ U.S. community. At least in urban areas of the former Soviet Union, residents were assigned to a nearby polyclinic, which would be among the first paths of approach to the medical system in non-emergency situations; same-day appointments were customary. At least in Ukraine, where several of my participants lived, ambulances staffed by *physicians* rather than paramedics were standard (Wright, Stack, McMurray, & Bolyukh, 2000), although this service underwent downgrades in quality during the post-Soviet years (Field, 1995).

*Attitudes toward doctors.* A certain distrust or lack of respect for doctors has been reported in the literature. This attitude may have grown at least in part out of Soviet policy: Doctors were paid less than factory workers (Barr & Field, 1996; Tulchinsky & Varavikova, 1996), a factor attributed by Cassileth, Vlassov, and Chapman (1995) to Soviet idealization of
physical work over mental work. At the same time, by Western standards, there was a glut of
doctors in proportion to population (Tulchinsky & Varavikova, 1996), and Cassileth, Vlassov,and Chapman (1995) argue that patients might also have lost respect for doctors because they
suspected “quantity trying to compensate for inadequate quality” (p. 1570). Quality control in
medical education was generally lax, with insufficient training not uncommon (Cassileth,
Vlassov, & Chapman, 1995; Field, 1995). Gender issues might also be relevant: In the decades
since World War II decimated a generation of men, women have made up 60 to 75 percent of
doctors in the Soviet and post-Soviet systems (Tulchinsky & Varavikova, 1996), and their efforts
might be somewhat devalued because of sexism (Ivanov & Buck, 2002). The fact that involuntary
psychiatric treatment was used against political dissidents also contributed to wary attitudes about
the medical profession (Duncan & Simmons, 1996).

*Attitudes toward medications.* Pharmaceuticals often engender a degree of distrust in
Soviet and post-Soviet residents, as such medications are viewed as potentially harmful chemicals
whose long-term use can be poisonous (Shpilko, 2006). Resick (2008), in a study of former-
Soviet immigrants in the U.S., writes:

Participants believed that Americans considered doctors “good” if the doctors gave pills
to do the healing. In contrast, in the Russian culture, doctors were considered good if they
did not use pills to do the healing. Fekla [a participant] said, “In Russia, if the doctor is
good, he will give you less medicine. Here the opposite, here pills . . . if the doctor gives
you pills, he is considered a good doctor.” (p. 251)

Similar attitudes are expressed by former-Soviet participants in Smith (1996). In a related vein,
Resick (2008) adds:

Nearly all the women reported that they did not always follow the treatment plan of their
physicians. Instead, they relied on their own plan of care. Many of the women reported
they often stopped taking prescription medications or adjusted the dose on their own after
reading about or experiencing side effects. (p. 251)

Use of herbal ingredients as medications is a common practice (Ivanov and Buck, 2002; Shpilko,
2006), and this practice is perceived as a milder approach than use of pharmaceuticals.
Preventive care vs. hospitalization. A number of researchers (Abbott, Turmov, & Wallace, 2006; Borovoy & Hine, 2008; Duncan & Simmons, 1996) have noted that Western-style preventive strategies, such as those around exercise and food choice, are not always priorities of people from the former Soviet Union. Aroian, Khatutsky, Tran, and Balsam (2001) also suggest that in the former Soviet Union, hospitalization is a preferred option for many patients looking for a yearly tune-up of their health. However, Abbott, Turmov, and Wallace (2006) note that socioeconomic stressors in the F.S.U. (such as many residents' lack of enough money to buy fresh fruits and vegetables) and day-to-day survival needs make Western-style preventive self-care somewhat difficult. Borovoy and Hine (2008) additionally note that Russian-speaking immigrants to the United States may have other priorities—such as helping children and grandchildren to succeed in the new country, or maintenance of important traditions—that sometimes take precedence over preventive self-care. (Borovoy and Hine’s critique of U.S. biomedical providers’ dealings with Russian-speaking immigrants will be addressed further in the section below about socialization of U.S. health-care providers.)

Attempts to manipulate the system. Immigrants from the F.S.U. have a reputation among U.S. health-care providers as being pushy or somewhat manipulative (Duncan & Simmons, 1996; Ivanov & Buck, 2002; Wei & Spigner, 1994). Aroian, Khatutsky, Tran, and Balsam (2005), for instance, write of immigrants who traveled from doctor to doctor until they were able to get the prescriptions or treatments they want, even if not considered necessary by the doctors. However, Aroian and her colleagues note that their study population was somewhat unusual, as they had settled in an area where many Russian-speaking medical providers were also located, and the doctors felt pressure to accommodate the patients’ wishes or else lose their business. Duncan and

4 Also true for many less advantaged populations in the United States (Guttman, 2000).
Simmons (1996) attribute the alleged manipulative and pushy behavior to socialization learned in the former Soviet Union:

[C]loser examination of the immigrants reveals these behaviors to be mechanisms learned in order to survive in the Soviet Union. The manipulative behaviors were necessary in order to obtain attention and an adequate response from the very complex bureaucratic health care system there. (p. 131)

Other researchers (e.g., Ivanov & Buck, 2002; Wei & Spigner, 1994) have suggested similar reasons for the stereotype.

Alleged passivity. Some researchers have portrayed immigrants from the F.S.U. as adopting a passive stance in terms of responsibility for their health. Korb (1996), for instance, found that in comparison with the expectations of U.S. nurses, Russian-speaking immigrants “might instead be expecting more authoritative helpers and recipient roles with less assumed individual responsibility” (p. 485). Ivanov and Buck (2002), doing focus groups with a small sampling of Russian-speaking immigrants, write the following about the 20- to 30-year-olds in their study: “This group believed it was the physicians’ responsibility to refer them for preventive services and tell them what they needed to know to remain healthy” (p. 23). They report something similar about their 37- to 46-year-old sample: “There was a lack of internal motivation in relation to preventive health services for this group. They considered preventive health care teaching as the physicians’ responsibility” (p. 23). In each case, the researchers portrayed the U.S. system as very focused on individual patients’ responsibility for self-management and decision-making in regard to health. However, Borovoy and Hine’s (2008) description of discordance between Russian-Jewish immigrants and diabetes educators includes this incisive observation:

The notion [by medical staff] that the majority of the elderly émigrés were depressed suggests that in the context of American ideologies of self-determination and individualism, there is little language for describing what one might call “empowered” or “strategic” dependency (the act of asking to be cared for) outside of the language of “giving up,” helplessness, or depression. (pp. 17-18)
Unrealistic expectations. Some of the former-Soviet immigrants in the research literature ascribe almost godlike powers of healing to U.S. medicine, with expectations that even terminal cancers will be curable (Aroian, Khatutsky, Tran, & Balsam, 2001).

Access to medicines. Many immigrants from the F.S.U. have commented on medicines that would have been over-the-counter in the F.S.U. but which require a prescription in the U.S.; because of such differences in access to medicines, as well as differences in cost and familiarity, it is common for immigrants to procure medicines or herbals from the F.S.U. for use in the U.S. (Brua, unpublished M.A. paper; Ivanov & Buck, 2002; Resick, 2008; Shpilko, 2006).

Symbols of professionalism. The clothing styles of some U.S. medical personnel (e.g., doctors in jeans and no lab coat) are sometimes perceived as unprofessional by immigrants, who may report difficulty recognizing who is a doctor and who is a janitor, and clothing style was also linked to perceptions of unsanitary conditions in U.S. medical facilities (e.g., providers without lab coats) (Ivanov & Buck, 2002).^5^  

Sticker shock. Entering a system in which payment for services is the norm is often traumatic for people accustomed to the former Soviet system of (in name at least) universal, free care. Resick (2008) notes of her study participants: “Another reason for distrust of American healthcare professionals was the perception that medicine is a business and that physicians are focused on making money rather than caring for people” (p. 251). However, we should also remember that “under the table” payments to medical providers in order to achieve better care have been common for decades in the Soviet and post-Soviet systems (Field, 1995: p. 1474).

Psychological vs. physical complaints. Because psychological complaints tend to be stigmatized in former-Soviet culture (and were potentially dangerous to reveal in a system where psychiatric hospitalization was used against political dissidents), problems that would be viewed

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^5^This comment was particularly startling to me in light of the reported conditions in some former Soviet medical facilities, e.g., no running water, dangerous protocols regarding reuse of needles, etc.
in U.S. parlance as mental-health concerns often undergo “somatization,” i.e., presentation as physical complaints, by people from the F.S.U. (Aroian, Khatutsky, Tran, & Balsam, 2001: p. 269).

*The importance of doctors’ “human touch.”* Immigrants from the former Soviet Union have sometimes expressed a preference for “human touch” rather than over-reliance on technology in medical practices. For instance, one focus group in Ivanov and Buck (2002) “felt that physicians in the former Soviet Union were of a ‘higher class’ because they relied on touching their bodies and looking at them to assess and diagnose illness rather than depending on technology and computers” (pp. 24-25). Another focus group in the same study had this evaluation:

This group also voiced that with all the equipment and technology the quality of care [in the U.S.] was good but they still felt that their physicians in the former Soviet Union were more thorough because they depended on touching their bodies and blood analyses to diagnose illness. One woman added that “Here you walk in, they quickly look at you, and tell you that you are okay.” (p. 25)

**Current Themes in U.S. Health Care**

The U.S. health-care system, while it shares many of the biomedical foundations of the Soviet and post-Soviet systems, also involves some substantially different beliefs and approaches. Immigrants from the former Soviet Union may find these differences to be rather challenging, at least in the early stages of their life in the U.S.

*Payment system.* In contrast with the Soviet system, the U.S. does not provide universal access to health care; instead, access is based on the patient’s ability to pay for services. Payment is made via a mix of approaches, including privatized (using one’s own money), socialized (using government programs such as Medicare and Medicaid), and in-between methods (using group insurance policies co-paid by employer and employee). Factors such as immigration status,
employment status and whether the employer offers health insurance coverage, income, etc., will constrain the options available to an individual or family.

_Role of primary care physicians._ In the current U.S. system, much non-emergency care is expected to be coordinated through a gatekeeper physician or other medical provider. Access to specialists is thus constrained—a different scenario than in the former Soviet Union, where patients frequently consult specialists directly (Aroian, Khatutsky, Tran, & Balsam, 2001).

_Advanced technology._ As noted earlier, medical machinery in the U.S. is generally much more advanced than in the F.S.U., with computerized diagnostics and record-keeping fairly widespread even in smaller hospitals. Possibly such technological expertise is related to a general tenet of U.S. medical education: viewing the body as machine (Loustauanau and Sobo, 1997). Medical anthropologists have noted that U.S. medical schools tend to socialize doctors away from seeing patients as whole human beings, in favor of a focus on the particular illness or injury that the patient embodies. For instance, in a discussion of U.S. medical education, Good (1994) writes:

Case presentations represent disease as the object of medical practice. The “story” is presented is a story of disease processes, localized spatially in tissue lesions and disordered physiology and temporally in abstract, medicalized time (Frankenberg 1988c). The person, the subject of suffering, is represented as the site of disease rather than as a narrative agent. The patient is formulated as a medical project, and given the extreme pressures of time, case presentations are designed to exclude all except that which will aid in diagnostic and therapeutic decisions. Get to the point, students are told. What’s the real story here? What do we have to do? (p. 80)

_Individual and group._ Another central tenet of U.S. biomedical practice is an emphasis on individual responsibility for health—an emphasis that Good (1994) cogently disputes. In a critique of the influential Health Belief Model, he notes, for instance, that “[t]he ability of the individual to appraise symptoms, review available resources, then make voluntary choices is simply a myth for many in our society and other societies” (p. 43). He adds:
It does tell us why some people choose to seek care for some problems, not others. However, it does so only by excluding those persons who have the least control over their lives, by treating as external to the model the most important structural conditions which constrain care-seeking, by ignoring much of what happens during the management of chronic and critical illness…, and by defining culture as the instrumental beliefs of individuals. (p. 43)

In her research on health communication ethics, Guttman (2000) similarly notes that intervention strategies often do not consider the (small) degree to which individuals can actually change some of the societal/structural factors that contribute to their ill health. Interestingly, while the post-Soviet citizens in Abbott, Turmov, and Wallace (2006) said they were responsible for their own health, a strong sub-theme in their accounts was the difficulty of maintaining health in an economically and environmentally devastated society. In Borovoy and Hine’s (2008) examination of cultural conflicts between U.S. diabetes educators and Russian-Jewish immigrants, the diabetes educators portrayed deviation from self-care as a moral failing and viewed the immigrants as noncompliant, but the immigrants saw things differently:

And yet while émigrés acknowledge the necessity of self-control in the abstract, daily needs, life priorities, and values other than those of medical control are at play: in particular, the prioritization of caring for the younger generations over themselves, their view of food as a vital necessity rather than an object of choice or desire, and their prioritization of “community” in one’s later years, including instilling traditional customs (often in the form of special foods) in the younger generation and the maintenance of social bonds through the sharing of food and ritual. Where the biomedical model defines optimal health as the rational goal of diabetes management, the émigrés make more complex decisions about value and risk, weighing health benefits against the costs of rigid self-control. (pp. 6-7)

Some of the most important differences in health-care socialization are shown in Table 2-2. Many of these differences—and some important similarities—in medical socialization of immigrants, medical providers, and interpreters will become salient in the data chapters, and these concepts will be revisited in the discussion chapter, as well.
Table 2-2: Potential points of tension for patients and providers

<table>
<thead>
<tr>
<th>Former Soviet health-care socialization</th>
<th>U.S. health-care socialization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal, free care was promised, although often not achieved.</td>
<td>Care is constrained by patient’s access to insurance, government aid, or income.</td>
</tr>
<tr>
<td>Necessary to manipulate the system to receive adequate care.</td>
<td>Manipulation of the system perceived as “pushy.”</td>
</tr>
<tr>
<td>Use of neighborhood polyclinics; many specialists.</td>
<td>Use of primary-care physicians and general practitioners.</td>
</tr>
<tr>
<td>Same-day appointments common.</td>
<td>Appointments generally made far in advance.</td>
</tr>
<tr>
<td>Medical infrastructure often lacks supplies or equipment; diagnosis via “human touch” seen as optimal.</td>
<td>Medical infrastructure includes many highly advanced machines; diagnosis via technology seen as optimal.</td>
</tr>
<tr>
<td>Health is seen as societal responsibility.</td>
<td>Health is seen as individual responsibility.</td>
</tr>
</tbody>
</table>

**Conclusion**

In attempting to provide useful background related to my three study populations—medical interpreters, immigrants from the former Soviet Union, and U.S.-based medical providers—I have examined a number of concepts from the research literature.

In regard to *medical interpreters*, we have seen that U.S. government policies require the use of medical interpreters at facilities receiving federal funds, as well as a range of permissible ways to comply with the policies. We also have explored some of the literature concerning the efficacy of medical interpreting in terms of health-care outcomes and cost reductions. Results are somewhat mixed, with some studies making a case for the use of professional interpreters, while others suggest that more evidence is needed before conclusions about efficacy can be reached.

We have also looked at two major approaches to categorizing medical interpreters: a) based on their degree of training or availability (e.g., untrained interpreter, bilingual physician, and phone interpreter) or b) based on their function (e.g., conduit, culture broker, gatekeeper, and the like).
In the data and discussion sections, I will apply these categorizations to the interpreters in my study and examine the ways in which they do or do not fit into the paradigms suggested in past research.

In terms of health-care socialization, we have looked at some of the most important factors operating in the Soviet and post-Soviet health-care systems, as well as their effects on the health-care beliefs and practices of people who grew up in those systems. Among the most salient factors were socioeconomic and environmental stressors that had negative effects on health; an expectation of universal access to health care; a wariness toward doctors and pharmaceuticals; and a perceived need to “work the system” in order to gain the best care possible under challenging circumstances. These beliefs and practices sometimes appear to be in conflict with the socialization of medical providers in the U.S. system, where health-care access is far from universal; logistics of care are different than in the Soviet Union (e.g., use of primary care physicians in the U.S.); preventive self-care is emphasized; and individual responsibility is emphasized and societal responsibility is thus somewhat obscured. Former-Soviet immigrants becoming acculturated in the U.S. system will face the challenge of coping with such differences, and medical providers treating the immigrants would benefit from being aware of such points of tension. In other words, while both the immigrant and medical provider participants in my study come from highly advanced biomedical cultures, the significant differences in those cultures will affect communication and access to care, as we will see in my data samples.

Finally, I should note that while many other researchers have explored cross-cultural medical communication and socialization with other groups, studies related to post-Soviet immigrants in the U.S. have been few (Aroian, Khatutsky, Tran, and Balsam, 2001). And studies of cultural discordance between immigrants and providers in semi-rural areas such as my study context have been extremely rare—a paucity that my study will help to address.
Chapter 3

Methodology: Directed Content Analysis

This chapter describes the central goals of the current study and the methods used in the attempt to reach them. I provide information about the study context, recruitment of participants from three stakeholder groups, transcription of the data, and the coding and analysis of the data. I begin with a brief overview of the theoretical assumptions that guided the study.

Theoretical Assumptions

A quantitative methodology is a useful approach in providing information about the characteristics of large population samples; it excels at examining large-scale trends but is less useful in showing particularities of individuals’ lived experience. In a complementary way, the strength of a qualitative methodology is its ability to depict smaller-scale experience in a fine-grained way; its limitation is its narrower scope in terms of sample size. Either family of methodologies might provide valuable insights about a given situation. However, my own strongest interests—and hence my strengths as a researcher—are in detailed, messy, and emotionally rich narratives that can convey both the flavor of an individual life and a sense of linkages to larger cultural and societal forces. The research of the medical anthropologist Cheryl Mattingly (e.g., 1998a, 1998b, 2006) stands out for me as an example of work that very successfully conveys such a view: In her analysis of interactions between occupational therapists and their clients, who oftentimes come from very different cultural and socioeconomic

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6For information about two prior studies in which I conducted preliminary investigations of health-care access in this context, and which have influenced the current study, please consult Chapter 1.
backgrounds, she is able to develop theory about the structure of experience while simultaneously providing striking portraits of her participants. In designing the current research, I have been strongly committed to a project that would preserve some sense of the life stories being told by the research participants. Thus, I looked to the qualitative family during my search for a methodology appropriate to my research goals.

The approach I eventually settled on, described in detail below, partakes of some characteristics of both phenomenology and grounded theory, as discussed in Starks and Trinidad (2007). Phenomenology, Starks and Trinidad write, aims to uncovers the meanings people assign to particular events they experience while grounded theory attempts to discover social systems at work. In my study, I repeatedly asked my participants to describe their experiences around seeking or providing medical care or medical interpretation, and thus was using a phenomenological question: “What is the lived experience of [the phenomenon of interest]?” (Starks and Trinidad, 2007, p. 1373). However, by asking such questions across groups of stakeholders with different involvements—that is, Russian-speaking patients, English-speaking medical staff members, and bilingual intermediaries—I was also seeking to answer what Starks and Trinidad describe as a grounded-theory question: “How does the basic social process of [X] happen in the context of [Y environment]?” (p. 1373). In other words, I was asking about stakeholders’ lived experiences in order to better understand the social processes involved in health-care access in an environment where the protagonists have divergent resources in terms of available languages and divergent histories in terms of the biomedical systems they have grown accustomed to.

As a further refinement of my approach, I modified the grounded theory approach by incorporating previous research and theorization in the literature—concerning medical interpretation and the ways in which people are socialized into health-care beliefs and practices—as well as the experiences reported by the participants in my prior studies. Thus, according to
Starks and Trinidad (2007), mine was not strictly a grounded theory approach. Hsieh and Shannon (2005) would describe it as “directed content analysis,” an analytic strategy that involves applying pre-existing theories during coding of the data, but also developing additional codes to cover aspects of the data that are not accommodated by the pre-existing codes. Whether we term it directed content analysis, mixed grounded theory, or another label, my analytical approach focused on using prior literature to gain an initial understanding of the data and on then expanding that understanding by looking for additional categories and patterns in the data.

**The Study Context**

The context of the present study is a Pennsylvania county that has become home to an estimated 2,000 immigrants and refugees from the former Soviet Union since the late 1980s (Dr. Catherine Wanner, Penn State Department of History, personal communication, April 15, 2002). The population of the county is approximately 140,000, according to census figures. The county is far from large cities, and at least one agency of the state government classifies it as rural. The study context is also several hours away from any large concentration of immigrants from the former Soviet Union. The medical infrastructure of the area does not include the degree of language accommodation that might be available in a big city (for instance, large pools of interpreters for less commonly spoken languages that are locally prevalent). Russian-English medical bilingualism is extremely rare among medical providers in the area, and the English proficiency of many of the immigrants is low. This is especially true of elderly members of the community. In addition, many of the immigrants are of low socioeconomic status, working in jobs in which employer-subsidized health insurance is rare, such as construction or housecleaning. While many do receive help with health-care bills from government-sponsored social support programs, the immigrants’ choices of medical providers are quite constrained,
since many providers do not accept payment from those programs. Medical communication and health-care access thus pose significant challenges to both patient and medical provider in this context.

**Data Collection**

My data are in the form of semi-structured interviews with members of three stakeholder groups: a) Recent immigrants to the United States from the former Soviet Union (n=12); b) staff affiliated with a medical facility where many immigrants from the former Soviet Union seek treatment (n=5); and c) “unofficial” volunteer interpreters who act as intermediaries between Russian-speaking patients and English-speaking medical personnel (n=3). I chose to interview these three groups because each brings a different perspective on health-care interactions. The patient and the medical provider are, by definition, central figures in any medical interaction. Because the patients and providers in my study context often had little or no ability to speak each other’s languages, it seemed evident that communication intermediaries would have an important role. I chose to interview non-professional, volunteer interpreters for three reasons: One was serendipity—Masha and Oksana, two of my pilot participants, both turned out to be volunteer interpreters in the community. Secondly, non-professional volunteers have been addressed in the literature less often than professionals. A third justification became clear in the course of my interviews with immigrant participants and medical staff: In my study context, professional interpreters are often not used, while volunteers of varying capacity often are.

The interviews were intended to gather information about: 1) currently existing communication resources (e.g., interpreters or bilingual paperwork) in cross-cultural medical interactions involving the stakeholder groups; 2) the degree to which such resources were or were not being used; and 3) participants’ ideas about ways to potentially expand the existing resources.
In particular, I asked participants to tell narratives about medical appointments between Russian-speaking patients and English-speaking doctors. This line of questioning ensured that in addition to information about communication, I would also be able to gather information about the participants’ health-care beliefs. All interviews were audio-taped for analysis.

As an outsider to all three stakeholder groups, I faced a dilemma described cogently by Katz and Csordas (2003) in their discussion of another researcher’s relationship with her participants:

She must somehow be with them, in an immediately provocative situation, and yet through that process get them to reveal the experience they have when going through their neighborhoods with their regular companions or when alone. This constant confrontation with ethnography’s Heisenberg dilemma is at once indispensable and almost dizzying in its personal demands. (p. 276)

While it is unlikely that I (or any outsider) could achieve total success in persuading participants to accurately describe their lives, it was possible to gather a fairly complex picture of those lives by using interviews with multiple participants from each stakeholder group.

I submitted my project to the Office of Research Protections at the Pennsylvania State University, which approved both the pilot phase (IRB #19708) and main phase (IRB #21360) of the study.

In the sections that follow, I detail the recruitment of participants and the data-collection methods used with each of the three stakeholder groups.

**Recruitment and Data Collection: Immigrant Participants**

I located interviewees from the immigrant community via two pathways: by posting a recruitment flyer written in Russian at an East European grocery store that is a central institution in the community, and by asking my contacts within the Russian-speaking community to ask their relatives, friends, or acquaintances to call me. In all cases, I asked people who were interviewed
to mention my project to others in their circle, in hopes of recruiting additional participants.

Sociolinguistic research even in highly troubled areas such as Northern Ireland (Milroy, 1987) has shown the efficacy of snowball samples conducted by outsiders.

The inclusion criteria were as follows: Immigrant participants were required to be at least 18 years old and to be a member of the Russian- or Ukrainian-speaking immigrant community in the study area.

The flyer posted in the East European grocery store listed contact information both for me and for Nina Vyatkina, a study interpreter I had hired to accompany me to interviews. Nina is a native speaker of Russian and a highly proficient speaker of English, and she has substantial experience in translation and in designing and carrying out research in applied linguistics and intercultural communication. Her cultural knowledge was invaluable, because although I had been ethnographically engaged with the Russian-speaking immigrant community since 2000, I am not a member of that community or its religious bodies.

Through the flyer and the snowball sampling, I enlisted the help of 13 participants from the former Soviet Union. Biographical profiles of the immigrant participants are given in data Chapter 4.

I conducted interviews from October 2005 through April 2006. The interviews were done in participants’ homes or at my office, based on each immigrant’s choice. I translated my consent forms into Russian, and then had them corrected by Nina Vyatkina. Potential participants were given the opportunity to read through the consent documents in English or Russian and to ask questions. All participants were financially compensated for their time ($20 per interview).

The questions for immigrant participants targeted the following:

- Narratives about seeking health care in the U.S. and the former Soviet Union;
- Degree of participants’ acculturation within the immigrant community and the surrounding majority community;
• Language-related affordances and constraints in seeking health care locally;
• Perceived viability of expanding the existing affordances;
• Beliefs about ways in which medical providers could better serve Russian-speaking immigrants.

The full list of immigrant interview questions is shown in Appendix B. Each interview lasted from 45 minutes to about 1.5 hours.

For nine of the 13 participants, the study interpreter (Nina Vyatkina) was available, and those participants were given the choice to conduct their interviews in Russian, English, or a mixture. However, because of difficulties with mutual availability of participants and the study interpreter, I needed to conduct interviews with four participants without an interpreter (i.e., in English only). When Nina was present, she interpreted participants’ answers in Russian into English. She interpreted my English utterances into Russian except in cases where the participant understood the question and answered before she could interpret.

**Recruitment and Data Collection: Staff at Medical Site**

I had heard anecdotally that a particular medical facility—which I will give the pseudonym “the Free Clinic”—served many immigrants, including immigrants from the former Soviet Union. This clinic, staffed mainly by dedicated volunteers, was relatively new, having been started only two years before my interviews there. Its mission was to provide free medical and dental care to people without insurance, both through on-site visits and through referrals to other physicians in the area who agreed to treat the patients for free.

I contacted an administrator at the facility and received permission to interview staff members. Inclusion criteria required that participants be at least 18 years old and have had experience interacting with Russian-speaking patients/clients at the facility. The site’s clinical
director lined up five participants—three clinicians and two social service providers—who were willing to be interviewed about their work with immigrants from the Russian-speaking community. Biographical details of the five participants will be given in Chapter 5.

To conduct interviews with staff, I visited the facility on Nov. 22, 2005. Each participant was given an opportunity to read the consent documentation and to ask questions. All were financially compensated for their time ($100 per interview). As is apparent, a considerable disparity exists in the amounts of compensation being offered to the immigrant and interpreter participants and to the staff affiliated with the medical facility. My rationale was this: Medical personnel in our society tend to receive high rates of compensation per hour (this is true at least for doctors), and I believed that without offering high rates of interview compensation, it might not be possible to recruit participants from that population. Members of the local Russian-speaking immigrant and volunteer interpreter communities, on the other hand, tend not to be employed in jobs with levels of compensation as high as those of clinicians. Therefore it seemed reasonable to assume that those participants would expect compensation that was more in line with the lower amounts.

The interviews with staff at the medical facility lasted approximately 30 to 45 minutes each. Interview questions for these participants targeted:

- Narratives about health-care encounters involving Russian-speaking immigrants;
- Institutionally available language resources;
- Constraints in seeking health care locally;
- Perceived viability of expanding the existing affordances;
- Beliefs about ways in which Russian-speaking immigrants could improve their access to health care.

The full list of medical staff interview questions is shown in Appendix C.
Recruitment and Data Collection: Volunteer Intermediaries

I interviewed three people who reported volunteering frequently as language and cultural intermediaries between Russian-speaking patients and English-speaking doctors in the study context. Inclusion criteria required that participants be at least 18 years old and that they report substantial experience acting as interpreters during appointments involving former-Soviet patients and the medical establishment in the study community.

The first two participants were Masha and Oksana (pseudonyms), whom I met during a pilot study for the current project, as described in Chapter 1. They themselves were relatively recent immigrants from the former Soviet Union, and my initial interest in them was as immigrants. The fact that they both turned out to be volunteer interpreters was somewhat serendipitous and prompted my interest in the role of unofficial linguistic and cultural mediators in the community.

The third participant in this phase was John Smith (pseudonym), who had learned Russian as an adult in order to assist a religious group that was sponsoring resettlement of former-Soviet immigrants. I had heard of him years earlier through an immigrant couple he had helped, and Oksana mentioned him again during my interviews with her. Later, he was mentioned by several of the medical staff members I interviewed, as well as another immigrant, although by that time I had already interviewed John Smith myself.

As noted in Chapter 1, in autumn of 2004, I conducted one interview with Masha (with a follow-up interview cancelled because of a long-term emergency in her family) and two interviews with Oksana. In September 2005, I conducted a third interview with Oksana, who had indicated her willingness to become a key informant in my study. I met Masha and Oksana in their homes for their interviews (and was greeted very hospitably with tea and snacks, as happened at all of the immigrants’ homes I visited). For the current study, I reanalyzed the interviews from the pilot study, using the coding methods described below.
My interview with John Smith, the third volunteer interpreter, was conducted in September 2005 at my office.

Potential participants were given the opportunity to read through the consent documents and to ask questions. All participants were financially compensated for their time. The rate during the pilot project (one interview with Masha and two with Oksana) was $10 per interview; the rate during the current project (one interview with Oksana and one with John Smith) was $20.

Questions for the volunteer intermediaries targeted:

- Narratives about interpreting situations in which they had been involved;
- Roles that these interpreters take on;
- Language-related affordances and constraints on health-care access;
- Perceived viability of expanding the existing affordances;
- Beliefs about ways in which Russian-speaking immigrants and English-speaking doctors could improve health-care access.

The questions for the volunteer intermediary group are shown in Appendix A (for the 2004 interviews with Masha and Oksana) and Appendix B (for the 2005 interview with Oksana and the interview with John Smith).

**Data analysis**

In the following sections, I detail my handling of the collected data. The first subsection discusses the making of descriptive notes from the interview tapes. The subsequent sections describe transcription of interviews, other transcription decisions, and coding of the transcripts.
Descriptive Notes

In order to better manage the data from the two larger stakeholder groups—immigrants and medical-facility staff—I listened to each tape and took extensive notes about recurring themes, contradictory ideas, detailed narratives, verbatim expressions of particularly interesting ideas, etc.

I did not take this step for the interpreter tapes because I had already been engaged with three of the five interview tapes for a year and had written papers about them. Both factors made it easier to gain an initial detailed sense of the interpreter data.

My descriptive notes from the tapes were organized around answers to questions I had asked during the interviews, while still allowing for the emergence of information that I had not anticipated in my questions. Thus, as noted above, my analysis was a form of directed content analysis (Hsieh & Shannon, 2005) or mixed grounded theory, in which initial theories guide the analysis but do not constrain it from addressing additional ideas that emerge from the data.

I should note that I eliminated one immigrant participant’s information from the project without analyzing it (i.e., the interview with a thirteenth immigrant). This participant’s story was such that I felt it would be impossible to discuss it in the current project while still protecting the participant’s identity. Thus, I did not include that participant’s information in the analysis or the project as a whole.

Transcription of Interviews

In addition to the detailed descriptive notes and preliminary papers derived from the

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7 Following Ryan and Bernard (2003, pp. 86-87), I use the term “theme” to describe higher-level concepts that are built from multiple occurrences (“expressions”) of speech, behavior, imagery, etc., in data. Ryan and Bernard write: “To us, themes are abstract (and often fuzzy) constructs…. You know you have found a theme when you can answer the question, What is this expression an example of?” (p. 87). I view the codes that I apply in the current study as operationalized themes.
interview tapes, I wished to avail myself of another rich source of data: transcriptions from the interviews. Two approaches might reasonably have been used at this point: Transcribing selected questions across all interviews, or transcribing entire interviews in order to capture information that was not necessarily in response to one of the interview questions. The latter option appeared more productive because of the potential for expansion of the analysis beyond the categories I had anticipated from reading previous research literature. All transcripts analyzed in this project are shown in Table 3-1. Detailed biographies of participants will be given in the respective data chapters.

**Table 3-1: Participant transcripts**

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Masha</td>
<td>Volunteer interpreter</td>
</tr>
<tr>
<td>Oksana (key informant -- 3 interviews)</td>
<td>Volunteer interpreter</td>
</tr>
<tr>
<td>John</td>
<td>Volunteer interpreter</td>
</tr>
<tr>
<td>Raisa</td>
<td>Immigrant <em>(affiliated with a large nearby university)</em></td>
</tr>
<tr>
<td>Veronika</td>
<td>Immigrant <em>(affiliated with a large nearby university)</em></td>
</tr>
<tr>
<td>Zhenya</td>
<td>Immigrant <em>(affiliated with a large nearby university)</em></td>
</tr>
<tr>
<td>Yakov</td>
<td>Immigrant <em>(affiliated with a large nearby university)</em></td>
</tr>
<tr>
<td>Marianna</td>
<td>Immigrant <em>(not affiliated)</em></td>
</tr>
<tr>
<td>Katya</td>
<td>Immigrant <em>(not affiliated)</em></td>
</tr>
<tr>
<td>Kirill</td>
<td>Immigrant <em>(not affiliated)</em></td>
</tr>
<tr>
<td>Filippa</td>
<td>Immigrant <em>(not affiliated)</em></td>
</tr>
<tr>
<td>Vanessa</td>
<td>Staff member at medical site</td>
</tr>
<tr>
<td>Andrea</td>
<td>Staff member at medical site</td>
</tr>
<tr>
<td>Gail</td>
<td>Staff member at medical site</td>
</tr>
<tr>
<td>Trina</td>
<td>Staff member at medical site</td>
</tr>
<tr>
<td>Jason</td>
<td>Staff member at medical site</td>
</tr>
</tbody>
</table>

I transcribed the interpreter and medical facility interviews myself, resulting in corpora of approximately 30,000 and 23,000 words, respectively. The decisions required in regard to the immigrant interviews—many of which included extensive conversations in Russian via the study interpreter—were more complex. While I have a basic knowledge of Russian, my proficiency is not sufficient to allow me to transcribe colloquial conversations about medical topics. As a result, I hired a Russian-English bilingual to transcribe interviews with three participants, with all
Russian and English turns included. This provided the opportunity to spot-check the accuracy of the study interpreter’s work.

Because the study interpreter’s skills were very strong, and because my primary interest was in the content of the interviews rather than Russian-language linguistic details, I made the decision that the remainder of the transcriptions would be done showing the English turns only (i.e., my statements, participants’ statements when made in English, the study interpreter’s comments in English, and the study interpreter’s English renderings of Russian statements made by participants).

Another decision concerned the selection of immigrant interviews for transcription. After elimination of one participant in order to protect confidentiality, as mentioned above, the immigrant interviews constituted 10 one-hour tapes covering 12 participants. (Two tapes included interviews with couples who chose to be interviewed together.) While it would have been optimal to analyze transcriptions from all 12 participants—in addition to using the descriptive notes, which were analyzed for all 12—because of limited resources I decided to constrain the sample somewhat.

Two of the participants were members of a non-Slavic nationality whose homeland had been annexed by the Soviet Union for many years before gaining independence. They had learned to speak Russian during the Soviet occupation of their homeland, and they had been recruited to my study by a Russian-speaking participant. I found this couple’s insights about medical care in the former Soviet Union and the U.S. to be interesting, especially because there was a marked degree of overlap with the attitudes of the Slavic participants in my study. However, because of the couple’s ethnicity and origins, I considered them to be less salient to my study of the Russian/Ukrainian immigrant population, and thus I did not transcribe their joint interview, although I did consult the descriptive notes of their tape during the analysis.

In selecting focal interviews from the remaining 10 immigrant participants, a valuable
filter was whether or not they had ties to a large nearby university. Five had either direct or spousal ties to the institution, while five had no ties to it. The question of this affiliation is important because those with ties to the educational institution had automatic access to relatively high-quality health insurance, while the others had much more constrained coverage or no coverage at all. Ultimately, I chose to do transcriptions of four participants from the affiliated group and four from the non-affiliated group. I did not transcribe the interviews with the remaining two participants—one from the affiliated group and one from the non-affiliated group. In one case, the decision was made easier because no study interpreter had been available during the interview; while talking with the participant (“Zoya”/non-affiliated) yielded some interesting narratives, I was not confident that we had consistently understood each other, because of our mutual limitations in finding a language we shared. The interview with the other participant (“Klara”/affiliated) was not transcribed because her responses seemed generally similar to those already given by other participants. While I cannot claim that these similarities demonstrated that my immigrant data had reached theoretical saturation (Glaser & Strauss, 1967), I made a decision not to transcribe her interview. Instead, I relied on the descriptive notes from her tape to supplement my analysis of the immigrant data.

The immigrant transcripts included two done by a hired, monolingual English speaker, with Russian turns indicated by phrases such as [speaks in Russian]; I transcribed interviews with three immigrant participants myself, again with Russian turns indicated by phrases such as [speaks in Russian]. Including the three tapes transcribed by a Russian-English bilingual, the immigrant interview transcripts yielded a corpus of approximately 40,000 words.

Other Decisions Regarding the Transcriptions

As Ochs (1979) has pointed out, transcription is itself a form of analysis, since any
transcription is selective in terms of what information it includes and what information it omits. My intent in this project was to investigate participants’ descriptions of their lived experience, in the hopes of better understanding social processes related to health-care access; as noted earlier, such an approach combines characteristics of phenomenology and grounded theory, as described in Starks and Trinidad (2007). Although interesting details of participants’ language emerged in the data—a potential resource for future studies I might do concerning Russian speakers’ acquisition of English or the ways in which native English speakers use “y’know” to build solidarity with their interlocutors—such linguistic details were not my primary concern. Since I was performing a directed content analysis (Hsieh and Shannon, 2005) rather than discourse analysis or Conversation Analysis, I chose to use a transcription style that captured the words spoken, along with laughter and noteworthy emphasis, without including fine-grained linguistic details such as intonation contours, breath intake, or timed pauses.

Transcription conventions were selected and adapted from those often used in Conversation Analysis: Words enclosed in (parentheses) indicate uncertain hearing; ellipsis … indicates omitted information; a hyphen- indicates a restart of a broken-off utterance; [square brackets] indicate a comment or clarification that I have inserted, while (double parentheses) enclose information masked or replaced, such as street names or other potentially identifying information. I generally removed fillers such as “um” and back-channels such as “um-hmm.”

Coding of Transcripts

In order to gain more than a merely anecdotal understanding of the data, it was necessary to develop a coding scheme and apply it to the data. Bradley and Curry (2006) note: “Codes are tags or labels for assigning units of meaning to descriptive or inferential information, and coding is the process of organizing the data into ‘chunks’ that are alike, moving from words and sentence
to ‘incidents,’ which are conceptually similar” (p. 92). As discussed above, I used a directed content analysis (Hsieh and Shannon, 2005) to approach the data; such a method differs from pure grounded theory (Glaser and Strauss, 1967), as Bradley and Curry (2006) suggest, because of the literature-based assumptions that guide the generation of initial codes, which are then expanded upon and made more complex.

In the case of my interpreter data, for instance, my initial codes included the following: professional interpreter (e.g., a person with training as a medical interpreter and employed in that capacity); and naïve interpreter (e.g., a child or family member with limited medical knowledge and/or bilingualism). Both of these categories have a prominent place in the research and policy literature on intercultural health communication and medical interpreting. Another code derived from the literature was interpreters’ values (used to label moments during the interviews when the interpreters explicitly or implicitly touched on moral and ethical judgments that guided their practices). However, some codes emerged from the particulars of my own data: One example would be the interpreter code courtesy. This code was a rather unexpected outgrowth of my interviews with the volunteer intermediary/interpreter Oksana, who at several points mentioned that she liked to deal with clients who were polite and thanked her for her help, rather than those who behaved rudely to her.

Because of the volume of data in the study transcripts (16 focal participants/17 interviews lasting approximately one hour each), it was helpful to use the ATLAS.ti qualitative software program, v. 5.0.66, in coding the data. I loaded each transcript into what the program calls a “hermeneutic unit” (HU), that is, a family of related data. One HU contained the interpreter transcripts, another the immigrant transcripts, and another the medical-site staff transcripts. The program allows multiple codes to be applied to each excerpt. The following excerpt, which is prefaced by the codes I applied to it, will serve as an example:
JOHN (a volunteer interpreter): But what was difficult for the men of (the/that) home to learn the language because after working all day they’re just exhausted, to go to class I mean it was sometimes three times a week (uh/or) two or three times. It was just too much, and to, you know, retain that knowledge (when) they’re going through it, and you’re going through just too much so (it’d) end up with the wife usually knows more English than (her/the/your) husband. And so there’s sort of a disadvantage of (like that).

(Source tape: "John Smith," Sept. 28, 2005)

The codes I used to label this excerpt indicate that John was talking about the Russian Baptist community, was making a comment related to gender, and was talking about ways in which job status could affect language learning and language proficiency. I believe his comment also reveals something about his values as an interpreter, certainly in terms of empathy for the immigrants and probably in terms of distribution of language proficiency across genders.

Another example comes from an interview with “Trina,” a social services provider interviewed at the medical site:

BRUA: And when a person who has Low English Proficiency comes in, how is that situation handled?

TRINA: Low English, you said? Proficiency? Well, ideally there’s someone that could serve as a translator, so we try (that)– or we just make our way [LAUGH QUAVER]. I’m conversational Spanish so sometimes I use my Spanish.

BRUA: And the translators, where do they– where do they come from?

TRINA: Well, it’s not the ideal situation, but a lot of people bring family members and– or friends. We also keep a list of some translators. We have some people that can do– translate Spanish, and we (now/n–) have one woman who can translate Russian.

(Source tape: "Trina," Nov. 22, 2005)

In this case, my codes indicate that Trina mentioned: bilingual staff (herself and possibly others) available at the site to help with communication accommodation; patients or clients who received
communication help from relatives (situations in which the intermediary was most likely a naïve interpreter); and her own language proficiency and that of the staff-affiliated people who help with Spanish- and Russian-speaking patients. Because the staff-affiliated interpreters’ degree of training was not clear to me at this point in the interview, I applied three other codes as a kind of catchall: interpreters; non-professional, non-naïve interpreters; trained interpreters.

I eventually arrived at 134 codes for the interpreter data, 138 for the immigrant data, and 143 for the medical-site staff data. Many of these codes (e.g., communication failed or communication succeeded) were the same for all three groups, because I continuously built upon my code list as I processed additional data. Some codes (e.g., interpreters’ values) had many tokens spread across multiple individuals. Other codes occurred only a few times in the entire data set, as with the code envy, which occurred four times with the interpreter Oksana. One of the strengths of grounded theory and directed content analysis is the ability to subsume such low-frequency, but potentially important, codes into larger categories. In the case of Oksana’s envy code, I co-coded it as an expression of the very frequent code interpreters’ values, and thus the low-frequency code was counted and will be discussed in that larger category.

The full, final list of 143 codes appears in Appendix D. In selecting codes for discussion in the data chapters, I used numerical cutoffs: for the interpreter and immigrant chapters, I discuss all codes that occurred 20 or more times; for the chapter on the medical-site staff, I discuss all codes that had 18 or more occurrences. I used the lower cutoff in that chapter because fewer codes in the medical-site staff corpus reached the level of 20 tokens. Thus, lowering the cutoff allowed me to address additional codes that otherwise would not have been discussed.
Central research question

During the analysis of the data, it became clear that—as in the pilot studies—the attitudes and behavior of the immigrants, medical personnel, and interpreters were strongly influenced by the health-care socialization they had experienced in the former Soviet Union or the United States. In addition, it became clear that language-related resources (and lack of them) had important effects. Thus, in the process of analyzing the data, I arrived at the following formulation of my research question: *In this health-care context involving members of the three stakeholder groups, how do factors related to language resources and health-care socialization enhance or impede access to quality health care?* This overall research question includes a number of related questions, among them: What is the medical-site staff’s conception of language, and how does this seem to affect the language accommodation measures taken or not taken at the site? Which particular aspects of U.S. health-care policy and practice do the immigrant participants regard with suspicion, and which do they view favorably? What ethical dilemmas are encountered by dedicated volunteer intermediaries who have not received intensive training in medical interpreting? In the data and discussion chapters that follow, I delve into all of these questions more fully in an attempt to answer them.

Conclusion

In this chapter, I have provided detailed information about the ways in which the current study’s interview questions were generated, how participants were selected, the process of the interviews themselves, the use of detailed “descriptive notes,” the decisions made in regard to transcribing the data, and the coding and analysis approaches used. Three data chapters devoted to detailed analysis of the interpreter, immigrant, and medical-site staff interviews now follow.
Chapter 4
Data: Immigrant Participants

Introduction

In the past 20 years, the study context has become home to a community of immigrants from the former Soviet Union. Like any group of people arriving in a new country, they face challenges, which will vary from individual to individual depending on available resources. One challenge facing many of the newcomers, however, is in obtaining medical care.

Language is one barrier to medical care: While many of the middle-aged and younger members of the community speak English to some degree (often quite well), elderly members and very recent arrivals might speak little if any English. For example, I once had tea with a family from the former Soviet Union and was introduced to a relative in his sixties or early seventies. He had lived in the United States for about six years at that point, but his ability to hold a conversation in English did not extend much past the word “hello.” Conversely, in the study area, very few medical personnel are able to speak Russian or Ukrainian, the languages spoken natively by many members of the former-Soviet immigrant community. As a further complication, younger members of the community, such as young adults and children born or raised in the United States, might have native proficiency in English but limited proficiency in Russian. Nonetheless, they often are asked to serve as interpreters between Russian-speaking patients and English-speaking medical staff. As these divergent language skills distributed among the older and younger immigrants and the medical providers will suggest, communication can become quite difficult.
Socioeconomic status is another challenge facing the immigrants. Many, especially those from the Russian Baptist community, are working in blue-collar jobs of relatively low socioeconomic status, such as construction or housecleaning. While children in the community are covered by government-provided health insurance, the situation of many of the parents is more complex. At any given time, some have government-provided medical access cards, some are able to afford private insurance, and some have no insurance (including people whose income has risen too much to receive government aid but not enough to afford self-coverage). My sample also includes a number of participants affiliated with a large university in the study area, and those participants have more clear-cut access to health-care coverage. However, for both subsets of my former-Soviet population, logistics of access to the U.S. system and expectations based on health-care socialization will have important effects on attitudes and behaviors related to seeking care.

My research question for the overall project was: In this health-care context—which involves Russian-speaking doctors, English-speaking medical staff, and bilinguals serving as intermediaries for the other two stakeholder groups—how do factors related to language resources and health-care socialization enhance or impede access to quality health care? The current chapter explores the most salient themes that emerged from interviews with immigrant and refugee participants in the study. Table 4-1 provides biographical information on the eight immigrant participants whose interview transcripts were analyzed using ATLAS.ti qualitative software. I also make some use of information obtained from my descriptive notes on four other participants’ interview tapes, and background information on those participants will be included in the text when pertinent.
Table 4-1: Immigrant participants whose transcripts were analyzed

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Time living in U.S.</th>
<th>Had ever lived elsewhere in U.S.?</th>
<th>Income</th>
<th>Reported medical training in F.S.U.?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yakov</td>
<td>30s</td>
<td>Less than 10 years</td>
<td>No</td>
<td>$30,000-39,000</td>
<td>No</td>
</tr>
<tr>
<td>Zhenya</td>
<td>30s</td>
<td>Less than 5 years</td>
<td>No</td>
<td>$10,000-19,000</td>
<td>Yes—level unclear</td>
</tr>
<tr>
<td>Raisa</td>
<td>30s</td>
<td>Less than 10 years</td>
<td>No</td>
<td>$30,000-39,000</td>
<td>Yes—extensive medical employment experience in former Soviet Union</td>
</tr>
<tr>
<td>Veronika</td>
<td>30s</td>
<td>Less than 5 years</td>
<td>No</td>
<td>$30,000-39,000</td>
<td>No</td>
</tr>
<tr>
<td>Kirill (married to Filippa)</td>
<td>40s</td>
<td>Less than 5 years</td>
<td>No</td>
<td>$20,000-29,000 [unclear whether this is single or combined]</td>
<td>No</td>
</tr>
<tr>
<td>Marianna</td>
<td>50s</td>
<td>Less than 5 years</td>
<td>Yes</td>
<td>Less than $10,000</td>
<td>No</td>
</tr>
<tr>
<td>Katya</td>
<td>40s</td>
<td>Less than 5 years</td>
<td>No</td>
<td>Less than $10,000</td>
<td>Yes—extensive medical employment experience in former Soviet Union</td>
</tr>
<tr>
<td>Filippa (married to Kirill)</td>
<td>40s</td>
<td>Less than 5 years</td>
<td>No</td>
<td>$10,000-19,000 [unclear whether this is single or combined]</td>
<td>No</td>
</tr>
</tbody>
</table>

I identified overarching themes in the data as follows: The descriptive notes I had taken on the interview tapes furnished some preliminary themes that I kept in mind as I turned to the actual transcripts. After loading the transcripts into the ATLAS.ti software program, I began reading through each transcript to generate codes that captured recurring ideas mentioned by the participants. As I processed my data across all three stakeholder groups (immigrants, medical
staff, and volunteer intermediaries), I used a universal coding list to which I added as new ideas emerged in any particular transcript. My code list for the interpreters included 134 codes; the list for the immigrant participants had an additional four codes, for a total of 138; and my medical staff data had an additional five codes beyond that, for a total of 143 codes. The complete list of all codes across the entire project is shown in Appendix D.8

In this chapter, I will analyze codes that occurred 20 or more times in the data set of immigrant transcripts, shown in Table 4-2.

Table 4-2: Top-ranked immigrant codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Total no. of tokens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portray U.S. System</td>
<td>Participants’ descriptions of health care in the United States</td>
<td>56</td>
</tr>
<tr>
<td>Medical Narrative</td>
<td>Stories about illness, injuries, or health-care encounters</td>
<td>54</td>
</tr>
<tr>
<td>Portray Rus System</td>
<td>Participants’ descriptions of health care in the Soviet Union and its successor states</td>
<td>41</td>
</tr>
<tr>
<td>Immigrant Medperson</td>
<td>Mention of immigrants who have medical training</td>
<td>34</td>
</tr>
<tr>
<td>Lang Profic</td>
<td>Mention of language skills as an important factor in an interaction</td>
<td>27</td>
</tr>
<tr>
<td>Cost Factors</td>
<td>Discussion of price in relation to health care</td>
<td>26</td>
</tr>
<tr>
<td>Insur</td>
<td>Mention of health insurance as a factor in medical access</td>
<td>21</td>
</tr>
<tr>
<td>Portray Medperson</td>
<td>A catchall category for evaluations of medical providers</td>
<td>20</td>
</tr>
</tbody>
</table>

In order to discuss themes most efficiently, I have chosen to combine related codes and filter others as follows:

- I combined Portray U.S. System & Portray Russian System into an analytic category I call Comparative Medical Systems. I additionally discuss interview excerpts from the code Russian Logistics (13 tokens—mention of how medical appointments are made in the former Soviet Union), which is closely related to Comparative Medical

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8For a more detailed discussion of the coding procedures, please see Chapter 3.
Systems, even though the logistics code was not numerous enough to make the 20-token cutoff.

- I filtered all of the other codes in the list above out of the Medical Narratives code to avoid duplication. That resulted in 16 quotations that did not contain any of the other most frequent codes. The resulting “narrowed” code was dropped from the analysis because it did not contain information that seemed particularly salient to my topic.

- I merged Language Proficiency with the codes Language Learning (12 tokens) and Language Attrition (2 tokens); even though the latter two were not numerically frequent, they seem to belong semantically in the same domain as Language Proficiency. The resulting analytic category will be called Language Skills.

- I merged Insurance into the code Cost Factors and also added in the less-frequent but semantically related High Cost (16 tokens) to form an analytic category called Cost Factors.

These operations leave five analytic categories that will be analyzed in relation to the immigrant participants (shown in Table 4-3).

Table 4-3: Analytic categories for immigrant participants

<table>
<thead>
<tr>
<th>Analytic category</th>
<th>Description</th>
<th>No. of tokens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparative Medical Systems</td>
<td>Portrayals of health care in the former Soviet Union and the United States</td>
<td>110</td>
</tr>
<tr>
<td>Cost Factors</td>
<td>Discussion of cost of care and issues related to health insurance</td>
<td>63</td>
</tr>
<tr>
<td>Language Skills</td>
<td>Discussion of language skills, language learning, and language attrition</td>
<td>41</td>
</tr>
<tr>
<td>Immigrant Medical Personnel</td>
<td>Mention of immigrants who have medical training</td>
<td>34</td>
</tr>
<tr>
<td>Portrayals of Medical Personnel</td>
<td>A catchall category for evaluations of medical providers</td>
<td>20</td>
</tr>
</tbody>
</table>
In order to capitalize on interrelationships or thematic “flow” in the excerpts, I will use the following order to discuss the analytic categories:

1) Comparative Medical Systems
2) Cost Factors
3) Immigrant Medical Personnel
4) Portrayals of Medical Personnel
5) Language Skills

**Comparative Medical Systems**

Highly advanced biomedical systems are found in both the former Soviet Union (F.S.U.) and the United States. While these biomedical systems have much in common, there are also significant differences, as noted in Chapter 2, including divergent priorities in terms of infrastructure resources (Barr & Field, 1996; Field, 1995; Tulchinsky & Varavikova, 1996). When interviewing immigrants, I made clear my interest in comparing the medical systems they had experienced in both the F.S.U. and the U.S. In response to narratives, I asked questions such as “Now if your medical visit had happened in Russia, what would have been similar and what would have been different?” But participants also commented without specific prompting on perceived similarities and differences in the two medical systems.

A number of sub-themes appeared in the data:

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9 While both geographical areas also manifest systems of alternative medicine, including use of herbal medications, a comparison on that level was less salient in the interview data. For instance, while immigrants made clear that they continue to use herbal treatments they learned in the former Soviet Union, in the interviews they did not really compare or contrast these with herbal treatments practiced in the United States.
• *Evaluation of quality.* Participants tended to portray U.S. health care as technologically superior but lacking in the human touch. Conversely, some of the participants implied that because they were being treated through a government support program, they faced particular problems with the quality of practitioners and materials used.

• *Logistical differences.* Participants discussed differences in how medical providers were selected and visited in the two biomedical systems. Issues of payment will be considered separately under the *Cost Factors* category.

• *Medication differences.* Participants noted that many drugs available over-the-counter in the former Soviet Union are controlled via prescription in the U.S. Several participants also expressed consternation about what they perceived as overuse of antibiotics at early stages of treatment in the U.S.

These sub-themes will be investigated in detail in the following sections.

Comparative Medical Systems: Evaluation of Quality

In speaking about the relative quality of U.S. and former-Soviet health care, several of the immigrants said that U.S. diagnostics are better. Katya (all participant names are pseudonyms), who had worked for many years in health care in the former Soviet Union, said through the study interpreter:

**INTERPRETER:** I think (just) the technical equipment is better here— the diagnostics is better, because when you come to the doctor— to the dentist here, umm, they do the— they— they look at everything — they do X-ray and then they tell you everything— what problems you have. In Russia you just come to the dentist and tell the dentist what problem you have yourself, so you— you have to tell it to the doctor yourself. But here, he does the complex, umm, investigation first, but then I just think, umm, we just get to— not to the best dentists, so I think the technical equipment and the procedure is better here, but not the doctors.

*(Source tape: “Katya,” Jan. 30, 2006)*

Katya here and in subsequent comments contrasted the system in the U.S., where she said a more
holistic dental exam is given, with the former-Soviet approach, which she said focuses more on the tooth identified as problematic by the patient. While she contended that the doctors she had encountered in the U.S. were not of top quality, she also prefaced that judgment with a limiting statement: "We just get to- not to the best dentists." As a Baptist refugee, she would likely be constrained in her choice of dentists because only a handful of dentists in her area accept payment via the government-issued medical access card distributed to the refugees. At another point she mentioned that the crowns installed in the former Soviet Union had remained in her mouth, while one installed in the U.S. had fallen out several times. Her implication seemed to be that the U.S. material or workmanship was inferior.

However, in telling the story of a relative who had died in the U.S., Katya (through the study interpreter) spoke more positively:

INTERPRETER: Well here, ((the relative)) had a ((major surgery)) and if she had better health in general, if she was stronger, she could have survived, but in Russia nobody would just, you know, have attempted to do a surgery for a person of her age and, you know, it’s just too complicated and too expensive in Russia. But here she was operated. So I think in general it’s better here.  

As with Katya, the role of U.S. technology was mentioned by Raisa, another immigrant who had worked in health care before immigrating:

RAISA: United States workers have so many machines, so many machines. This is good, this is bad- for people because this is, on the one side this is help us work faster, but on emergency situations this is bad because so many people don’t thinking, don’t working by (their) hand.  
(Source tape: "Raisa," Oct. 9, 2005)

It was unclear to me whether she was speaking about the medical profession in particular or the U.S. workforce in general. Her point seems important in several ways: First, it is a reminder that her original experiences as a patient and a health-care provider occurred in the former Soviet Union, where infrastructure challenge—such as lack of running water in 15 percent of hospitals as of 1990 (Tulchinsky & Varavikova, 1996)—were common. Secondly, it may speak to her
experience growing up in a culture that within living memory had experienced the deaths of many millions of soldiers and civilians in World War II and that had been under generalized socioeconomic stresses in more recent decades (Abbott, Tumov, & Wallace, 2006; Barr & Field, 1996; Brown & Rusinova, 1997; Field, 1995; Lipsitz, 2005; Salmi, 2003; Tulchinsky & Varavikova, 1996; Wright, Stack, McMurray, & Bolyukh, 2000). And thirdly, her perspective offers an interesting question about the ability of the U.S. medical infrastructure to cope with large-scale disasters if deprived of its advanced technologies—a question that does seem significant in the wake of events such as the 9/11 terrorist attacks or the inundation of New Orleans during Hurricane Katrina.

A few lines later, Raisa portrayed American laypeople as afraid to offer first aid because they have been socialized to just call 911 and stand back, so as to avoid responsibility or liability for bad outcomes. She said that by contrast, many people in the Soviet Union know how to perform first aid or do simple health-related tasks such as checking blood pressure.

In discussing quality of health care, another immigrant, Veronika, contrasted two U.S. doctors whom she had dealt with. She said one doctor gave health exams in a cursory manner if it was just a routine visit, but her preferred doctor was thorough even during routine exams, an approach that Veronika said she expected from her experience living in Ukraine. She also mentioned U.S. diagnostics, although in this case it is not clear that high technology was used in the diagnosis:

VERONIKA: Here. Here yeah. So in our country it’s not [SHIFTS TO RUSSIAN]

INTERPRETER: The diagnostics [VERONIKA: yeah] is better here.

VERONIKA: Yeah, better [SHIFTS TO RUSSIAN AGAIN]

INTERPRETER: It’s like uh Veronika had a problem and she assumed what it could be. But the doctor said a completely different thing, so she had some doubts, but in the end in fact it turned out the doctor was right, and now she trusts the doctor.
VERONIKA: Yeah, really I trust her.  

Kirill and Filippa, a married couple who asked to be interviewed together, expressed a number of strong misgivings about health care in the United States, as we will see in later sections. (Kirill, in fact, at one point used the English term “bloodsuckers” to describe U.S. doctors.) One quality issue that emerged was also related to form of payment:

INTERPRETER [speaking after Filippa has spoken in Russian about a dental appointment]: And also the- their daughter has insurance but for some reason they give her- the filling is somehow dark, it's (a) darker color, so if you pay real money they give you very good material for filling, but to ((daughter)) they gave her some dark material.  
(Source tape: “Kirill & Filippa,” April 8, 2006)

There was no indication in Filippa’s narrative why she considered the “dark material” to be inferior in quality. But the excerpt does hint at Kirill and Filippa’s rather pronounced distrust of the medical system in the United States.

An immigrant named Zhenya was perhaps even more skeptical. While her family had insurance coverage, at one point the insurer declined coverage for treatment of an ER visit by Zhenya, and a months-long struggle to rectify the situation commenced. During this period, Zhenya’s young child was injured while playing. She took him to a hospital but experienced the physicians’ treatment as less than satisfactory. At this point, Zhenya’s ER bill had not been paid, and she believed that the doctors knew this:

INTERPRETER: So she thinks that that was the reason that they didn’t assign any X-ray or tomography, what would be appropriate as she thinks. Umm, because they have (not x) their first bill paid and they just looked at him and said, OK it has been five hours already and we don’t see any signs that, umm, (what is it, the) hematoma is developing or, you know, something bad is developing in the brain or something. So they said, you don’t have to do anything- tomography and X-ray can be dangerous for the child, so we recommend you not to do anything.  

According to Zhenya, the doctors recommended painkillers and two days’ of bed rest for the child. She opted to keep him out of school for five days while he recovered.
Zhenya did, however, encounter U.S. medical personnel whom she trusted. In one episode, she was treated by a physician’s assistant, who asked detailed questions. The physician’s assistant then brought in a doctor for consultation, who in turn called in a third doctor (at no charge). Zhenya said that appropriate tests were ordered and the situation was resolved to her satisfaction. The interpreter relayed the following comment from Zhenya: “And the last case convinced her that actually the doctors here are good if they are really interested in finding out about the cause.” Zhenya, who had some unspecified medical training herself, expressed more confidence in the health care offered in her home country:

INTERPRETER: So she thinks it’s an absolutely different experience from medical treatment in Russia and here. Because in Russia she can count 100 percent that somebody would help her, because she had this, umm, neighborhood doctor she was assigned to… And emergency is free in Russia… And all the doctors—emergency doctors are all trained and (have power/empowered) to give you help on (site) when they come. And, umm, she is also certain that if she comes to an emergency room in Russia, the doctors in the emergency room will prescribe her everything that is necessary for the treatment.


An immigrant named Marianna expressed a less rosy view of health care in the former Soviet Union. At one point, the interpreter relayed the following: “She thinks that in general, the general principle of the medical care in Russia and the Ukraine is ‘help yourself.’ (Basically) cure yourself…. And people go to the doctor just as the last resort, if they (can) help themselves.” I asked Marianna why she believed this, and the following answer emerged via the interpreter (Marianna’s comments in Russian were interspersed throughout, often in overlap, and I have included only the interpreter’s turns below):

INTERPRETER: It’s if you want to get reasonable help you have to pay now, because doctors are paid very poorly in the Ukraine, so you have to count on expenses if you want (real) help from the doctors in Ukraine now. … Also, second reason. It’s pretty

10 As noted in the literature review, in Ukraine and presumably other parts of the former Soviet Union, ambulances are staffed by physicians rather than paramedics (Wright, Stack, McMurray, & Bolyukh, 2000).
difficult to find a qualified personnel - medical personnel in the Ukraine... The hospitals are in very poor condition ( ) they don't have (equipment) necessary (x) ... Even basic like cotton balls, it's ( ) ... If you go to the hospital, you have to buy your medicine yourself and take it with you ( ) ... And also pay them ( ) ... So you have to (pay) (x x x) at the hospital ( ), you have to pay the nurses and the assistant personnel so that they take good care of you.


I then asked whether these payments were “under the table” and Marianna replied that they were.

However, Marianna then went to some lengths to say that the former-Soviet system did have some advantages over the U.S. one:

INTERPRETER: But now there are clinics where it’s official, so they’re not (x x) and you have to pay officially... Of course it’s much less than here if you compare to here, but if you take into account the salaries of the people in the Ukraine, it’s a lot for them. Although it’s - you can’t compare it to these prices here... There are good doctors in the Ukraine. And if you have money, it can be much cheaper in the Ukraine- if you find a specialist, it will be much cheaper and (you’ll/he’ll x good) surgery or if you find a good specialist, it will be cheaper than here ... Yeah, emergency room (use-) - emergency room is free in the Ukraine. So you can get reasonable help if it’s really an emergency... So although there is some medical personnel that is definitely underqualified, but there are also people who are highly qualified ... Many- many doctors don’t- ( ) take even less money from people. [FROM CONTEXT, THE MEANING WAS THAT SOME GOOD DOCTORS DON’T TAKE UNDER-THE-TABLE PAYMENTS, OR ARE EVEN LESS EXPENSIVE.] And there are many good doctors that work for free.


We will return to the issue of health-care prices in the section on Cost Factors below.

A number of the attitudes expressed above by participants in my study have been noted in previous literature about immigrants from the former Soviet Union. For instance, in research with women who had recently moved to the U.S. from Belarus, Russia, and Ukraine, Ivanov and Buck (2002) reported of one focus group:

This group also voiced that with all the equipment and technology the quality of care [in the U.S.] was good but they still felt that their physicians in the former Soviet Union were more thorough because they depended on touching their bodies and blood analyses to diagnose illness. One woman added that “Here you walk in, they quickly look at you, and tell you that you are okay.” (p. 25)
I was somewhat surprised that the participants in my study portrayed health-care in the F.S.U. in such a relatively positive way, in light of the research literature’s portrayal of Soviet and post-Soviet health care as abysmal (e.g., Barr & Field, 1996; Field, 1995; Tulchinsky & Varavikova, 1996). An exception was the relatively negative view of “last resort” F.S.U. health care described by Marianna, who portrayed doctors in Ukraine as often underqualified and hospitals as lacking basic materials such as cotton balls. The idea of seeking official health care as a last resort was also expressed by the immigrant participants in Ivanov and Buck [2002]—but in relation to U.S. health care, because they said they could not afford their co-payments.

There are several possible reasons for the immigrants’ relatively positive portrayal of former-Soviet health care. It may be that Western research literature is biased against the post-Soviet system, for reasons of political or medical-culture ideology (e.g., assuming that a Western model is the best model for health care). However, the literature has sometimes taken pains—as in Tulchinsky and Varavikova (1996)—to point out things that the Soviet health-care system did well, such as suppressing infectious disease in the early part of the 20th century. A second possibility is that, while health-care in the F.S.U. was problematic, the different problems facing the immigrants in the U.S.—such as high cost or lack of language accommodation—might be more salient since they are experiencing them currently. One major difference between the F.S.U. and U.S. systems is in the logistics of access, and I will now turn to that topic.

**Comparative Medical Systems: Logistical Differences**

Participants mentioned a number of differences between the former-Soviet and U.S. health-care systems in terms of logistical factors such as scheduling of appointments. These differences often seemed to influence patients’ evaluation of the quality of care they received in the U.S. system.
Veronika, whom we have encountered above and who expressed general satisfaction with the care she had received in the U.S., said she was initially unsure about the ways in which generalist/specialist duties are distributed in the American system:

VERONIKA: Uh in our country if you have problem with something, you chose [HER PRONUNCIATION]- you must chose different doctors for that. For example if you have (a) leg pain you go to khirupri( ) surj-

INTERPRETER: surgery

VERONIKA: surgery and if you have an- I don’t know something with your lungs, you go to the therapy- physical therapy. If you have problem with your, I don’t know, head maybe, you go to another doctor. So you choose uh different doctors for that. And here it’s one doctor for all problems. And so um I um have a um little bit [SHIFTS TO SPEAKING IN RUSSIAN]

INTERPRETER: I am a little bit afraid.

VERONIKA [IN ENGLISH:] Fraid yeah with that because uh sometimes I have different problems and I don’t know what I must do with that. But uh doctor (was nice doctor) and when I come to her and uh and says her I have uh something this ( ). And they exactly know what happened, they check me and exactly know what happened with me, and they says me your condition it’s really good, ( ) I um I feel better in shorter time bef- after that.

(Source tape: "Veronika," Oct. 9, 2005)

An immigrant named Yakov spoke at length about the logistics of going to the doctor in the former Soviet Union:

YAKOV: But if it’s not emergency, then basically a person would go to some kind of clinic, more like multifunctional, it’s called polyclinic, at the like- at his residential area, normally closest to the person’s home. And if- generally, if a- if the person lives in that area for like kind of some period of time and has already been applying for some kind of medical help, there will be some kind of card or some information about the person, so the person just goes to a kind of- it’s called registratura in Russian- it’s kind of reception department in that clinic and says that “I have certain problem and I need to s- (wait)- to see some- see doctor,” depending on what kind of problem is it, it can be (is) a surgeon or like a therapist or (whatever). And then the receptionist would give him (a) kind of appointment- like what they used to have in most cases, normally the same day if there is time available. (But). And then the person would go to the office of that specialized doctor. Normally- I don’t know maybe now system is changing, but before it was not like a family has a doctor for primary care physician or family doctor.
He said that a similar clinic-based approach would apply when making dental appointments.

From the accounts given by Veronika, Yakov, and some of the other participants, we can see several ways in which former-Soviet health care was, at least during the time when many of the immigrants were experiencing it, quite different from the current U.S. practice: 1) Patients were assigned to a polyclinic in the vicinity of their homes (at least in urban areas); 2) upon reaching the polyclinic, the patient would be routed to a specialist who (Yakov noted) would be in the same building or one close by; 3) and patients generally would be seen by a doctor that same day\textsuperscript{11}.

The immigrants encounter very different logistics in their new home, a relatively low-population town and the surrounding semi-rural areas. Patients are not assigned to a doctor based on geographical proximity to their residence (a factor that can make life more difficult for patients who do not have a car); instead, patients typically will be given a list of participating providers based on insurance coverage or state-provided access cards. In some cases, the lists might be quite constraining, and geographic proximity to a patient’s home is not a given.

Secondly, as Yakov noted, the U.S. system tends to be based on coordination by a central provider (e.g., a general practitioner) who should be consulted before seeing a specialist—if one wants to be reimbursed for the visit.

My participants also mentioned a potentially more frustrating difference: Walk-ins are standard in the former-Soviet system, while they are unusual in non-emergency health-care in the

\textsuperscript{11}As Yakov noted in his interview, and as has been noted often in the literature (e.g., Abbott, Turmov, & Wallace, 2006; Barr & Field, 1996; Brown & Rusinova, 1997; Field, 1995; Lipsitz, 2005; Salmi, 2003; Tulchinsky & Varavikova, 1996; Wright, Stack, McMurray, & Bolyukh, 2000), the former-Soviet health-care system has been changing rapidly since the collapse of the communist regime. Privatized (e.g., based on personal insurance) and socialized approaches are now in flux, and one result has been increased difficulty in access to health care. Depending on when each immigrant came to the U.S., they would have experienced different permutations of the post-Soviet system.
immigrants’ U.S. community. Thus, getting in to see the doctor in the United States can take much longer than a single day, the standard to which the former-Soviet patients are accustomed.

Although two Soviet-born interpreters will be considered in Chapter 6 on interpreters, a comment by one, Oksana, seems worth mentioning here. Oksana was generally very laudatory of the U.S. health-care system, but she did have this criticism:

OKSANA: Some people who come from uh from- (come) from Russia, they um they were wondering- it’s- it’s completely different system. In Russia you can just, if you're g- uh if you (‘re) sick you could- uh you can go to doctor right away, you don’t need to make an appointment or anything. Or if you make an appointment, you don’t have to wait such long. So maybe I have to t- to say to doctors [LAUGH QUAVERS] could you, could you like- we need to get your help as soon as possible and why we have to wait such long to get y’know to get your help?

BRUA: Now when you say wait that long, do you mean in the waiting room or maybe a couple days you have to wait?

OKSANA: Yes. Not couple days, couple of months

BRUA: Uh-hmm

OKSANA: Sometimes. It depends what kind of specialist you making an appointment to.

BRUA: So in Russia it was easier to just get access. [OVERLAP]

OKSANA: ( ) Go right into doctor’s room, that’s it, (we) don’t have to wait.


The immigrant Kirill made a similar critique concerning the scheduling of appointments:

KIRILL: And actually there is a problem in this area. I don’t know is it particular problem in the ((Town Name)) area or it’s a problem entirely in the medical system (at all). When I tried the first time to get a medical appointment, just for driver license purposes (it's uh). I have tried to get couple medical offices even ((another smaller town)), and no one, no one gave me appointment closer than months ahead... Yeah and everyone asked me, Are you patient here? I said no. OK, we have for you just 30, 35 days ahead, that’s it... I said OK I would pay money if we (have). [QUOTING VOICE:] OK we know- (no/know we ) you don’t have medical insurance, OK we know but we can’t do much about it.

(Source tape: “Kirill & Filippa,” April 8, 2006)
Interestingly, at the end of the excerpt above, Kirill links wait time with form of payment. Initially, I assumed that Kirill was offering to pay under the table to get in more quickly. If he was doing so, then he was attempting to use a technique from the former Soviet Union in dealing with the U.S. system. However, a different interpretation is also possible. Based on the context of his remarks here and elsewhere, he may have been echoing a suspicion—voiced by other immigrant participants as well—that use of the government-provided medical access card led to second-class treatment, and he may have been offering to pay his bill directly in cash. I am unsure which interpretation of his remark is more accurate.

At another point, Kirill noted ruefully that a dentist had charged him extra for emergency help—which still entailed a three-day wait before an appointment was available.

**Comparative Medical Systems: Medication Differences**

Access to medication was a difference mentioned by several of the immigrant participants. Yakov, for instance, said: “So (it was) basically, in Russia, much wider circle of medications is available without prescriptions, which is not the case here.” Kirill and Filippa developed this theme at length in their interview.

**FILIPPA: [SPEAKING IN RUSSIAN]**

**INTERPRETER: I needed something simple because I know what I used to use in Russia for that, it’s a specific medicine, and you can get it over the counter in Russia and here I can’t get it over the counter and I have to call my friends, my Russian friends, and somebody just gave it to me, the Russian medicine.**

**KIRILL: So it’s (v- v-) actually it’s very simple stuff. But you never can get something like this here.**

(Source tape: “Kirill & Filippa,” April 8, 2006)

Elsewhere in the interview, Kirill gave voice to a similar frustration:

**KIRILL: I guess a lot of Russians already said this because you can’t buy antibiotics over counter. You definitely should go to the doctor. And if you have some kind of medical coverage, that’s fine. But if you have no, you should pay- antibiotic itself, it’s**
pretty cheap, it’s 15, 20 dollars per course. But you should pay for visit about 50 or 60 dollars, just for the visit to the doctor. Just for piece of paper.
(Source tape: “Kirill & Filippa,” April 8, 2006)

The participants in Ivanov and Buck (2002) similarly mentioned importing medicines from the former Soviet Union because the medicines either were not available over-the-counter in the U.S. or were more expensive here. Shpilko (2006) notes that other reasons for use of imported medications include a preference for familiar medications. She adds that there are some dangers in this practice because of potential interactions with the drugs prescribed by immigrants’ U.S. doctors, who might be unaware of the use of imported medications.

One other medication difference emerged around views on the use of antibiotics:

FILIPPA: And [THEN CONTINUES IN RUSSIAN]

INTERPRETER: And also I have an impression that the local doctors don’t know anything but antibiotics. So it would be nice if they could prescribe something else.

FILIPPA: [SPEAKS IN RUSSIAN]

INTERPRETER: I know that Russian—good Russian doctors never prescribe you antibiotics at first, they try different other drugs first, because antibiotics are very damaging to the organism, to human organism.
(Source tape: “Kirill & Filippa,” April 8, 2006)

A similar viewpoint emerged in interviews with two immigrant participants from a non-Slavic region that had been under Russian control until the collapse of the Soviet Union. Both had spent some of their formative years under the Soviet health-care system. The husband noted:

We don’t really rely very much (in) antibiotics at the very first treatment (when) (yes) we know that antibiotics actually kill(ing) good bacteria, not only bad. So we try to start with something that would be little bit milder treatment and then, as a last resort, go to antibiotics.
(Source tape: “Non-Slavic couple,” Nov. 25, 2005)

12 This reason was also mentioned by the participant Oksana in my study.

13 Although not Slavs themselves, they spoke Russian in addition to their native language, and they were enlisted for my project by other immigrants from the Russian/Ukrainian community.
Several interesting observations can be made in regard to the immigrants’ attitudes toward the use of antibiotics. One is that these stances are not unique to my study population: Ivanov and Buck (2002) report that one of their focus groups “expressed dissatisfaction with the heavy reliance on medications to treat illnesses with penicillin as a ‘cure all’ rather than relying on alternative therapies such as massage and herbal teas” (p. 22). Another noteworthy point is that bacterial resistance to antibiotics is a growing problem worldwide, and one reason for this trend is overuse of antibiotics; thus, the immigrants’ reluctance to use antibiotics may have an adaptive side. Thirdly, some immigrant participants, including Kirill, did mention a desire to use antibiotics when they believed them to be necessary.

Cost Factors

We have seen some mention of cost factors already, as when Zhenya and Marianna said that emergency care is free in the former Soviet Union, or when Zhenya contended that the doctors did not provide adequate treatment to her injured son because of her family’s unpaid bills, or when Kirill and Filippa implied that their daughter received substandard dental fillings because of her payment method. But the immigrant participants expressed a wide range of attitudes toward health-care costs, and I will now delve into these in more detail.

Katya made the following comment:

**INTERPRETER**: And actually, before coming here, we heard—people were threatening us that here if you have no money you have no access to medical care whatsoever. That’s not true. So, anyway, everybody gets access one way or another. So somebody would help you, pay for you if you don’t have money….


Her assessment may have been influenced by her situation as a medically trained immigrant—she said that she rarely went to the doctor because she generally could take care of herself. It is true
that in many areas nationwide, free care at hospitals is available to those with very low incomes; in addition, in Katya’s town there is a health-care clinic for people with no insurance—the Free Clinic that will be described in Chapter 5. However, as Kirill, Filippa, and the interpreter Masha noted in their interviews, immigrants and refugees’ health-care coverage (via the government-provided medical access card, employer-provided insurance, or self-provided insurance) could fluctuate depending on a person’s income—more income might mean the loss of government-provided coverage, or it might mean that the immigrant would receive employee benefits because of a better job or at least have more money to devote to medical care.

Zhenya, who was skeptical of the treatment her child received for an injury, also told of an earlier encounter with the U.S. health-care system in which cost was an issue. Soon after her arrival, she experienced worrisome symptoms. She recounted the following (only the interpreter’s turns are shown):

INTERPRETER: So she called ((an ambulance corps)) and they came and explained to her that it will be very expensive to her, about $1,000 if they take her... So they recommended to go to the emergency room, but by herself... It happened after- 10 days after they arrived in the U.S., and they didn’t have car so they had to call for a cab.


As noted above, she and her family became embroiled in a dispute with their insurance company following her treatment at the ER (only the interpreter’s relay of the story is included below):

INTERPRETER: The husband did have an insurance already, and she was certain that she– she was automatically enrolled. But then something very unpleasant happened... He has a contract, umm, and he is covered 100 percent, but his wife and children are covered only with 70 percent. So when they- the nurses and the doctor- the doctor offered treatment, they- they agreed to everything and it was not- actually not much: two tests and then medicine, a prescription medicine... When they received the first bill, it came to their home address and it was altogether one thousand two hundred or three hundred dollars. (This) $1,000 for tests and hospital services and two or three hundred for the doctor’s visit.

Zhenya thus characterizes the services received as “actually not much,” at least in the context of the amount charged. Because of a paperwork problem, the insurer initially declined to provide any coverage at all for Zhenya; she reported that it took from August to April to resolve the problem, during which time she kept receiving bills for $1,200.

Kirill and Filippa told several narratives in which financial considerations constrained their actions. The following story involved a dental problem that Filippa had experienced:

INTERPRETER: So I have to wait for one week, and [FILIPPA: (to/two)] it got worse

BRUA: This is when you had the bad tooth?

FILIPPA: um-hmm [speaks in RUSSIAN]

INTERPRETER: ( ) get it out but I didn’t have money at that point.

FILIPPA: [in RUSSIAN]

INTERPRETER: So I waited for one month and then I just couldn’t

FILIPPA: ( )

INTERPRETER: couldn’t bear it any more

BRUA: Sure. Sure.

FILIPPA: [in RUSSIAN]

INTERPRETER: I had inflammation, I had fever

FILIPPA: [in RUSSIAN]

INTERPRETER: I borrowed some money and went to the dentist and they took it out

KIRILL: ( )

FILIPPA: [IN RUSSIAN]

INTERPRETER: In ((name of town where they lived)) it’s more expensive

KIRILL: Much more expensive, but also

INTERPRETER: Yeah, they have done a good job, but it was much more expensive...
In this case, while Kirill and Filippa seemed satisfied with the eventual outcome, it also seems noteworthy that lack of money caused Filippa to delay treatment for a month until she could no longer stand the pain. Filippa also said that financial constraints might prompt her to take extreme measures:

**FILIPPA:** [IN RUSSIAN]

**INTERPRETER:** So I think if I get very sick, I will have to go to Russia to get myself cured, because it costs here an incredible amount of money, and I will not be able to afford it.

**FILIPPA:** [IN RUSSIAN; LAUGH QUAVER]

**INTERPRETER:** ’Cause I will stay in debt for the rest of my life.

Early in my ethnographic engagement with the Russian-speaking community, I had been startled to hear that international medical travel was considered a cheaper alternative to U.S. health care. In that early case, an immigrant told me of a relative who traveled back to the former Soviet Union to have a set of false teeth made for $50 (plus airfare). But the strategy was by no means an isolated occurrence. In addition to Filippa’s remark in the preceding excerpt, the immigrant Marianna expressed something similar. She reported that when she first arrived in the U.S., she had bought health insurance at a cost of $100 a month but soon dropped it because it was too much of an expense. Later in the interview, we returned to the issue of Marianna’s early health-insurance coverage in the U.S.:

**INTERPRETER:** But after that she decided to cancel the insurance, it was just an emergency insurance, and she decided to- she decided in emergency, she would go to (a city in the former Soviet Union).

Former-Soviet immigrants in other studies have expressed similar concerns about cost as a barrier to health-care in the United States. Ivanov and Buck (2002), for instance, note of their middle-aged focus group:
Although all women in this group had insurance, they considered the cost of health care as a major barrier and used it only when no other home remedies or Russian medications worked. They shared that most of their money was used for groceries and household expenses with little left to spend on seeing physicians when ill and even less for preventive health care. (p. 23)

**Immigrant Medical Personnel**

One interesting and unanticipated outgrowth of my interviews was encountering immigrants and refugees who had been medically trained in the former Soviet Union, a category I am calling “immigrant medical personnel.” Of the 15 immigrants/refugees I interviewed (including two serving as interpreters), four were members of this category: Katya, Raisa, Masha, and Zhenya. In the following section, I will focus only on Katya and Raisa because their training was actually completed in the former Soviet Union; with Masha and Zhenya on the other hand, either their training was disrupted by the move to the U.S. (Masha) or it was unclear during the interview whether the training had been completed or was only partial (Zhenya).

Katya had been a clinician for many years in the former Soviet Union, but in the U.S., she worked as a housecleaner. However, she also was volunteering at a medical facility that served many members of the Russian-speaking community; she mentioned helping with patient intake, paperwork, and with translation. We talked a bit about why she was not working for pay in the medical field here. She said, via the study interpreter:

**INTERPRETER:** I have teenagers children—teenager children, so I want to spend more time with them, and I know if I start the certification process— it will take a lot of time and I would prefer to stay (day and night) with my kids now.


Katya’s unofficial (i.e., unpaid) medical role was not solely focused on the facility where she volunteered. Because of her years of clinical experience and her native proficiency in Russian, she also helped friends and relatives as an unofficial medical adviser. In fact, when I first met her—at the home of an immigrant family where I was conducting an interview with another
participant—one of the others smiled, pointed to Katya, and said something along the lines of “This is *our* doctor.” Katya naturally also used her knowledge for self-care. When I asked her (as I did all the immigrant participants) how she knew which U.S. doctors were good and which were not, she replied that she still didn’t know. She portrayed her situation as follows:

**INTERPRETER:** I’m a ((clinician title)) myself, so if know for sure that, for example, I need an antibiotic then I go to the doctor. And if not, then I take care of myself.

*(Source tape: “Katya,” Jan. 30, 2006)*

Katya mentioned that she sometimes calls the former Soviet Union to ask her onetime medical colleagues for advice.

The immigrant Raisa mentioned that she had also worked as a clinician in the former Soviet Union. Upon arrival in the United States, she initially devoted her energies to caring for her family. She had recently begun working at a facility as a Certified Nursing Assistant. I asked Raisa whether she eventually hoped to work in the U.S. as the same kind of clinician she had been in the F.S.U. She answered:

**RAISA:** This is so different way, because, like I found, I need to pass three exam. This exam(’s/is) expensive, not so expensive, but expensive for me. Umm, this exam, umm, for my [PAUSE] umm science knowledge, like medical science; for my practical medical knowledge. And this exam include maybe English language exam, umm and medical, umm, practical knowledge, umm, contains two parts. What I say about three exam. Umm, difficult for me pass this exam on English language, because my English now is not perfect and I think I need learn again about whole medical science on English. This is not easy, it’s not easy.

*(Source tape: “Raisa,” Oct. 9, 2005)*

She also mentioned that if she did pass the exams, she might have to be separated from her family for long periods for further training, a situation she was not eager to experience. Currently, in addition to working as a Certified Nursing Assistant, she also volunteered at a medical facility where many speakers of Russian sought care. And, like Katya, Raisa took on a role in her circle of family and friends as an unofficial medical adviser. She mentioned helping friends to prepare for medical appointments by telling them what kinds of lab tests they might need to ask the
Thus both Raisa and Katya, who had years of experience as clinicians in the former Soviet Union, had undergone a sort of “downshift” of their medical roles (Pylypa, 2008), having either dropped substantially in the medical hierarchy (Raisa) or dropped out of an official/paid medical role entirely (Katya). The downshift they have undergone seems like a waste of talent and expertise—one that the U.S. medical system might do more to address. The International Medical Graduate (IMG) interest group of the American Medical Association reports that about 5,000 to 7,000 internationally trained physicians were jobless in the U.S. as of 2008 (American Medical Association, 2008). The interest group argues: “[T]he unemployment of qualified IMG physicians in the face of a shortage of services is unconscionable. It is a terrible waste of an individual’s education and their potential to care for patients who need them” (American Medical Association, 2008: p. 28). The group additionally argues:

Not only do IMGs have diverse language capabilities and the natural openness and sensitivity in caring for members of different ethnic groups, but they also are able to assist in developing sensitivity and understanding of cross cultural issues among their non-IMG colleagues. (p. 11)

The interest group recommends more job-shadowing opportunities, uniform state licensing, and other steps to improve the situation.

While it seems likely that international medical graduates’ personal experiences have increased their awareness of intercultural issues, I believe it would be assuming too much to contend that such experience automatically endows IMGs with “natural openness and sensitivity” in cross-cultural care. However, there are efforts, both in the U.S. and elsewhere to make better use of the expertise of internationally trained medical personnel. For instance, Baj (1995) chronicles a training program to help nurses from the former Soviet Union prepare to enter the U.S. workforce, and the University of Calgary has operated a program to help immigrant physicians attain better pragmatic skills in communicating with Canadian patients (Watt,
Crutcher, and Lake, 2006). Additionally, Holy Cross Hospital in Montgomery County, Maryland, enlists IMG physicians as culture brokers who help immigrants—including Russian-speaking immigrants—to understand the U.S. health-care system (Satyanarayana, 2008):

Friar [a hospital administrator] is enthusiastic about developing one particular source of help: foreign-trained doctors who cannot practice medicine in the United States. Who better to overcome the many challenges immigrants face, Friar thought, than a doctor who not only speaks the language but understands the system his participants come from? “It popped into my head one day, after hearing stories of doctors working as nurses’ aides, in housekeeping, hotels and restaurants,” Friar said. “If I could get more, I’d bring them on in a second.” (p. HE01)

As will be discussed in the section on language factors below, in my study both Katya and Raisa suggested that reliance on bilingual medical personnel would be a good solution to Russian-speaking immigrants’ health-care-access problems—but both also noted that their own English was probably not currently adequate for such a role.

**Portrayals of Medical Personnel**

In earlier sections about comparative medical systems and cost, we have already seen a number of portrayals of U.S. and former-Soviet medical personnel. The current section will look at some additional themes that emerged during immigrant participants’ description of medical encounters.

One concerns doctors who seem rather uninterested in thorough care. Katya, for instance, mentioned going to one of the few local physicians who accepted the “yellow card” (medical access card) provided by the state government. She evaluated him this way:

**INTERPRETER:** I can assume that there are here doctors which can be better, but with this doctor, because I have a lot of experience communicating with doctors in Russia, I had an impression that this is not a very good doctor, because he used to say: “Oh, this is nothing, this is nothing.” When I had a problem … and it hurt, he said, “Oh this is nothing,” and then when my ((relative)) had a problem …, he also said, “Oh, this is nothing.” But being connected
to medicine myself, I know that it cannot be nothing, because it was something.


Katya reported a similar experience with a U.S. dentist.

The immigrant Zhenya, as noted above, was very skeptical about U.S. doctors, believing that they would give shoddy treatment because of previous medical bills that were still unpaid. She eventually did find a thorough physician’s assistant and associated physicians who seemed interested in her condition and explored her situation to a degree that she found appropriate.

The immigrant Veronika said that her family initially had not understood the workings of a group practice where they received treatment, with the result that they sometimes met with a doctor who seemed quite conscientious but at other times had a less satisfactory doctor. Eventually, they learned to ask for appointments with the doctor they preferred. Veronika described her experiences this way, via the study interpreter:

INTERPRETER: Uh so with the kid, uh with the pediatrician, so their doctor, uh they think he does closer physical examination even if it- if it’s regular. And the other doctor was just checking for paper. “Oh, he’s healthy. OK, goodbye, see you”.... And the first doctor is very considerate and this is closer to the procedure they have in the Ukraine, they used to have back home where the doctors are you know, uh with kids it’s closer attention to the kids even if it’s a regular checking... Closer physical exam and here it’s more formal if you have no problem. If you have a problem they will deal with it, but if it’s no problem they will just say, “See you again.”


As noted earlier, some of the participants in Ivanov and Buck (2002) preferred doctors in the F.S.U. because they “were more thorough because they depended on touching their bodies and blood analyses to diagnose illness”; one woman in that study, in a comment that echoes the concerns of some of my participants, said: “Here you walk in, they quickly look at you, and tell you that you are okay” (p. 25).

While Katya, Zhenya, and Veronika all expressed discontent with doctors whom they experienced as perfunctory or uninterested, Kirill and Filippa described a different undesirable
trait. They recounted the following narrative about a time when their child was ill:

KIRILL: And we’ve gotten this appointment, we have come, and ( ) we’ve got a prescription from the doctor as antibiotics. But actually we was a bit scared about antibiotics because ((daughter)) have taken them within a year already. And we didn’t- we didn’t trust this doctor actually [LAUGHS]. [BRUA: OK] But I (don’t)-

BRUA: That- that person was at the- so that was a doctor you had to go to because of your access card or um ((daughter’s)) access card?

KIRILL: Yeah, it was assigned there. At this point yeah we decided to change the PSP provider. Yeah and we have switched her to the ((name of another facility)). And actually the doctor there was a young lady and she tried to prescribe the basically same stuff, and we tried to argue to her. And she asked us, What- what you scared for? It’s OK, it’s fine, it’s regular situation, you just- she just have some kind of uh ((condition)) or somewhere, something like this. And that’s it, you’ll see the results within a week, it’s OK. Filippa (her) a bit calmed down and we took this prescription and everything was pretty OK.

BRUA: So the second doctor you trusted, but the first one you didn’t, is that?

KIRILL: It wasn’t his fault actually. It’s was just lack of I’d say patience, patience and that’s it.

BRUA: So the first doctor didn’t really have patience or?

KIRILL: Yeah, yeah exactly.

(Source tape: “Kirill & Filippa,” April 8, 2006)

It may be that the second doctor, whose advice they took, communicated her recommendations in a way that more fully engaged with the parents’ concerns. While Kirill portrays that second doctor as challenging his and Filippa’s reluctance to follow the prescribed treatment, still she addressed their concerns in a way that apparently answered their questions and calmed their fears somewhat. The impatient first doctor, whom Kirill and Filippa left, may not have explained the situation as clearly—although my interpretation is speculative, since Kirill did not specify what lack of patience involved in an operational sense. In addition, the second doctor may have benefited from the fact that she came second in the sequence. In other words, Kirill and Filippa
may have been more willing to accept her advice because they were hearing the same recommendation a second time. The first doctor would not have had this advantage.

Kirill and Filippa also described a more intense instance of disagreement with medical personnel, related to tuberculosis screening in the U.S.:

KIRILL: There is a TB [THEN SPEAKS RUSSIAN TO THE OTHERS]. There is some kind of epidemic center in ((town name)) and every immigrants should pass there.

BRUA: So they should get the TB tests (? )?

FILIPPA: ( ) [OVERLAPS]

KIRILL: TB tests, yeah, yeah, something like that.

FILIPPA: [IN RUSSIAN]

INTERPRETER: They [HEALTH AUTHORITIES/THE CENTER] think here that everybody who comes from Russia has TB- (a/uh) TB positive, and they make you take terrible pills for nine months.

FILIPPA: [IN RUSSIAN]

INTERPRETER: In Russia I never- I have never had (a) positive TB test.

FILIPPA: [IN RUSSIAN]

KIRILL: [TO FILIPPA] (Process)

INTERPRETER: Yeah.

FILIPPA: [IN RUSSIAN]

INTERPRETER: So they were forcing us to take this pill for nine months.

FILIPPA: [IN RUSSIAN; KIRILL ALSO SPEAKS IN RUSSIAN]

INTERPRETER: But I said no because it affects your liver in a very bad way.

BRUA: And they were OK with you saying no?

INTERPRETER: [IN RUSSIAN]

FILIPPA: [IN RUSSIAN]

[OVERLAPS HERE]

INTERPRETER: They tried to force us ( ) more and more.
[FILIPPA: SPEAKS IN RUSSIAN] Yeah, I had big problems with that.

KIRILL: It’s not big problems, but they just psychologically press us (et cetera, et cetera)

BRUA: um-hmm

KIRILL: You have to do that, you can be sick, blah blah blah. But actually I would say, Russia itself has pretty much concern about this stuff. In my childhood I have passed multiple tests for TB when I was—( ) it started in kindergarten, maybe from 4, 3 years old, every kid in Russian kindergartens should have this test, and every year and it continues in school till maybe 5th grade, it’s every year, once a year you should pass this test. And also there’s X-rays, you should pass it once a year. Especially it was pretty much developed in Soviet times because no matter where you are, where you (were/work), you should pass this test once a year. X-ray test.
(Source tape: "Kirill & Filippa," April 8, 2006)

While Filippa, via the interpreter, described the situation in aversive terms (“terrible pills,” “tried to force us”), Kirill downplayed the situation slightly (“It’s not big problems”). However, he also portrayed the situation as somewhat coercive when he said, “They just psychologically press us.”

I have heard other immigrants from the former Soviet Union make the same complaint—that U.S. (or possibly local) health authorities assume all people from the F.S.U. will test positive for exposure to tuberculosis. However, from an epidemiologic standpoint, the concerns of the U.S. system might be prudent: Field (1995) reports that rate of tuberculosis infection tripled in the F.S.U. in the years since 1991. Shpilko (2006) likewise notes a “severe rise” in the number of people infected with tuberculosis; she cites CDC data showing an increase “from 45,000 (34 cases per 100,000 population) in 1991 to 124,000 (85 cases per 100,000) in 1999” (p. 333).

Interestingly, Ivanov and Buck (2002) suggest that the time when immigrants go through TB screening might be a good opportunity to provide them with information about navigating the U.S. health-care system. This might be a good idea, especially if the information is provided in Russian, since understanding might be limited otherwise (Ivanov & Buck, 2002). However, considering at least some former-Soviet immigrants’ perception of unjust treatment in regard to tuberculosis screening, health-care authorities would be wise to communicate in a friendly,
clearly explained, and empathetic way: Shpilko (2006) notes that physicians’ and health educators’ attitudes can make the difference between having a patient who details his/her total health practices (including “alternative medicine” such as herbal treatments) and a patient who hides such practices from physicians (p. 339). This advice would also seem helpful during the TB-screening process.

Language Skills

Interestingly, and at first somewhat surprisingly to me, language-related issues were often not at the top of immigrants’ concerns. Cultural beliefs and logistical practices related to health care seemed to be at least as salient as language factors, if not more. Still, issues of language proficiency, language learning, and language attrition did arise often in the interviews, both in response to language-related questions and in other narratives.

Katya, who had been a clinician in the former Soviet Union for many years, discussed the role played by language proficiency in assisting—or impeding—her understanding of the medical situation of a severely ill relative. She herself had often been unavailable to go to the relative’s appointments because of work commitments, so a family friend was enlisted to accompany the relative as an interpreter. I asked how communication went, and Katya answered (only the interpreter’s turns are shown):

\textbf{INTERPRETER}: No, it wasn’t that well and smooth because ((the friend)) didn’t know much about medical terms... We wish we had somebody who was a specialist in medical field... Once I asked ((the friend’s)) son and he has been here for eight years and he’s pretty good at English, but it was more difficult for me—sometimes I understood better than him, because I knew the medical matters and sometimes we just couldn’t understand each other. He didn’t understand what I meant and the doctors... So he couldn’t understand the doctor because of the terminology and he probably didn’t understand my Russian, because it was a younger kid and probably his Russian is not that good... And ((the adult...}
friend)) also shares with me that sometimes she doesn’t understand and has to guess…. Although she speaks very well.  

Later, Katya’s relative was treated at a hospital in a larger metro area, and Katya recounted the following communication outcomes:

**INTERPRETER**: For example, in ((the larger metro area)), umm, my friend was helping my ((relative)) and me, and it was all very vague- she used just descriptions to explain things and it was not clear. But when I talked to the Russian-speaking doctor there, it just- it was two different things. Everything became absolutely clear to me, she explained to me everything, so she was originally Russian, but she spoke very good English and she was a doctor, a professional person.  

On the basis of Katya’s narrative about her ill relative, I suggested to Katya that she herself might be a good candidate for a medical interpreter if she could solidify her fluency in English. She said such a role would give her great pleasure. I also made another suggestion that led to a discussion of Katya’s beliefs about medical bilingualism:

**BRUA**: So just- it occurred to me now that so maybe, one thing that would- one thing you’re suggesting is that the local medical community needs to recruit a doctor who is Russian-English bilingual.

**INTERPRETER and KATYA**: [SPEAK TOGETHER IN RUSSIAN; KATYA LAUGHS]

**INTERPRETER**: Maybe so, but preferably a person who speaks perfect English and perfect Russian [LAUGHS], umm, but yeah it would be nice if this person also had medical background.

**KATYA and INTERPRETER**: [SPEAK TOGETHER IN RUSSIAN]

**INTERPRETER**: In the worst-case scenario, just a good interpreter, speaking both good Russian and English.

**KATYA**: [SPEAKS IN RUSSIAN]

**INTERPRETER**: But best thing would be a medical worker who speaks both languages.

**KATYA**: [SPEAKS IN RUSSIAN]

**INTERPRETER**: Um-hmm. But if a good interpreter is translating very closely what a doctor is saying- that is OK, too. Just very close translation.  
The “perfect” bilingualism and medical expertise mentioned by Katya with a chuckle does sound like an optimal (if idealized) situation. Such an optimal situation was quite far from the normal experience of the community. Katya noted that when she herself needed medical care, she often would rely on her teenage children to interpret because (she said) they had good English. She also said via the interpreter: “So mostly Russian grandmothers, they take their grandchildren with them [to medical appointments], or children.”

We talked a bit about English as a Second Language classes, but Katya had not been impressed by what she had experienced in her town. She portrayed ESL classes through a local school district as “a waste of time basically” because only a few words were learned per session, and she described ESL training at her church as “also not enough, it’s just once a week and it’s a lot of confusion and it’s just not helpful again.”

The immigrant Raisa, who likewise had professional experience as a clinician in the former Soviet Union, also discussed her views about language proficiency. She portrayed the general state of the community as follows:

**INTERPRETER**: So most of the people who come from the former Soviet Union now— they grew up in the Soviet Union, and even if not Russian, they speak Russian. And they speak poor English basically, most of them, especially the elderly people.

(Source tape: “Raisa,” Oct. 9, 2005)

When asked what advice she had to help U.S. doctors provide better health care to Russian-speaking immigrants, she had this to say:

**RAISA**: [LAUGHS] This is easy, but this is not easy. Umm, Russian-speaking office.

**BRUA**: OK.

**RAISA**: If ((the local town)) (x x) had one office who has Russian-speaking nurses, Russian-speaking doctors. Russian— umm, this general— it’s very (helpful).

(Source tape: “Raisa,” Oct. 9, 2005)

She went on to say that such a system would enable doctors to be more productive because it
would be less time-consuming than using an interpreter. She elaborated on her thoughts, via the study interpreter:

**INTERPRETER**: Maybe another way would be to employ people who are bilinguals, but they have medical education background. But she is saying in the area, we have (at least/just) one to just a couple, so who work now... So like for example, Raisa is familiar with a problem, but she cannot- she doesn’t know the nuances of the medical terminology (in) the language, so she cannot explain that to the doctor... So, a person should have medical background and be fluent in both languages.

(Source tape: “Raisa,” Oct. 9, 2005)

As we saw earlier in the section about immigrant medical personnel, Raisa believed that in order to be an effective clinician in the U.S., it would be preferable for her to undergo medical training in English from the ground up.

The immigrant Kirill suggested a solution that echoed Katya and Raisa. The following exchange occurred:

**BRUA**: So my question to you is: If you could tell medical personnel one thing they could do to give better help to Russian immigrants or refugees, what would you tell them?

**KIRILL**: Learn Russian.

**BRUA**: What’s that?

**KIRILL**: Learn Russian. Actually, it’s a pretty simple situation. If people learn English, there is no such problem as communication. But if people don’t learn English, there is a problem. And here is another- or another approach. Medical offices can use some interpreter help, for part-time or full-time basis or on-call basis, I don’t know how they organize it, but they- it can be pretty useful.

**BRUA**: Any of the offices you’ve ever gone to so far, have they had interpreters, either in person or on the phone?

**KIRILL**: Actually, I have no idea because I never used this kind of service. (The/their) only thing that I ever met something like this, it was in welfare. They have used (their/a) phone interpreter service once, when I was maybe month or less here. Just first few weeks, my English was pretty poor. They couldn’t understand me much. They have used this service. But I guess this system pretty expensive, and they can use it like in emergency.

(Source tape: “Kirill & Filippa,” April 8, 2006)

Kirill thus suggested the use of bilingual medical staff, as did Katya and Raisa, or the use of
interpreters. While participants mentioned a handful of Russian-speaking medical staff in the study context—dental hygienists, dietitians, and others—no one could name any local physicians who were bilingual in Russian and English. One chiropractor with a large client base in the Russian community was said to be learning Russian. Kirill’s contention that professional telephone interpretation services are used rarely was certainly not contradicted by anything told to me by other participants.

The immigrant Zhenya, as discussed above, sought treatment in an emergency room soon after her arrival in the U.S., and her narrative about the incident also suggests a paucity of institutionally provided telephone interpretation. She mentioned dealing first with a nurse who took her blood pressure and did similar intake tests. I asked how the communication went, and Zhenya replied, “Very well.” She then shifted into Russian to elaborate:

INTERPRETER: She [ZHENYA] told her that she was very weak, umm, in English, so the nurse was aware of that, and she was speaking very slowly and she showed on her body everything she was—she was going to do. (Source tape: “Zhenya,” Oct. 19, 2005)

However, Zhenya reported that she soon had to provide fairly substantial language accommodation for herself in the absence of institutionally provided services. Zhenya had a Russian-speaking friend who worked as a registered nurse in another state, and she relied on this person as a language mediator via her own cell phone during parts of the medical visit:

INTERPRETER: OK, after the nurse did her job, then Zhenya had to wait for the doctor, it was about twenty minutes. And she had to fill out some paperwork and what she di—she was calling (during) one hour on her cell phone to this friend in ((another state)) and was asking her about all the terms. To be able to fill out the paperwork.

ZHENYA [IN ENGLISH]: Because there was no translator there. I asked for Russian translator, but there was nobody. And the doctor was very glad to hear that I can communicate with him (with) the help of my friend.

BRUA: So did you keep your friend on the line while the doctor was talking with you?
The facility where Zhenya was being treated is mandated by federal guidelines (Office of Minority Health, 2001; U.S. Department of Health and Human Services, 2003) to provide language accommodation.

While Zhenya’s experience might seem startling, lack of institutionally provided language accommodation is by no means rare in the United States. Many studies have discussed situations in which patients with Low English Proficiency or no English proficiency sought medical care in the absence of institutional interpretation support (e.g., Derose, 2000; Flores, 2005; Flores, Torres, Holmes, Salas-Lopez, Youdelman, & Tomany-Korman, 2008; Ginde, Clark, & Camargo, 2008; Jacobs, 2008; Ku & Flores, 2005; Morales, Elliott, Weech-Maldonado, & Hays, 2006; Ramirez, Engel, & Tang, 2008; Regenstein, Mead, Muessig, & Huang, 2008). As noted in the literature review section, medical appointments involve many different permutations of interpretation—from the use of children with little medical bilingualism or conceptual understanding, to the use of bilingual physicians, to the use of trained medical interpreters via a telephone or video service.

Some studies tend toward promoting the use of trained interpreters (e.g., Bernstein, Bernstein, Dave, Hardt, James, Linden, Mitchell, Oishi, & Safi, 2002; Karliner, Jacobs, Hm Chen, & Mutha, 2007), and certainly this is the stance taken in government documents such as the CLAS Standards (Office of Minority Health, 2001). However, some studies have examined ways in which professional interpreters might actually block patients from being heard by the physician because the interpreter filters out or answers many questions without relaying them to the physician (Davidson, 2001). Others that have similarly portrayed institutionally provided interpreters as potential gatekeepers, sometimes allied with the institution rather than the patients, include Leanza (2005); Edwards, Temple, and Alexander (2005); and Greenhalgh, Robb, and
Scambler (2006). The article by Edwards and colleagues makes an especially cogent argument about the reasons why patients often prefer to rely on interpreters they themselves have provided (even if of questionable linguistic proficiency), because the patients do not believe the institutional interpreter cares about them.

From Zhenya’s narrative, however, it appears that she would have preferred an institutionally provided interpreter. She was lucky to have had access to her medically trained friend—assuming, that is, that the friend’s ability to convey medical information in both English and Russian was strong.

A number of participants in my study described an evolution of their abilities (or their family members’ abilities) to navigate health care using English. The immigrant Yakov, for instance, reported that when his family first arrived, he acted as an interpreter for their medical visits, but that such help was usually no longer necessary because his wife was now able to handle medical communication in English by herself. He also said: “I don’t remember of any negative reaction related to our not perfect language.”

The immigrant Marianna, who conducted her interview mainly in Russian with the study interpreter present, said that she always went alone to doctor’s appointments and was able to ask questions of the doctors until there was mutual understanding. For phone communication, she sometimes asked for help:

\textbf{INTERPRETER:} When she was certain that she was capable of scheduling an appointment on the telephone, she did it herself…. But when she had to schedule this mammogram, it was more complicated because she had to answer some questions, call one place and get a voucher and (to) another place, and she asked her employer because she is Russian-speaking and she also fluently speaks English. So she helped her.

\textit{(Source tape: “Marianna,” Oct. 23, 2005)}

The immigrant Veronika discussed her own language evolution at several points in the interview. For example, in regard to health-care-related telephone calls, she often relied on her husband:
INTERPRETER: Veronika is (afraid of) calling because of her English ability she is not certain that she can express herself properly, so it’s usually her husband who makes all the calls. If she had more practice she would be not that afraid.

(Source tape: "Veronika," Oct. 9, 2005)

However, Veronika later portrayed her telephone skills as having improved from her early days in the U.S. In fact, as she noted with amusement, she was now able to use her language skills to filter out unwanted callers:

BRUA: Do you find sometimes um- telephone interactions, especially can be difficult for people. I- they’re hard for me sometimes too just because you don’t see the people, you can only hear the voice. Yeah.

VERONIKA: I understand. Uh first uh- first time I don’t hear nothing and uh I not answer for some call. But after I don’t know after maybe five or six months after we arrive here- and arrived here, and I try sometimes to answer and [CHUCKLES] it’s uh uh

[SHIFTS TO RUSSIAN]

INTERPRETER: Oh, uh advertisements, telemarketing.

VERONIKA: Yeah. I says, Oh sorry sorry sorry I don’t interested in that, sorry, bye. But uh important call I understand when some people tell me (x) for example from doctor’s office for appointment I understand and I says when I can go and. So now I can telephone and if I don’t understand I ask person (x x x x) that I don’t hear enough and please tell me again ( x x possible) because I’m not good in English, sorry. And so now I understand.

[BRUA: Good.] But first time it was big problem, big, really big problem.

(Source tape: "Veronika," Oct. 9, 2005)

Interestingly, Veronika categorized visits to the doctor differently than visits to the pharmacist in terms of risk of negative medical outcomes:

INTERPRETER: So she goes to the pharmacy herself. So she is not afraid to ask the pharmacist because you can ask again if you don’t understand something, but with the doctor she still wants to have her husband along.

BRUA: Can you tell me about the difference um- so you’re talking in both cases about appointments where you’re physically there. What’s different between talking with the doctor and talking with the pharmacist?

VERONIKA: [SPEAKS IN RUSSIAN BACK AND FORTH WITH INTERPRETER]

INTERPRETER: (It’s because) it’s crucial for your health, and if
you don’t understand something because the doctor–doctors speak really ( ), they use medical terms and she just thinks it’s so important (to the) health, that’s why she doesn’t want to take risks.


As Veronika continued speaking, however, she revealed that she also wants to avoid the risk of embarrassment:

VERONIKA: [SPEAKS IN RUSSIAN]

INTERPRETER: Oh, once she decided to go by herself. She decided [OVERLAP] that she was ( )

BRUA: To the doctor?

VERONIKA: Yeah [THEN SPEAKS IN RUSSIAN]

INTERPRETER: ( ) for the driver’s license ( )

VERONIKA: [SPEAKING IN RUSSIAN]

INTERPRETER: Ahh, but she had to get some immunization, a shot, and the doctor explained to her what it was, but she just didn’t get it absolutely.

VERONIKA: Yeah [THEN SPEAKS IN RUSSIAN]

INTERPRETER: She understood it was against some bugs.

[VERONIKA LAUGHS AND CONTINUES IN RUSSIAN]

INTERPRETER: Bugs or something that would ( ). And she recommended this to ((a friend)) to go and get the same immunization, because ((the friend)) is allergic to some

VERONIKA: bugs

INTERPRETER: bugs (to ) you know (bugs )

VERONIKA: [SOUNDS AMUSED, OVERLAPPING IN RUSSIAN]

INTERPRETER: And when ((the friend)) came to the same doctor

VERONIKA: [SPEAKS IN RUSSIAN, AMUSED]

INTERPRETER: The doctor said, No I didn’t say anything like that

BRUA: um-hmm, um-hmm

INTERPRETER: (about) immunization against bugs.

VERONIKA: [SPEAKS IN RUSSIAN]
INTERPRETER: So Veronika was really embarrassed and she didn’t want any problems for the doctor.

Veronika also discussed another situation in which she felt embarrassed because of a difficulty in communication, although in this case, she attributed at least part of the difficulty to a medical staffer whom she believed was not a native speaker of American English. Veronika recounted that because she could not understand the staffer’s accent, it was necessary to bring in her husband, who had been waiting in the hall. I asked how she had felt about that situation, and she replied (only the interpreter’s turns are shown):

INTERPRETER: She actually is pretty independent. She doesn’t want anybody to do anything for her... And she was actually upset um because she... She knows that her husband is very busy and she actually can do her own business herself but (if it’s with) the language (x)... She just decided to study English more diligently... So comprehension-listening comprehension has really improved.

Veronika’s reported evolution as a proficient user of English is laudable and has likely improved her access to health care in the U.S. However, in closing out this section on language proficiency, we should take care to remember that many members of the local Russian-speaking community still struggle with insufficient English proficiency to communicate with their medical providers, and that interpreter services are often not available.

Conclusion

In this chapter, I have explored some of the most salient findings from my interviews with immigrants from the former Soviet Union, based on code frequency. These topics included:

• Participants’ comparisons of the former-Soviet and U.S. medical systems. In evaluating the quality of the two systems, participants tended to portray the U.S. as technologically
and diagnostically superior but somewhat lacking in thoroughness and true caring in comparison with the former Soviet Union. These attitudes were sometimes tied in with issues related to logistics of access, as several participants suggested that their methods of payment in the U.S. (sometimes by government-issued access cards) negatively affected the quality of care they were given. Participants also discussed the differences in appointment-scheduling and medication availability in the U.S., which they sometimes experienced as confusing or burdensome.

- **Cost factors.** This topic is an outgrowth of the differences between the two systems. The price of medical care in the United States was generally experienced as a negative stressor by the immigrants, who portrayed their access as being impeded by costs.

- **Immigrant medical personnel.** Meeting immigrants who had been medically trained in the F.S.U. was an unexpected outgrowth of the interviews. While not employed at the same level of the medical hierarchy as they had been in the F.S.U., both Katya and Raisa were using their medical knowledge: one in volunteer roles, and the other in volunteer and paid roles.

- **Portrayals of medical personnel.** Participants discussed ways in which they experienced U.S. doctors positively (experienced as thorough or diagnostically skilled, for instance) or negatively (experienced as uninterested or impatient, for example). Many of these portrayals are likely to have been influenced by the health-care socialization experienced by the immigrants and the doctors in their respective cultures.

- **Language skills.** While language proficiency was less foregrounded for the participants than I had initially expected, they still spoke of many ways in which their ability to use English (and Russian or other Slavic languages) did or did not allow them access to medical care in the U.S. Participants discussed ways in which they secured language assistance from family, friends (including those in distant states), or employers. These
issues of language accommodation are considered further in Chapters 5 and 6 on the medical-site and interpreter participants.
Chapter 5

Data Analysis: Staff at Medical Site

Introduction

This chapter presents the analysis of interview data from staff affiliated with a medical site where many low-income and uninsured residents—including many members of the Russian-speaking community—seek medical and dental treatment. In fact, the medical site makes it a primary mission to provide free care for people with no health insurance. According to an information brochure disseminated by the facility, which I will call by the pseudonym “the Free Clinic,” as of 2005 its service area included “an estimated 11,000 working poor without health insurance and 30,000 without dental insurance.”

During our interview, the clinical director estimated that the facility provided 200 physician consultations a month, with 20 to 30 additional visits for nurse consultations, lab work, diabetic education, etc. The facility additionally provided appointments with social workers who helped clients navigate the application process for social services such as heating assistance or food stamps. Helping patients apply for Medicare and Medicaid benefits—which would allow them to receive care elsewhere—was also a priority. The clinical director reported:

We don’t track our phone contacts because they’re just astronomical as far as the number we might talk to in a day, but all visits average somewhere around 4-, 5-, 600 a month. And that should reflect dental as well. Probably closer to 600 if we’re including dental.

(Source tape: “Gail,” Nov. 22, 2005)

At the time of the interviews (2005), the clinical director estimated that people from the Russian-speaking community made up “in the neighborhood of 5 percent or more” of the facility’s
patient/client load. Of my 13 immigrant participants, four mentioned seeking treatment at this facility.

In discussing Russian-speaking clients, one of the site’s social workers told the following narrative, which illustrates some of the complex tasks taken on by the staff:

TRINA: I had one older adult daughter translate for a mom one day, and that family was really large, I think they had seven or eight children, they’re patients here. And I just— my first thought was— whenever we see a child come through this clinic, we want to get them on insurance because it’s easy for kids to get insurance in this state. And so my first thought is, Oh gosh, I wonder what the immigration status is of the family, because it’s really— there’s gonna be a lot of obstacles if they’re not citizens or have green cards, so. So y’know I was working with the family— (I did) some of the members were citizens, some weren’t y’know, (and) we try to— (still) we’re able to apply people for food stamps and energy assistance and medical assistance right from our office... So y’know we try to apply people, a lot of times that’s a barrier, their immigration status, which is frustrating in this country.


The clinic’s case-management efforts involved seeking help for clients from federal and state agencies and local secular and religious groups that fielded social-services efforts. Another social worker at the facility expressed efforts this way: “We work with a variety, and if we can’t find a resource [for patients/clients] then we’ll keep looking until we can find it.”

The facility provides at least one of the functions of the neighborhood polyclinics found in the former Soviet Union: It serves as a central location that refers patients to specialists for treatment. However, unlike the polyclinics, this facility was not the physical “home” of specialists; instead, patients generally had to travel elsewhere in the county after receiving a referral. In addition, unlike the former-Soviet polyclinics described by immigrant participants in my study, this facility is not a walk-in site, and appointments generally had to be scheduled in advance. The facility was portrayed by several Russian-speaking participants as extremely busy—a condition that seems unsurprising considering the site’s mission to help uninsured and medically underserved people in an area where they are numerous. Three of the immigrant
participants expressed disappointment at the wait times they experienced in dealing with the facility. For instance, the immigrant Kirill, whose responses are detailed in Chapter 4, told this narrative about seeking care at the facility:

KIRILL: Actually it’s pretty simple case and any doctor solve it very- in very fast manner. But (they start) bureaucracy, they start gather some kind of documents, make decisions, and all this stuff, stretching in like months or more, and within that time I’ve got other job, I’ve got the money, and I have find a way how to cure myself [LAUGH QUAVER]. And after that I just wasn’t need their help.

(Source tape: "Kirill & Filippa," April 8, 2006)

The facility was not a recipient of federal funding (e.g., it did not receive reimbursement from Medicaid or Medicare). Thus, while federally funded medical sites are nominally required to provide language accommodation for patients with Low English Proficiency (U.S. Department of Health and Human Services, 2003; Office of Minority Health, 2001), this medical facility was not. That fact should be kept in mind as we examine the facility’s approach to communication with patients whose English skills were weak.

On Nov. 22, 2005, I conducted interviews with five staff members affiliated with the facility. Biographical sketches are shown in Table 5-1.

Table 5-1: Staff interviews at the medical site

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age14</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andrea</td>
<td>50s</td>
<td>Medical clinician</td>
</tr>
<tr>
<td>Trina</td>
<td>30s</td>
<td>Social worker</td>
</tr>
<tr>
<td>Vanessa</td>
<td>20s</td>
<td>Social worker</td>
</tr>
<tr>
<td>Gail</td>
<td>30s</td>
<td>Medical clinician</td>
</tr>
<tr>
<td>Jason</td>
<td>50s</td>
<td>Medical clinician</td>
</tr>
</tbody>
</table>

Only one of the participants chose to be interviewed in a private office. Each of the others met individually with me in a break room as other staff came and went, conducted cell phone conversations, faxed documents, or sorted through cabinets. While not optimal for taping an interview, this situation gave me a sense of the high energy level at the clinic, as well as its space

14I asked each medical-staff participant her/his year of birth.
constraints. I audio-taped the interviews and later transcribed them. Further details on participant recruitment and data collection methods are given in Chapter 3.

My research question for the overall project was: In this health-care context—which involves Russian-speaking doctors, English-speaking medical staff, and bilinguals serving as intermediaries for the other two stakeholder groups—how do factors related to language resources and health-care socialization enhance or impede access to quality health care? I identified overarching themes in the Free Clinic data using the following approach: I first listened to the tapes and wrote descriptive notes about answers to questions I had asked, unexpected ideas expressed by participants, particularly interesting utterances, etc. Those notes provided me with an initial list of rough codes, which I then expanded upon in the subsequent step. Using the ATLAS.ti software program, I read through each transcript to apply codes that encapsulated ideas mentioned by the participants. As I processed my data across all three stakeholder groups (immigrants, medical staff, and interpreters), I used a universal coding list to which I added as new ideas emerged in any particular transcript. My code list for the interpreters included 134 codes; the list for the immigrant participants had an additional four codes, for a total of 138; and my medical staff data had an additional five codes beyond that, for a total of 143 codes. The complete list of all codes across the entire project is shown in Appendix D.\(^\text{15}\)

While in the other data chapters I use a cutoff score of 20 tokens to determine which codes to analyze in detail, the medical staff data requires a slightly different approach. The medical staff interviews were generally shorter than the interviews with other participant groups (30 minutes vs. 60 minutes, respectively, on average); one outgrowth of this fact is that there were fewer code tokens overall in the medical staff data than in the other corpora. To extend the

\(^{15}\) For a more detailed discussion of the coding procedures, please see Chapter 3.
breadth of the analysis that follows, I have moved my cutoff score downward to 18 tokens so that more categories can be included.

Most of the top-ranked codes deal in some way with language or with people serving as communication intermediaries. In order to achieve more thematic breadth in the analysis, I decided to also address a code not so narrowly related to language. I made the selection as follows: The next several codes below the 18-token cutoff primarily focus on language and communication as well: Trained Interpreters (16 tokens); Bilingual Staff (16); No Resource (16); Communication Accommodation (15); and Non-Professional, Non-Naïve Interpreters (15). The next code in terms of frequency—Kids (13 tokens)—is well-represented in the code Naïve Interpreters, which will be discussed below, and the code Types of Help (12) has been covered in some of the demographic background provided in the introduction. Therefore, I choose to additionally address the code Medical Narrative, which had 12 tokens in the medical staff corpus, in the hopes of enriching the analysis. The medical-staff codes that will be analyzed in this chapter are shown in Table 5.2.

Table 5.2: Medical staff codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Total no. of tokens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpreters</td>
<td>Mention of interpreters in general, from any source</td>
<td>26</td>
</tr>
<tr>
<td>Accompany to doctor</td>
<td>Mention of the people who attend medical appointments with patients to provide language help or other assistance</td>
<td>22</td>
</tr>
<tr>
<td>Comm. help from relative</td>
<td>Mention of patients’ relatives serving as communication intermediaries</td>
<td>20</td>
</tr>
<tr>
<td>Language proficiency</td>
<td>Discussion of issues related to stakeholders’ language abilities</td>
<td>20</td>
</tr>
<tr>
<td>Volunteer</td>
<td>Mention of people taking on a volunteer role at the medical facility</td>
<td>18</td>
</tr>
<tr>
<td>Naïve interpreter</td>
<td>Mention of people with low levels of bilingual ability or medical knowledge serving as interpreters</td>
<td>18</td>
</tr>
<tr>
<td>Medical narrative</td>
<td>General category for stories about medical interactions</td>
<td>12</td>
</tr>
</tbody>
</table>

Several intervening codes were omitted to allow more thematic breadth (see text for details).
In order to group codes more efficiently along thematic lines, I collapsed three of them into a larger category: The codes *Accompany to Doctor*, *Communication Help from a Relative*, and *Naïve Interpreter* are generally concerned with helpers provided by the patient, and thus I group them together in the category *Patient-Supplied Intermediaries*.

The other codes will be treated separately because they are less clearly linked thematically. Thus, my analysis will consist of the following analytical categories: 1) *Patient-Supplied Intermediaries*; 2) *Language Proficiency*; 3) *Volunteer*; 4) general instances of the code *Interpreters* not discussed in relation to the other codes; and 5) instances of the code *Medical Narrative*. These codes will provide a lens with which to understand both the strengths and the challenges faced by the medical facility and the Russian-speaking patients who sought help there.

The final set of analytic categories that will be discussed in this chapter is shown in Table 5-3.

### Table 5-3: Medical staff analytic categories

<table>
<thead>
<tr>
<th>Analytic category</th>
<th>Description</th>
<th>Total no. of tokens</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Patient-supplied intermediaries</em></td>
<td>Mentions of people whom patients bring to provide communication help, including relatives and/or naïve interpreters</td>
<td>60</td>
</tr>
<tr>
<td><em>Interpreters</em></td>
<td>Mentions of interpreters in general, from any source</td>
<td>26</td>
</tr>
<tr>
<td><em>Language proficiency</em></td>
<td>Discussion of issues related to stakeholders’ language abilities</td>
<td>20</td>
</tr>
<tr>
<td><em>Volunteer</em></td>
<td>Mention of people taking on a volunteer role at the medical facility</td>
<td>18</td>
</tr>
<tr>
<td>Several intervening codes were omitted to allow more thematic breadth (see text for details).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Medical narrative</em></td>
<td>General category for stories about medical interactions</td>
<td>12</td>
</tr>
</tbody>
</table>

Because many instances of the general code *Interpreters* overlap with occurrences of the more specific codes *Language Proficiency* and *Volunteer*, I choose to address the more specific codes before *Interpreters*. 
Patient-Supplied Intermediaries

During my interviews with the facility’s staff members, the finding that most startled me was the degree to which patients were expected to provide their own interpreters. As noted above, the facility’s funding was such that it was not required to provide language accommodation under federal guidelines. When I mentioned the Language Line telephone-based interpreting system, a staff member said that the facility unfortunately did not have enough funding to subscribe to such a system. While the staff members pointed out at numerous times that it could be risky to rely on patient-provided interpreters, such interpreters still seemed to be the default option used at the facility.

For instance, when asked what the Russian-speaking community could do to improve its health care, one clinician said that foremost, the immigrants should not be shy about seeking medical help; she then added:

GAIL: Um, the second part of that question would be particularly for any- any culture, whether it’s the Russian population or the Asian community in (Name of Town), that they make sure that they come with someone who can adequately translate for them, and really work with us to work with the patient to help them really understand their diagnosis, their- y’know the plan that the physician is recommending for them for treatment….

(Source tape: “Gail,” Nov. 22, 2005)

A social services provider at the facility also said that patients were often expected to provide interpreters:

BRUA: Now when somebody comes in who has Low English Proficiency, how’s that handled?

VANESSA: Uh typically it- y’know we would pick that up on the phone. Um a lot of times folks have translators that will call for them. Um or if somebody's on the phone and there does seem to be a language barrier, we would ask if they have a translator and if so if they could bring that person with them. Uh we try to steer away from them having their children as translators, particularly with medical care. Um though (i-/y-) sometimes (i-) that may be the only option that we have. But certainly it wouldn’t be our first choice. Uh we do also have volunteers that are- that serve as translators.
Wariness about using children as interpreters was mentioned by other staff members as well. For instance, the clinician Gail said the following:

GAIL: Probably one of the challenges that we have … is that we often find that the children are bilingual, they’re very good at English and Russian and they become the spokesperson for an adult in the family that’s here for services, and we’re not always real comfortable with that. Oftentimes that’s when we might contact Dominika [A HIGHLY SKILLED BILINGUAL VOLUNTEER] to make sure that there’s some clear lines of communication, that there’s a strong understanding on both sides.

(Source tape: “Gail,” Nov. 22, 2005)

The volunteer interpreter Dominika happened to be present with us at this moment, and she was quick to challenge one of Gail’s assertions—that the children of the Russian community speak Russian well:

DOMINIKA: Usually like official offices, they don’t accept children. They even say, “Don’t come with children.” Because they- their English (probably) good [LAUGHS], but their Russian is very low, it’s usually related to kitchen….

(Source tape: “Gail,” Nov. 22, 2005)

We should also recall the experiences described in Chapter 4 by Katya, an immigrant seeking interpretation help for an ill relative: When an adult friend failed to interpret adequately, Katya turned to the friend’s young son, who had grown up mostly in the United States, but she described his Russian proficiency as too weak for him to understand her questions.

The clinician Jason also mentioned concerns about the use of children as medical interpreters:

JASON: Well, it’s very frustrating to say the least [LAUGH QUAVER] obviously, every time there’s a language barrier. And y’know usually they come with someone who can interpret for them. This has been an ongoing frustration we have. Sometimes that unfortunately is a young child that they come with.

(Source tape: “Jason,” Nov. 22, 2005)

Andrea, another clinician, said:

ANDREA: Sometimes (it/that)- y’know if they have children with
them—although they try their best, they’re not the best medical historians y’know for their parent if y’know that’s the case. I mean y’know their interpretation of what the complaint is might—y’know what I’m saying?—might not come across. 
(Source tape: “Andrea,” Nov. 22, 2005)

Concerns about using children as interpreters have also been noted in the research literature.

Flores (2005), for instance, states: “Studies indicate that there is an especially high risk of adverse consequences when the ad hoc interpreters are children, including not interpreting perceived embarrassing but important clinical questions (Ebden et al. 1988) and frequent interpreter errors of potential clinical consequence (Flores et al. 2003)” (p. 294). Certainly the use of children as interpreters is strongly discouraged in the federal CLAS Standards (Office of Minority Health, 2001). However, the issue of interpreter choice is an ethically complex one, as is touched upon in a narrative told by Trina, a social services provider at the clinic. She noted that a Russian-speaking patient had come in for eligibility screening the day before:

TRINA: The only time he could have his translator come would be in the afternoon because his translator was his child…. It just really struck me, I mean, ’cause I mean ideally you don’t want a child [LAUGH QUAVER] translating just because of confidential information when they’re seeing the doctor and maybe the child’s limited y’know medical kinda knowledge in terms of being able—the words and things like that. So that was tricky and it really made me y’know realize that y’know we need to [LAUGH QUAVER] see if Dominika [THE HIGH-PROFICIENCY BILINGUAL VOLUNTEER INTERPRETER] is available. But then I wondered, Well how does this man—how would this man feel about having a strange woman be his translator?


Trina said when she met with this client in the future, she would let him know that Dominika was available to interpret; she also said she would defer to his wishes about who should serve as his communication intermediary. Although the facility was not governed by federal guidelines on language accommodation, Trina’s approach nonetheless was in accord with the recommendations of the U.S. Department Of Health and Human Services’ “Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination
Affecting Limited English Proficient Persons” (U.S. Department of Health and Human Services, 2003). Those guidelines say that patients should be offered free, skilled interpreting help but that patients’ choice of interpreters should be used unless there is evidence of incompetence or abusive relationships. Still, the guidelines recommend against the use of children as interpreters.

When Trina pondered the client’s potential response to an unfamiliar person as his interpreter, she raised an important ethical dilemma: While the facility and patient face risks when relying on children or other interpreters of unknown or dubious ability, there are also risks attendant in the use of other interpreters. The clinician Andrea spoke of similar concerns:

**ANDREA:** We do have some other Russian volunteers but then again you get ( )- I mean, although everybody signs a confidentiality statement, I think you know those- going into a room where you might be doing private exams and things like that, you get into I think some confidentiality issues there...^{16} (Source tape: "Andrea," Nov. 22, 2005)

Such concerns might be especially salient in a relatively small community such as the town in which the Russian-speaking immigrants and refugees had settled. In the literature, Raval (1996), Rhodes and Nocon (2003), Robinson and Gilmartin (2002), and others have noted patients’ preference for family interpreters because of confidentiality concerns.

As Trina’s narrative suggests, choice of interpreter can be a difficult decision for both patient and provider, as there are many pros and cons to consider. For example, Flores (2005) writes that “some LEP populations may only accept an interpreter of the same gender as the patient and thus forego a trained professional interpreter of the opposite gender in favor of an untrained family member of the same gender, with potential serious implications for the quality

^{16}The other Russian-speaking volunteers at the facility included at least two people with medical backgrounds. However, my own “quick and dirty” estimation of their communication ability in spoken English leads me to question whether they would function adequately as medical interpreters in a “live” interaction.
of communication” (p. 293). Issues of interpreter gender did not seem particularly salient in my immigrant participants’ narratives.

Another decision point for patient and provider comes in the affiliation of the interpreter. Edwards, Temple, and Alexander (2005) note that patients in their study sometimes distrusted institutionally affiliated interpreters, whom they felt did not care about them as people. The patients often preferred to use known interpreters (family and friends) even if their linguistic aptitude was weak. Davidson (2001), Angelelli (2004), and Greenhalgh, Robb, and Scambler (2006) have additionally noted the tendency of some institutionally affiliated interpreters to suppress or distort communication in a way that aligns with the medical institution’s needs and blocks patients’ access to empowered decision-making.

When family members are chosen to serve as interpreters, the literature points out that they might take on multiple roles simultaneously. Rosenberg, Leanza, and Seller (2007) note: “Many family interpreters also play care-giving roles comparable to those played by persons who accompany patients even when there is no language barrier” (p. 290). The researchers add: “Some physicians in our study relied on family interpreters to report symptoms the patient does not mention, to arrange further contacts with health care services and to translate/explain their statements to the patient after the visit” (p. 290). However, they also note that the physicians often assumed that the family member would undertake such roles but did not actually confirm this with the family member.

While the choice of interpreter was a difficult and important one, from my analysis of the medical-site data, it seemed that the medical-site staff often did not deeply explore the potential consequences of the decision process. Assessment of communication effectiveness seemed to me

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17Singy and Guex (2005) note that choice of medical provider can also be governed by such gender concerns, as when a patient’s husband in their article cancelled her appointment with a male gynecologist because the husband objected to the provider’s gender. Ivanov and Buck (2002) report similar concerns voiced by patients themselves.
to be a particularly weak link in the system. The social worker Vanessa noted the following, for instance:

VANESSA: Um sometimes understanding the medication can be a challenge um knowing how to take it and y’know there’s a whole movement out there now about health literacy for the- y’know entire population, but if you- y’know add into the fact that y’know English may not be somebody’s primary language, or translating between English and Russian or another language could be difficult. Um y’know making sure that they’re understanding how to properly take their medication, um what the medication is for, helping them understand their medical diagnoses, all those things can be challenging, um particularly when y’know the doctor has to trust that the translator is familiar with all of the medical terminology and try to help explain that to somebody else.


At another point in her interview, this interchange occurred:

BRUA: How do you handle um it just occurred to me, liability and stuff like that whenever there are these sort of unknown [LAUGH BREATH] parties that are coming in with, with families y’know

VANESSA: Right.

BRUA: translat(ing)?

VANESSA: Right. Um typically y’know it is someone’s family member so we(’ve)- y’know we try to make sure that y’know, Are- Are you clear on what we’re saying? Y’know we make sure that they are and then make sure that y’know the patient in turn is clear. Um y’know we certainly don’t just let anybody come into the room. Certainly if it would be somebody that it would be a non-family member, the y’know individual would have to consent to having somebody else in the room during y’know their examination.


It thus seems that assessment of interpreters’ proficiency is at least sometimes based on “trust” or asking the family interpreter questions such as “Are you clear on what we’re saying?” Jacobs (2008) cautions against relying on such information from patients:

[T]he physician may erroneously think the communication is adequate when it is not because the patient does not really understand what is being said. The patient may be reluctant to reveal his or her lack of understanding because of embarrassment, lack of awareness of what is being missed in the interaction, fear of being discriminated against or stigmatized because they don’t speak English… (p. 1724).
Asking patient-supplied interpreters whether they have fully understood information would seem to be equally problematic. John Smith, one of the non-professional but non-naïve interpreters in my study (Chapter 6), commented that Russian immigrants often try to save face and indicate that they understand when they really do not (as do many of us, whatever our backgrounds, I would add). And as Oksana, another of the non-professional but non-naïve interpreters, mentioned, in such a case it will be difficult for the medical provider to know during the appointment whether the interpreter—and thus the patient—has really understood or not.

It should be remembered that Vanessa was a social services provider and not a clinician. However, the clinician Gail also described matters in a way that suggested a rather trusting or laissez-faire approach to assessment of communicative success:

> GAIL: We just kinda try to get a feel for y’know really [PAUSE] kind of getting a feel for their level of understanding with the family member that they’re bringing to kinda be that interpreter for them. [BRUA: um hmm] And based on how we feel that’s going and also what we see with compliance, we may or may not pull someone else in.

(Source tape: “Gail,” Nov. 22, 2005)

I was startled by the idea of using compliance—for instance, adhering to a medication regimen—as a means of assessing communication, since very serious outcomes could occur for the patient between one visit and the next if communication was not successful the first time. However, as another clinician noted during her interview and as is shown in the medical-policy literature, health literacy and understanding of medical instructions are difficult even for native speakers of English, and lack of understanding is widespread (Barrett, Puryear, & Westpheling, 2008). It seems quite possible, then, that “compliance” might be used widely (if implicitly) in the medical profession as a measuring rod of communicative success.

A somewhat different type of compliance comes into play when helping patients navigate the logistics of the referral process (i.e., appointments with other providers to whom the facility
had given a referral for treatment). The clinician Andrea noted that much of her job involved setting up such off-site appointments for her patients:

ANDREA: And there y’know I get into problems too because I often can’t make the appointment right when they’re here, I have to talk to office managers and they have to get back to me, so then I’m on the phone y’know trying to explain all this, or trying to find that family member that does speak English so I can tell them about this appointment. So I get into a little problem there, not just with the Russian patients (but) also the Asian population, trying to find someone. ’Cause the phone is of course much more difficult [LAUGHS] than in person.

(Source tape: "Andrea," Nov. 22, 2005)

Andrea noted that she makes great efforts to identify a family’s telephone intermediary before the patients leave her office.

However, as has been noted in the research literature, family members serving as communication intermediaries can sometimes become impediments to communication, because of cultural taboos or their own beliefs (e.g., Rhodes and Nocon, 2003; Vegni, Visioli, & Moja, 2005). In my study, the social worker Vanessa told a story about a client who had work-related chronic health issues. He did not speak much English, so his adult daughter served as his interpreter. The daughter disagrees with the course of action recommended by the facility, and Vanessa recalled:

VANESSA: So it was difficult trying to communicate y’know with the individual when we had to go through the daughter who clearly had her strong opinions and y’know it wasn’t that we wanted to tell him what to do, ’cause that’s not our business here, but to be able to discuss different y’know, different options and really come up with a plan as to what would be the best thing y’know for him to do was- was a challenge.

(Source tape: "Vanessa," Nov. 22, 2005)

However, we should not forget that institutionally affiliated interpreters also can introduce their own sociopolitical or religious agendas, suppress information, or give unwanted advice to patients (Angelelli, 2004; Davidson, 2001; Dysart-Gale, 2005; Greenhalgh, Robb, and Scambler, 2006).
Language Proficiency

A number of issues related to language proficiency have already been discussed in the section about patient-provided interpreters. These include the greater speed with which children acquire a second language as compared to adults; the possibility that U.S.-raised children serving as interpreters will have experienced too much attrition of their parents’ primary language (or possibly never learned enough of it in the first place) to serve as viable interpreters; and the implicit fact that because the medical and social services staff did not speak Russian, they were at a disadvantage in assessing the success or failure of communication that relied on interpreters.

A few other issues related to language proficiency seem salient. For instance, the social services provider Vanessa noted the importance not just of bilingualism but of medical bilingualism. The following interchange occurred:

BRUA: If you could tell people from the Russian-speaking community one thing that would help them to improve health care that they should know, what would you tell ‘em?

VANESSA: Hmm. That’s a tough question. [PAUSE] I guess just making sure that um if they don’t feel comfortable y’know understanding medical terminology in English, making sure that they had somebody that was comfortable with medical terminology um both in English and in Russian? … ‘Cause (not) understanding the medical terminology is different than y’know just understanding the language… And we’ve had some students who y’know in various languages … that want to volunteer but we have to say, Do you understand medical terminology? Because if you don’t then y’know while you can translate other sayings or maybe helpful during y’know the eligibility appointment or something, it may not be y’know the best thing during (a) medical appointment.


In addition to the differentiation Vanessa made between medical and non-medical terminology in a second language, Greenhalgh, Robb, and Scambler (2006) note that medical interpreters are not only dealing with language but worldviews: “Medical talk is not merely specialised vocabulary but an entire meaning-system that presupposes a particular view of the body (and mind) and a
particular approach to managing illness and distress” (p. 1178). The researchers note that shifting back and forth between lay and provider talk is difficult for interpreters to manage, with a risk that meanings will be distorted.

Language proficiency also figured in the medical staff’s views on the immigrants’ long-term prospects in the United States. The clinician Jason and others on the staff noted that low English proficiency could severely inhibit the immigrants’ access to quality health care. In telling of one immigrant’s difficult medical and legal saga, Jason said:

JASON: In meeting him it was overwhelming because the story was so complex, but everybody had the same impression as we always (did), he’s just a charming, nice, appreciative fellow. And we always do have that, but when I’ve- some of my- many of my encounters have extended well past an hour, because- because that’s the problem with the- a complex storyline with going through an interpreter. And I don’t know whether you want to include this, but I think this is a lot of the problem he had with dealing with the system. I think for instance even ER visits (and) other evaluations, people were not patient enough to get an accurate story. ’Cause the story was complex and y’know just- y’know it takes a long time to go through a complex story through an interpreter.

(Source tape: “Jason,” Nov. 22, 2005)

Jason also commented on what he saw (I believe accurately) as gender-specific aspects of the immigrants’ acquisition of English:

JASON: A sizable percentage of the men that I have dealt with work in construction trades. Particular with ((Name’s)) construction business, and it’s been my experience that because so many of them [WORKING FOR THAT BUSINESS] are Russian-speaking men … they don’t have the impetus to be forced to speak more English. It’s- just so many of the wives or the women that I’ve dealt with seem to be working in housecleaning. Or in some other- some have been in- seamstresses and things like that in which I think because of- they’re forced to interact more with the public, they invariably seem to have the higher level of English. And of course all the kids speak Eng- American English. [LAUGH QUAWER] ’Cause they grew up here mostly.

(Source tape: “Jason,” Nov. 22, 2005)

When asked for one piece of advice that would help the immigrants improve their health-care access, Jason again touched on issues of language proficiency:

JASON: Well, certainly having more- y’know having reliable people
to interpret. But y’know and this, the unfortunate thing is, those who do not become English-proficient are always gonna be held back. Because it’s gonna be harder for them to access health information. And that’s just reality... And though I am extremely irritated with the conservative issues of and prejudice against immigrant people, and I have such great deal of respect for all immigrants to this country, and I don’t care if they’re illegal or not, there’s a reasons why that happens. They have to be admired for their industry and what they do to make a better living for themselves, but what you see that, if you don’t become proficient in English, you’re always going to be at a disadvantage...

(Source tape: “Jason,” Nov. 22, 2005)

He then added his advice to the religious bodies affiliated with the Russian-speaking community:

JASON: I would encourage these churches to really push their members into English proficiency, because that’s their- that is their best key to improving their situation. And always keep speaking Russian. Because I- nothing is better than being bilingual. So keep- teach the kids, make them speak Russian at home. Seriously.

(Source tape: “Jason,” Nov. 22, 2005)

The social service providers at the facility mentioned that one of their jobs was to help immigrants gain access to training in English as a Second Language, since English proficiency had a major impact on the immigrants’ job prospects and health-care access.

Volunteers

In the data above, we have already encountered one volunteer mentioned frequently by the facility staff: Dominika, a highly proficient Russian-English bilingual who served as an interpreter. Dominika actually arrived to talk with Gail during my interview with that clinician, and Gail greeted her enthusiastically, saying: “There’s Dominika! Come on in. This is my Russian case manager social worker lady.” Dominika seemed like an important resource for the

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18 Dominika mentioned that she is also called in to interpret at government offices and other agencies in the study context.
facility, having helped to translate some materials from English to Russian and acting as a communication intermediary for some Russian-speaking immigrants. The clinicians Jason and Gail both told narratives about a patient whose complex and recalcitrant symptoms required many referrals to other physicians, and both clinicians highlighted Dominika’s contribution to the treatment. Jason referred to her as “the main consultant” for that case. Gail mentioned the following during her narrative:

GAIL: So y’know that also caused us to go to the other ((type of specialty)) doctor who felt as though ((another specialist)) was too anxious to jump right to surgery. And felt that it really needed a little more exploration, and y’know that was a lot of communication between me and Dominika and Dominika and the family y’know of helping them understand, ’cause no one wants to say, “Oh, yes! I’d like surgery, please.” [LAUGH QUAVER] … And that all went very well, and Dominika was instrumental in really making sure that that happened well with this particular woman.

(Source tape: “Gail,” Nov. 22, 2005)

At least two other Russian-speaking women volunteered at the facility, and both had medical training in the former Soviet Union. The staff mentioned that one had helped to translate materials into Russian. (The facility reported having 31 informational documents in Russian, although it was not clear whether all had been translated by local volunteers.¹⁹) In general these two volunteers seemed to be called upon to provide more logistical support than language support.

As noted above, issues of language accommodation were not always a high priority for this particular facility, which was heavily burdened in dealing with patient load. At one point the following interchange occurred with the clinician Andrea:

BRUA: And she had said that you have some Russian-speaking volunteers here (right)?

¹⁹ Topics covered were: asthma—babies, asthma—children, bedwetting, bullies, concentration problems, discipline, exercise (for children), immunizations, nutrition, physical discipline, putting babies to sleep, sexual assault, solid food for babies, stress, verbal discipline, keep your teeth, reduce dental bills, ecstasy (the drug), alcohol, best exercise for you, regular exercise, are you feeling good today?, asthma, better health, healthy eyes, breast health, hepatitis B, herpes, men’s health, PAP test, and sexual health.
ANDREA: We do. We do have a couple. It just- if they coincide with a Russian patient’s visit, if- that would normally- that’s not planned, that would just be coincidence, that they’re here, so.

(Source tape: “Andrea,” Nov. 22, 2005)

From the context of our conversation, I believe that Andrea was talking about the Russian-speaking volunteers other than Dominika, who seemed to be in a different category. It occurred to me at that moment that the facility might make better use of its resources if it scheduled Russian-speaking volunteers to coincide with the visits of Russian-speaking patients. But two factors make the clinic’s stance more understandable. One was stated in the next turn by Andrea:

ANDREA: But then y’know you get into confidentiality issues too with a volunteer here going into the room with the patient, so.

(Source tape: “Andrea,” Nov. 22, 2005)

The other complicating factor was that two of the Russian-speaking volunteers other than Dominika seemed (from my own brief encounters with them) to have relatively weak proficiency in English. Despite their medical backgrounds, then, it might be problematic to rely on them too much for “live” communication mediation during medical visits.

At least one staff member saw volunteers as important to potential improvement of the facility’s ability to serve Russian-speaking immigrants. When I asked the social worker Vanessa how the facility might obtain additional materials in Russian, she mentioned volunteer help:

BRUA: Um any suggestions f- sso for instance any of these resources we just talked about um translated materials like the dental extraction or the diabetes stuff, um how that resource could be obtained?

VANESSA: [BREATH]. No. [LAUGHS] Other- and (uh) (y-) to be honest I- I believe that it was one of our volunteers that translated our y’know eligibility sheet so I don’t if y’know she might be willing to do something like that or not. Or y’know someone else that maybe a different y’know individual that could do that. We rely a lot on volunteers, so and that's really- that’s [LAUGHS]

BRUA: Sure

VANESSA: my first thought is, (maybe) there’s a volunteer that could (x) [LAUGH QUAVER] help with that. But unfortunately we
haven’t found (i-) like I haven’t come across any printed or y’know anything already developed so maybe something exists but I haven’t come across it yet.


However, at least in the view of the clinician Jason, the supply of volunteers was not adequate. At one point he said, “There have been unfortunately too few identified volunteers from the Russian community who sometimes accompany them as interpreters.” At another point, he became quite impassioned as he spoke of the need to seek help from the Russian-speaking community:

JASON: I have certainly brought up this issue before with our staff, and I just don’t know that it has been (followed) the way it is. We have a large Russian immigrant population ... and we have a large church, the Baptist church— (it/just ) was built. Y’know somebody here- it should be Dominika, or (name of another Russian-speaking volunteer)), needs to go to their church community and say, “We need interpreters. We need- we need a staff of volunteers we can call,” and this was the most obvious one since we first started, and why that hasn’t happened, I don’t know.

(Source tape: “Jason,” Nov. 22, 2005)

He added:

JASON: Gail [CLINICAL DIRECTOR] or Wanda [EXECUTIVE DIRECTOR] needs to be asked that question.... But y’know you raise these issues but I just don’t have enough energy left over taking care of patients to try to keep pushing and pushing these agendas. But that seems obvious to me, because there’s a particular(ly)- so many of them are churched. Churches are great organizations for looking after- y’know helping people, y’know, and particularly their own people. So I don’t know why Dominika’s the only face I see in here that comes in as a volunteer. Maybe it is that so many of them are just working and don’t have the time.

(Source tape: “Jason,” Nov. 22, 2005)

Incorporating more Russian-speaking volunteers from the community does seem like a potential resource for this facility. Use of such volunteers—especially in the presence of a training program or other filter of proficiency—is among the approaches suggested by the U.S. Department of Health and Human Services (2003). However, as noted above, volunteers also bring potential problems in terms of confidentiality and bilingual proficiency.
Interpreters

This code was the most general and catchall of those used to filter my medical-staff interviews, and thus most instances of its occurrence have already been discussed in relation to other, more specific codes. However, there are a handful of data points that I will touch upon, since they can enrich our picture of the communicative context in which the facility operates.

At one point, the clinician Andrea told a narrative about an elderly Russian-speaking patient who was at risk of severe medical problems because of noncompliance with her medication regime. Andrea noted that the woman’s daughter often interpreted for her, but that another interpreter had helped, as well:

BRUA: And you say she’s (all x x x)- she’s also- so she’s had the daughter, she’s also worked-

ANDREA: She’s had the interpreter.

BRUA: And the interpreter is somebody from your staff?

ANDREA: No this is- there’s an interpreter in the community that’s- comes with her very frequently. There’s two- there’s two main- I think there’s two main interpreters in the community that sometimes the patients will pre-arrange or we will pre-arrange if we know that they’re coming, so.

(Source tape: “Andrea,” Nov. 22, 2005)

Andrea mentioned that one of the community-based interpreters, whom she portrayed as “very laid back” and “very good,” often accompanied patients to the emergency room, including during the night. Andrea portrayed the other community-based interpreter as demanding: “If she is with a patient in the hallway and she has to wait, she will just come in and find the doctor and say she has to be seen now.” When I asked Andrea for the names of these two female interpreters (wondering if they might be Oksana and Masha from my study), she referred me to another staff member. Unfortunately, when I later asked that staff member about interpreters in the community who had worked with the facility, she only mentioned “John Smith,” who will be discussed briefly in this section and at length in Chapter 6. It is also possible that the volunteer Dominika—
whom two other staffers said had worked on this case—was one of the community interpreters mentioned by Andrea; if so, Andrea apparently did not know Dominika’s name.

The only other community-based interpreter mentioned during the interviews was John Smith (pseudonym), who will be discussed at length in Chapter 6. Three staff members independently mentioned him and his service as an “advocate” for one patient. (I did not tell the staff at any point that I had talked with John Smith or was aware of his volunteer work as an interpreter.) The clinician Jason described John this way:

JASON: And we have one to me fascinating case of a ((Place Name)) employee who learned Russian on his own because of his church’s involvement with this Russian emigration effort that has been ongoing in this community for a few decades now. So I’ve been particularly fascinated by him because he- what a huge challenge. So he’s been coming in with one individual for which we’ve had a lot of major medical problems.

(Source tape: “Jason,” Nov. 22, 2005)

Jason then gave information that identified this interpreter as John Smith. Jason went on to tell a complicated narrative about the patient and John’s work with him, a narrative that matched the account John had given me in his own interview two months earlier.

In summing up the role of interpreters at the facility, it seems that several different kinds were active: a) patients’ family members (including young children) and friends; b) community-based interpreters brought in by patients or called in by facility; and c) volunteers at the facility and d) the high-level bilingual Dominika. The preponderance of the interpretation work seemed to reside with the patients’ family members or other interpreters brought by the patients themselves.

Medical Narrative

In order to broaden the analysis with data that is less closely tied to issues of language, I will consider the code Medical Narrative. While most of the data from this code has already been
considered under other codes above, three different clinicians independently told richly detailed narratives about the same patient; these narratives provide interesting and sometimes conflicting accounts of a patient’s response to medical directives.

The clinician Gail described the patient as follows: “She reminds me of y’know the cute little old lady with her babushka on and y’know she’s just always smiling and happy.” Gail went on to say that communication with the patient involved multiple levels of her family (the patient, a relative from a younger generation, and a relative from a younger-still generation). She spoke admiringly of the family’s interpersonal style:

GAIL: And so they’d have these conversations y’know about what was going on, but very tight-knit family, y’know, very caring, very supportive, very compliant, and very grateful for the services that they received here, and y’know not that I want to harp on gratitude, because we’re not here to receive gratitude, although it’s nice to have people say thanks for the hard work that we do, but they just have a warmth- that particular family has a warmth about them that is probably what makes them stand out most to me, is their connection with each other and their ability to reach out for help.

(Source tape: “Gail,” Nov. 22, 2005)

However, two other staff members portrayed the same patient as endangering her own health through ongoing noncompliance. The clinician Andrea described the situation this way:

ANDREA: She’s very pleasant, always hugs us. But has ((a condition)), dangerously ((= further description of condition)). The ((accompanying relative)) speaks English. The woman- really we’ve had a lot of compliance issues, she doesn’t take her medicines. When we look at our refill log, long periods of time go by and she doesn’t order her ((medication)). Dr. ((Name)) knows her well, he’s spoken with her, we’ve spoken with the ((relative)), I’ve even said to the ((relative))- explained the risks of ((the condition)). And for whatever reason- and this lady’s delightful- but she doesn’t take her medicines … she just doesn’t want to take the medicines. When she’s here she says she will. Her ((relative)) understands English, she interprets right at the time, and you think everything’s great, gives you a hug good-bye, we’re wonderful, but she doesn’t take them. She doesn’t take them.

(Source tape: “Andrea,” Nov. 22, 2005)

Andrea added: “I don’t know if she just doesn’t believe us. Y’know, I don’t know. Because it’s been explained time and time again…. So whether she doesn’t understand the risk/benefit, I don’t
know.” She noted that in addition to the relative acting as the patient’s interpreter, an interpreter from the community had also assisted. (As noted earlier, it may be that she was referring to Dominika, since Gail and Jason said that Dominika had been heavily involved with this patient’s case.)

The clinician Jason described the patient as “everybody’s wonderful grandmother.” He said that for one condition, which caused the patient pain, the facility was able to successfully help her. But for another, quite dangerous condition that had no symptoms, the patient got her medicines refilled only half as often as necessary. He noted:

JASON: So that became contentious though we always hugged each other in the end, because y’know she was still so appreciative, (a) tremendous positive transference. And so appreciative. Because her main problems that caused her pain, we dealt with over time and were finally able to give her relief.

(Source tape: “Jason,” Nov. 22, 2005)

Jason described the patient and her family as charming but overwhelmed by the difficulties of making ends meet. He also spoke worriedly of the patient’s likely future:

JASON: And who’s gonna- she will ((experience a catastrophic condition)), I fear, and what’s gonna happen to her?

BRUA: Right. Because if they’re already frazzled, yeah.

JASON [impassioned]: Well, she’s not gonna have Medicare. She not gonna have any means what- this country does not make accommodation for that class of person.

(Source tape: “Jason,” Nov. 22, 2005)

At this and other points in the interview, Jason voiced many criticisms of the U.S. system of health-care financing, which he portrayed as neglectful of the poor.

The three clinicians’ narratives about this patient raise interesting points. All three described the patient as someone they enjoyed spending time with—she was pleasant, grateful, warm, and demonstrative. It may be that Gail’s divergent narrative—portraying the patient as compliant—was colored by her affection for the patient. Or perhaps she was remembering only
the condition for which the patient received successful treatment, rather than the other condition for which the patient did not follow the medication regimen.

Borovoy and Hine (2008) emphasize the need to examine the cultural assumptions of biomedicine as well as those of immigrant patients. As expressed by the clinicians Andrea and Jason in the case of the “wonderful grandmother,” these assumptions seem to be: 1) because medications can help to control the patient’s dangerous condition, they should be used; 2) patients should trust medical providers; 3) providers have a duty to explain cost-benefit scenarios to patients, repeatedly if necessary; 4) avoidance of catastrophic medical outcomes (disability or death) is desirable; 5) one reason for avoidance of catastrophic medical outcomes in the present case is that the patient and her family will be under severe stress if she becomes disabled.

The research literature may shed light on the situation described in Andrea’s and Jason’s narratives. One possibility is that the patient and clinicians have distinct and conflicting “frames” and “knowledge schemas” (Tannen & Wallat, 1987). In terms of frames (basically, what each party sees as the goal of the interaction), while the clinicians may be attempting to heal the problem and reduce the patient’s risk of death, the patient may be attempting to gain information, gain social contact (Aroian, Khatutsky, Tran, & Balsam, 2001), or gain treatment for noticeable problems but not invisible ones. Loustaunau and Sobo (1997), in fact, note that patients sometimes use medical appointments to confirm their own self-diagnosis; having achieved this goal, they may then ignore or modify the physician’s recommendations. Resick (2008) notes similar attitudes in her study of Russian-speaking immigrants:

Nearly all the women reported that they did not always follow the treatment plan of their physicians. Instead, they relied on their own plan of care. Many of the women reported they often stopped taking prescription medications or adjusted the dose on their own after reading about or experiencing side effects. (p. 251)

In terms of schemas (basically, how a person organizes available knowledge in relation to a particular subject or task), such divergence might reflect the differences in medical knowledge
available to the layperson and the medical providers. However, there may also be a schema
divergence in values. In their study of conflicts between American diabetes educators and former-
Soviet immigrants, Borovoy and Hine (2008) write:

And yet while émigrés acknowledge the necessity of self-control in the abstract, daily
needs, life priorities, and values other than those of medical control are at play: in
particular, the prioritization of caring for the younger generations over themselves, their
view of food as a vital necessity rather than an object of choice or desire, and their
prioritization of “community” in one’s later years, including instilling traditional customs
(often in the form of special foods) in the younger generation and the maintenance of
social bonds through the sharing of food and ritual. Where the biomedical model defines
optimal health as the rational goal of diabetes management, the émigrés make more
complex decisions about value and risk, weighing health benefits against the costs of
rigid self-control. (pp. 6-7)

For the patient described by the clinicians in my study, it is less clear why her “noncompliance”
would be motivated by the values expressed by Borovoy and Hine’s former-Soviet participants:
Her medicine was provided free (seemingly entailing little need for sacrifice on behalf of the
younger generation), and the act of taking the medicine did not require giving up cherished food
traditions per se (although such restrictions might have been a corollary of the treatment
regimen). However, it is possible that the patient or her family did see picking up the medications
as a burden, since medical visits often involved a three-generation constellation of family
members—the patient, a younger relative with a job, and a minor, school-age child.

Another potential motivation might be the avoidance of long-term medication use.
Shpilko (2006) and Resick (2008), for instance, write that immigrants from the former Soviet
Union tend to look askance at long-term medication, viewing the medicines as potentially
harmful chemical agents. As discussed in Chapter 4, several immigrant participants in my study
expressed similar trepidation; such concerns among the immigrants will also be mentioned by one
of the interpreters in Chapter 6.

Whatever the reason for the compliance issues between the “wonderful grandmother” and
the clinicians, the narratives about this patient reveal an important fact: The interactions involve a
constellation of family members, not just the patient herself. The patient and her two accompanying relatives (one a minor) all are agents in the communication between patient and provider. Rosenberg, Leanza, and Seller (2007) found that providers in their study often viewed family interpreters as inferior interpreters but superior sources of information about the patient as well as potential caregivers. In such situations, communication can become quite complex because of the multiple actors, roles, and agendas involved.

Conclusion

This chapter has described a medical facility whose dedicated staff helped improve health-care access for many low-income members of the larger community, including Russian-speaking immigrants. However, as analysis of five interviews with staff members has shown, treatment of Russian-speaking patients was complicated by several factors.

As detailed in the section about patient-supplied intermediaries, the facility generally expected patients to bring interpreters with them to appointments. This often meant reliance on family members of dubious proficiency, including children from the ages of 10 to 20. The risk, which I do not think was fully appreciated by members of the staff, was that the medical and social service providers—who did not speak Russian at all—thus had few options for assessing any communication relying on patient-provided interpreters. Patient compliance with treatment recommendations was one method used to assess communication.

A highly proficient bilingual volunteer, Dominika, acted as a communication intermediary and consultant during dealings with some Russian-speaking patients—but not by any means all of them. At times, Dominika was called in to clarify matters when communication difficulties became evident. Several other volunteers from the Russian-speaking community also helped at the facility, although they apparently did not generally function as interpreters. Reliance
on volunteer help was a staple of the facility’s operations because of limited funding.

While attempting to provide health-care access for a medically underserved population, the facility thus still faced daunting challenges to quality care because of issues related to 
interpreters and to language proficiency of patient and staff alike. In addition, as the medical narratives concerning the “noncompliant” grandmother suggest, the divergent health-care socialization of former-Soviet patients and U.S. providers—such as diametrically opposed views on long-term use of medications—may play an important role in the success or failure of health-care efforts.

In the discussion chapter, I will further address the challenges faced by the facility, as well as possible way to improve its ability to provide quality health-care and access to Russian-speaking patients.
Chapter 6

Data Analysis: Volunteer Intermediaries

Introduction

Much of the literature related to medical interpreting has focused on trained interpreters as the best option available in cross-cultural health-care interactions. Flores (2005), for instance, reviews 36 studies and finds evidence suggesting that “optimal communication, the highest patient satisfaction, the best outcomes, and the fewest errors of potential clinical consequence occur when LEP patients have access to trained professional interpreters or bilingual health care providers” (p. 296). Karliner, Jacobs, Hm Chen, and Mutha (2007) review 28 studies and find similar trends toward better outcomes when professional interpreters provide mediation efforts. Policy documents such as the National Standards for Culturally and Linguistically Appropriate Services in Health Care (Office of Minority Health, 2001) encourage the use of professional interpreters, and certainly the guidelines of professional groups like the National Council on Interpreting in Health Care (2005) assume that the best interpretation is provided by professionals.

Arguments for the use of professional medical interpreters have many merits; nonetheless, at many medical sites, patients’ ability to access the help of professionals remains quite limited (e.g., Chan, Alagappan, Rella, Bentley, Soto-Greene, & Martin, 2008; Flores, Torres, Holmes, Salas-Lopez, Youdelman, & Tomany-Korman, 2008; Ginde, Clark, & Camargo, 2008; Ku, and Flores, 2005; Ramirez, Engel, and Tang, 2008; Regenstein, Mead, Muessig, & Huang, 2008). In many real-world contexts, patients must make do with no interpreter or with non-professionals. As noted in Hsieh (2006), in addition to professionals such as trained hospital
interpreters or telephone interpreters, communication might rely on *chance interpreters* (family members, friends, strangers in the waiting room); *untrained interpreters* (medical staff or community members with medical bilingualism but without training in interpreting); and *bilingual physicians* (doctors with some degree of proficiency in the patient’s L1). In my study context, there are very few professionally trained Russian-English medical interpreters or bilingual physicians. Telephone interpreting services are available at some locations, but even there, they might not be offered consistently. The immigrant participants in my study generally reported reliance on what Hsieh would categorize as chance interpreters or untrained interpreters. While this situation might not be optimal for health-care communication, it is the situation that currently exists in my study context—and in many others across the United States. The situation “on the ground” is thus worthy of further investigation.

In this chapter I present data from three people who volunteer as medical interpreters between English-speaking medical personnel and Russian-speaking immigrants in my study context. While all three reported significant levels of medical bilingualism, none reported professional training (although Masha said she had taken a course on English medical terminology); none described herself/himself as a professional interpreter, and in fact, two of them took pains to mention limitations to their interpretation ability. When these three serve as volunteer go-betweens, they are usually recruited by members of the Russian-speaking community, although they are sometimes contacted by medical or social service agencies. Unlike professional interpreters, who are primarily affiliated with specific medical and clinical institutions or telephone services, the three lay interpreters are primarily embedded in the non-medical community. Karliner et al. (2007) would categorize these three volunteers as ad hoc interpreters; Hsieh (2006) would call them untrained interpreters. I will use slightly different terminology: *volunteer intermediaries*. This term avoids the negative connotations of “ad hoc” and “untrained,” and as we will see, the volunteers’ roles encompass more than interpretation.
Simplified and Messy Contexts

Holland and Quinn (1987), among other researchers on processes of cultural model-building, have noted that human beings have a strong tendency to mentally impose order on our otherwise disconcertingly complex world. Discussing Charles Fillmore’s deconstruction of the meaning of the word *bachelor* (for instance, why is the Pope not considered a bachelor?), they write:

Fillmore proposed … that the word *bachelor* “frames,” in his term, a simplified world in which prototypical events unfold: Men marry at a certain age; marriages last for life; and in such a world, a bachelor is a man who stays unmarried beyond the usual age, thereby becoming eminently marriageable. (p. 23)

As Quinn and Holland point out, while the construction of “simplified worlds” has its uses in helping humans to navigate their physical and social surroundings, such simplifications can also impede our understanding of “messy,” real-world contexts. This seems to be the case with the construction—in guidelines of the National Council on Interpreting in Health Care (2005), the Language Line telephone service (2009), and some research literature—of what we might call “the idealized professional interpreter.” Such an interpreter:

- Accurately transmits everything said by all parties without addition or deletion, but provides cultural nuances where necessary for understanding;
- Effaces herself/himself, becoming an invisible conduit for the patient’s and doctor’s communication;
- Maintains neutrality during the interaction, except when advocacy is needed to protect a patient from institutional abuses;
- Is able to clearly delineate between roles such as conduit, culture broker, or advocate and to move among them as needed.

As discussed in Chapter 2, a number of researchers have critiqued such idealized versions of professional interpreting as an incomplete or misleading picture of what actually occurs. Among
the critiques are arguments that machine-like transmission of information across languages is an unrealistic expectation (Singy & Guex, 2005); that self-effacement and invisibility of the interpreter’s gender, ethnicity, or age are impossible to attain (Angelelli, 2004); that, instead of achieving neutrality, institutionally employed interpreters sometimes side with the institution’s needs and use their own considerable power to block patients’ access to health care or empowerment (Angelelli, 2004; Davidson, 2001; Greenhalgh, Robb, & Scambler, 2006; Leanza, 2005); and that interpreters face dilemmas in trying to sort out the various, sometimes contradictory, roles they are expected to play (Dysart-Gale, 2005; Angelelli, 2006).

It thus appears that the simplified world does not adequately capture the complexities of interpreting as confronted by practitioners in daily life. Another limitation of the simplified world is that it assumes the availability of professionally trained medical interpreters in the first place. In many contexts, including the geographic area where I am conducting my research, professionally trained interpreters are few. In such a context, non-professionals step in. Sometimes these intermediaries are the patient’s friends or family members, including children in elementary school; such interpreters often lack stable medical bilingualism and/or enough life knowledge to successfully interpret, in addition to the potential for added stresses experienced by young family members acting as interpreters (e.g., Jones & Trickett, 2005). In other cases, the intermediaries are Russian-English bilinguals who have a fairly high degree of stable medical bilingualism and life knowledge but who are not professional interpreters. It is on three representatives of this latter category—people I call volunteer intermediaries—that this chapter will focus. The functions served by professionals and by volunteer intermediaries have some overlaps but also differ in important ways.

For instance, the idealized professional interpreter described in the standards of practice of the National Council on Interpreting in Health Care (2005) is instructed to restrict his/her role only to the medical appointment (or the scheduling of the appointment). This constraint avoids
role-blurring and is seen as promoting respect. For instance, in order to promote “patient autonomy,” the interpreter is told: “For example, an interpreter directs a patient who asks him or her for a ride home to appropriate resources within the institution” (p. 7). However, in a context where few institutionally provided resources are available to patients, such a constraint might be problematic. One of the volunteer intermediaries in my study mentioned that she sometimes drives interpreting clients to mandatory green-card checkups in a city 40 miles away; it certainly seems possible that if she declined to provide such help, her clients (peers from her community) might find her behavior alienating.

As will become clear in the data, the volunteer intermediaries in my study have a greater degree of availability to and involvement with clients than do professional medical interpreters who are affiliated with an institution. The volunteer intermediaries—who provide interpretation help and take on several other roles, as well—are more closely connected to their clients as they travel through time and space. As will also become clear, there are both dangers and potential benefits for the patient in the greater degree of involvement found among the volunteer intermediaries.

**The Three Volunteer Intermediaries**

My research question for the overall project was: *In this health-care context—which involves Russian-speaking doctors, English-speaking medical staff, and bilinguals serving as intermediaries for the other two stakeholder groups—how do factors related to language resources and health-care socialization enhance or impede access to quality health care?* As part of the effort to answer this question, I conducted interviews with three volunteer intermediaries, Masha, Oksana, and John (described briefly in Table 6-1, with further details in the data section).
Initially, two interviews each were scheduled with Masha and Oksana in the autumn of 2004, as described in detail in Chapter 1. However, after the first round of interviews, Masha experienced a family health emergency that caused her extreme and ongoing difficulties, and I opted not to trouble her further. A second interview was conducted with Oksana as scheduled. One year later, after I had further clarified his project objectives and questions, a follow-up interview was held with Oksana, who had earlier indicated her willingness to act as a key informant. An interview with John was also conducted in the autumn of 2005.

**Table 6-1: Volunteer intermediaries**

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Language-learning sequence</th>
<th>Other descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Masha</td>
<td>Russian (as a child), then English (as an adult)</td>
<td>Relatively new resident of study context; had some medical training in former Soviet Union; had taken a medical terminology course in U.S.</td>
</tr>
<tr>
<td>Oksana</td>
<td>Russian (as a child), then English (as an adult)</td>
<td>Relatively new resident of study context; reported reading widely on medical subjects; employed on a contract basis to interpret at an agency once a month, but otherwise reported serving in volunteer interpreter capacity</td>
</tr>
<tr>
<td>John</td>
<td>English (as a child), then Russian (as an adult)</td>
<td>Longtime resident of study context; chose to learn Russian to assist resettlement efforts of church; described self as an advocate for patients</td>
</tr>
</tbody>
</table>

I transcribed the interpreter interviews, grouped them into a single “hermeneutic unit” in the ATLAS.ti software program, and then coded them. Across the three stakeholder groups of the entire project, I used a universal coding list to which I added as new ideas emerged in any particular transcript. My code list for the interpreters included 134 codes; the list for the immigrant participants had an additional four codes, for a total of 138; and my medical staff data had an additional five codes beyond that, for a total of 143 codes. The complete list of all codes across the entire project is shown in Appendix D.20

20 For a more detailed discussion of the coding procedures, please see Chapter 3.
I then ran a query in ATLAS.ti to find which codes had the most tokens. In order to focus the analysis, I adopted a cutoff score of 20; in other words, the analysis that follows will deal with all codes that had more than 20 tokens. As shown in Table 6-2, eight codes met this criterion:

**Table 6-2: Top-ranked codes for the volunteer intermediaries**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Total no. of tokens</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Interps’ Values</em></td>
<td>Moral or ethical attitudes expressed by the three central intermediaries, either explicitly or implicitly</td>
<td>71</td>
</tr>
<tr>
<td><em>Types of Help</em></td>
<td>Kinds of help mentioned as being provided by these intermediaries to their clients</td>
<td>63</td>
</tr>
<tr>
<td><em>Non-Professional, Non-Naïve Interpreter</em></td>
<td>The code used for the three focal volunteer intermediaries: helpers who are at an intermediate level between professionally trained medical interpreters, who have stable medical bilingualism, and low-proficiency interpreters, who have unstable medical bilingualism and/or medical knowledge (such as minor children or family members of the patient)</td>
<td>45</td>
</tr>
<tr>
<td><em>Interpreters</em></td>
<td>Mentions of interpreting in general, including other interpreters in the community</td>
<td>40</td>
</tr>
<tr>
<td><em>Language Proficiency</em></td>
<td>Characterization of the kinds of language aptitude displayed (or needed) by non-naïve interpreters</td>
<td>40</td>
</tr>
<tr>
<td><em>Portray U.S. System</em></td>
<td>The three central intermediaries’ characterizations of medical practices, health-care financing, or attitudes of people who were socialized in the U.S. health-care system</td>
<td>32</td>
</tr>
<tr>
<td><em>Language Learning</em></td>
<td>Pathways to medical bilingualism experienced by the three volunteer intermediaries</td>
<td>29</td>
</tr>
<tr>
<td><em>Medical Narrative</em></td>
<td>Stories focusing on a time-specific, non-repeated interaction</td>
<td>22</td>
</tr>
</tbody>
</table>

In accord with grounded theory (Glaser & Strauss, 1967), I merged six of these codes into two overarching categories, which will be discussed along with the remaining two codes from the original eight:

- **Interpreter Identity**: Incorporates the codes Non-Professional, Non-Naïve Interpreters, Interpreters’ Values, Types Of Help, and a few instances from Interpreters (general);
• *Language Proficiency*: combines that category and *Language Learning*;

• *Portrayal of the U.S. System*;

• *Medical Narrative*.

The resulting analytic categories are shown in Table 6-3.

**Table 6-3: Analytic categories for the volunteer intermediary data**

<table>
<thead>
<tr>
<th>Analytic Category</th>
<th>Description</th>
<th>Total no. of tokens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpreter Identity</td>
<td>Portrayals of interpreters’ values, types of help they gave, their status as non-professional but non-naïve interpreters, and some discussion of interpreters in general, including other interpreters in the community</td>
<td>219</td>
</tr>
<tr>
<td>Language Proficiency</td>
<td>Discussion of language skills and pathways to medical bilingualism</td>
<td>69</td>
</tr>
<tr>
<td>Portrayal of the U.S. System</td>
<td>Mention of the volunteer intermediaries’ attitudes toward the U.S. health-care system</td>
<td>32</td>
</tr>
<tr>
<td>Medical Narratives</td>
<td>Stories focusing on a time-specific, non-repeated interaction</td>
<td>22</td>
</tr>
</tbody>
</table>

I will begin with the category *Medical Narratives*, for reasons discussed in the following section.

**Medical Narratives**

The first code I discuss, *Medical Narratives*, is not really an analytic category so much as a genre. I begin with it in order to introduce the three protagonists and give a sense of their activities. Presenting the narratives in their entirety will better preserve their coherence than would the presentation of the points piecemeal.

**Narrative #1 (Masha): Learning That Good Communication Is Crucial**

((Masha has been talking about a severe illness faced by a member of her family when they first arrived in the United States.))
MASHA: So because I was understand I need to start study and study English and, because was moments I was need to do by myself. Even- even I was scared I didn’t know how to use map (oo) go somewhere, find some clinic to bring my ((relative)) there, to explain what, uh to understand what does she need later. Um it’s- that’s that’s really [LAUGH QUAVER] really tough time, so. Even I was using dictionary with me so. But anyway I’m so glad for everybody who was with me that time. Around me, so. Really helpful.

BRUA: Now that you live here in- in the ((town name)) area, do you find that you and your friends help each other when someone is sick (and) like what kind of help?

MASHA: Um, yes. But um I don’t how was here uh when I li- I didn’t live here. I didn’t know how was things goes. But since I’m here uh I’m trying to tell everybody … if you don’t know how, just give it- j- give me a call. So maybe I can’t help directly with this problem or another problem, I will- I will help you to find right person or uh to find somebody um d- depends what you need, what question is. Because then better communication, then better problem solves.


While she did not explicitly link her current role with her earlier trial by fire during the severe illness of her relative, it seems fair to wonder whether they were connected. In the large city where she and her relative lived at that time, other immigrants helped as much as they could but were often unavailable because of work commitments, Masha said. Thus, as she noted above, she needed to develop her own proficiency in English and her ability to operate as an intermediary for her relative. In her current community, Masha portrayed herself as a source of information and as a person able to direct others to appropriate types of help, in addition to providing interpretation assistance. In addition to interpretation during medical appointments, she offered her peers help as a culture broker (e.g., Angelelli, 2004; Dysart-Gale, 2005; Longo & Donahue, 1997).

Narrative #2 (Oksana): Long-Distance Help

OKSANA: By the way, two weeks- three weeks ago, was um emergency situation, one girl was trying to- she’s just ((an infant)), she was trying to swallow ((a dangerous object)).

BRUA: Ooo.
OKSANA: So ( ). They get- got it out but they were afraid if something ( ) because it was blood. And she (throw up)

BRUA: So maybe she hurt herself when she tried to swallow it?

OKSANA: Uh-hm. Uh yes. And we went to emergency and uh when they um got (up ) the X uh ray film, their concern was it might m- in fact it might be a hole in her trachea. So they sent her to ((a large city several hours away by car)) on a helicopter and me and my husband we went to ((the large city)) as well because they don’t speak English at all and they might be need our help, so we went there ((by car)). And thank God it [SIGHS] (turn/come) OK, it wasn’t anything serious.


I have included this narrative because it demonstrates Oksana’s high level of dedication to her clients (and, as we will see in the Interpreters’ Values section below, especially to those in vulnerable situations, such as the very young or the elderly). The narrative also gives a good example of Oksana’s highly developed English abilities, which in addition to her native proficiency in Russian, make her a valuable player in cross-linguistic medical consultations.

Narrative #3 (John): Compelled to Be an Advocate

John’s longest and most dramatic narrative concerned his role helping a Russian-speaking man who had been injured on the job. Because the narrative is so complex and rich in detail, I will consider it at length. John noted that he himself had not been at the hospital to act as an intermediary for the worker immediately following the injury; rather, the worker had contacted him about a month later because of ongoing problems. John continued:

JOHN: He received some therapy in ((town name)) and then he was told, “This will be the end of your therapy because um you have no more sessions,” or something like that. Or your- your- something about your insurance. And so he thought that was it and then I- (w/-we)- I went to his house and he couldn’t even barely go up the steps to go to the restroom. And um he had a leg contusion, um and his ankles were really bothering him, and his … arm was swollen and he- he couldn’t, he could only move (for x) so and this was supposedly after therapy, (and I mean) yuh- I couldn’t believe that he was still suffering from all this and so-called done with therapy.

Several characterizations seem salient in John’s narrative up to this point. One is that the injured worker “thought that was it”—i.e., that he had no further recourse to receiving therapy—after his therapy was terminated. This contrasts with the portrayal, often seen in the literature (Aroian, Khatutsky, Tran, and Balsam, 2005; Duncan & Simmons, 1996; Ivanov & Buck, 2002; Wei & Spigner, 1994), of Russian-speaking immigrants as “pushy” in regard to medical care.

Another interesting point is the reported extent of the man’s injuries one month after the initial episode. And the third, and most important for our consideration of John’s role, is John’s sense of disbelief, shading toward anger, that the man would be treated in this way by the medical/insurance system. John then continues:

JOHN: So I started helping him and getting him set up for some more therapy and (to/did) see his family physician, and, and started taking it from there. And sending those—those bills to compensation, (they) were actually declining things left and right... Anyway he’s um we had him evaluated by different, you know, doctors um we (just with) with compensation, I mean we actually, it’s in, the whole thing’s in litigation. And with worker’s compensation. So decision’s (gonna be) comin’ about as far as that, and we filled out (the) paperwork for disability and he’s actually— they ruled in his favor.


In the preceding excerpt, John portrays himself in a very active role, much more so than the role taken on by someone acting as an interpreter only. John portrays himself as arranging further therapy and medical appointments for the client, as well as beginning the process of challenging the declined claims. By the end of the preceding excerpt, the worker’s situation is still in flux, but some good developments have begun. John then expanded the circle to discuss ways in which the dangers of the situation were not just restricted to the patient. The injured man next took a job that involved operating dangerous machinery in public spaces; John said: “He had all these ailments, but he felt he had no other way to survive than to work.”

John went on to describe health problems that raised questions about the worker’s ability to safely carry out his new job. John went on:
JOHN: So he really needed attended to and he’s extreme case, and I – I do my work is just all voluntary, and I felt compelled (and/uh) to help him. Like I’m- like I must.

Taken as a whole, the narrative about the injured worker illustrates a number of themes that seem central to John’s self-construction of identity as an intermediary between immigrants and the U.S. medical and legal systems. Perhaps foremost is that he does not see interpretation as his only role; as he said later in the interview, “And in addition to translation, I would also be like the advocator.” In taking on this role, John assumes a level of activity that seems to go beyond even the interpreter/advocate role portrayed in the literature (Angelelli, 2004; Dysart-Gale, 2005; Greenhalgh, Scambler, & Robb, 2006), since he is actively formulating strategies that his client can use to challenge the health-care coverage system and enlisting medical allies in this cause.

John portrays himself as being motivated by a number of factors: concern for the injured worker, anger at what he perceives as an unjust situation, and concern for the physical well-being of other people who might be endangered by the injured man. Themes of fairness and empathy came up at several other points during John’s interview, as when he said:

JOHN: Just because they’re from a different country don’t, you know, know the language, you just can’t shrug them off or, you know, they have rights, much like um we Americans do here. So um. (And) I oftentimes (put) myself in their shoes and how would it-how would it be for me if I were going through these things in- in Russia?

Elsewhere he noted:

JOHN: you know you try going into a- a foreign country yourself and try, (and) with a language you don’t understand and try and uh make it, it’s [PAUSE]

BRUA: Very tough.

JOHN: Yeah.
John’s sense of empathy for the injured worker seems admirable, and certainly it is a strong motivator of action. As we will see in the section on interpreter values, however, strong action can also lead interpreter/advocates and their clients into ethical gray zones (Brua, 2008).

**Interpreter Identity**

**Interpreter Identity: Types of Help Provided by the Interpreters**

All three of the intermediaries mentioned accompanying patients to appointments where they then provided interpretation between the patients and medical staff. In most instances, it seemed that the interpreter was enlisted by the patient rather than a health-care site. Masha pointed out that such interpretation is difficult:

*MASHA:* That’s really hard. You know uh, what I can tell. That’s even uh for teenagers who speaks really well but they not really know about some disease or some medical problems what cause. Um, they can’t um shows (on) time what’s really important for special person with special problem.


John and Oksana both similarly mentioned the need for *medical* bilingualism, not just bilingual ability. John, for instance, said: “But um medical terminology’s a- a whole ’nother language and uh unless you know or a Russian, y’know, that reads up on it and is able to know all that terminology, y’know, it can get difficult.” John, however, distanced himself somewhat from being a conduit-style interpreter by casting doubt on the exactitude of his interpretation:

*JOHN:* And there are some individuals in town who actually do translate, you know, for hire and um for specific reasons they need to be brought on board, whether it’s in (a) court of law or, you know, if surgeries are (in)– or if you need to get every minute detail from a person, then they really should be called in, because uh I do not even myself even claim to know it all and be able to translate (x x). I can within my own Russian um terminology [LAUGHS] of terms explain in– in (x) a general fashion but um.

Interestingly, while he here seemed to be putting surgery—or some types of surgery—into a realm demanding more accuracy than he could promise, he elsewhere did mention having provided interpretation help during “two or three” surgeries.

While I cannot say for sure in the absence of data from actual interpreting sessions, my sense of the three volunteers was that they did not generally function in the conduit role described by Dysart-Gale (2005) among others and critiqued by Angelelli (2004). Certainly they described attempts to clearly and accurately convey information, but self-effacement and machine-like accuracy did not seem to be their priorities.

However, examples of culture brokerage as described in the research literature did come up fairly often in their interviews. As we have seen above in Medical Narrative #1, Masha portrayed herself as an information clearinghouse able to refer people to other sources of help—a form of cultural brokerage. John described one of his activities with newcomers as “mainly just talking with the families, explaining to them our customs.” Oksana, in a dental narrative that will be discussed at length in the Interpreters’ Values section below, portrayed herself as attempting to help clients understand what procedures were likely during a first-time U.S. dental visit (only X-rays and teeth-cleaning, but no major work, she told them). She also mentioned helping her peers learn to handle their own medical communication:

OKSANA: I’m trying to explain wh- how to call and to make an appointment. I’m saying what they need to- to say. Um and uh if um they wanna try to go with- for an appointment with uh without interpreter, eh I’m just explaining them what they need to say…. So if they are ask me, How am I supposed to say that word?, or uh uh How am I supposed to explain the situation?, I can say (it to them).


She added, however, that clients attempting communication on their own might fail to completely understand the medical providers.
Of the three interpreters, only John talked in detail about acting as a patient advocate (Dysart-Gale, 2005; Greenhalgh, Robb, & Scambler, 2006; National Council on Interpreting in Health Care, 2005). It may be that his status as a native speaker of English and longtime resident of the area give him more cultural capital in dealing with U.S. bureaucratic structures than would be available to Masha and Oksana as Russian L1 immigrants. His advocate role was seen quite dramatically in Narrative #3 above about the injured worker. In that narrative, John specifically noted: “And um in addition to translation, I would also be like the advocator.” And as was discussed in Chapter 5, three medical staff members who had dealt with John also described him as performing an advocate role for the injured man.

Strong action was one hallmark of John’s advocate role, and it sometimes seemed to veer into ethical gray zones. Other activities by the volunteer intermediaries also seemed potentially problematic, as well. For instance, there were moments when two of them described behavior that might come perilously close to a “gatekeeper” function in which their alignment with the medical system impedes the patient’s access to quality care (Angelelli, 2004; Davidson, 2001; Greenhalgh, Robb, & Scambler, 2006).

John, for example, threw an immigrant’s outdated medicine down the toilet against her wishes (as will be discussed in the section on Interpreters’ Values below). In effect, he was setting himself up as the representative of the biomedical establishment and enforcing its guidelines regarding expiration dates. While he was most likely motivated by a wish to protect the immigrant from harm, the fact that he disregarded her wishes would have the potential to make her mistrust him in future interactions, including those in which he might serve as her interpreter. John also noted that, because of clients’ socialization in the Soviet health-care system—where under-the-table payments to doctors were sometimes necessary to receive quality care (Field, 1995)—Russian-speaking patients in the U.S. often distrust the diagnoses they receive. He then noted: “And um sometimes I would have to convince them that they- they do
have this, that, you know, the results are showing that you have this, and- and so some of them would, you know, listen to me and- and trust me in that.” John thus had stepped out of the interpreter role and into one in which he was a persuader—in some sense a representative of the medical establishment rather than the patient’s concerns. At another point, however, John told a narrative whose explicit point was that doctors can be mistaken in their diagnoses and that immigrants would do well to seek a second opinion.

Oksana also sometimes seemed to display a strong alignment with the U.S. health-care system. In the following excerpt, she told of patients contesting their diagnoses:

OKSANA: They didn’t have any problem over there [in the former Soviet Union], but when they came here, they were diagnosed with thyroid glands.

BRUA: I see.

OKSANA: And they (were) insisting, I mean, “No, I’m pretty sure I don’t have this kind of problem. And just- doctor just wrong, he doesn’t- know what he’s doing,” you know [LAUGH QUAVER] this kind of things.

BRUA: Um hmm um hmm

OKSANA: So. Yeah, it- it happened very often.

BRUA: Um hmm. Now in that case, for instance, were they saying to you in the presence of the- while you’re at the doctor's office, they’re saying, “No (this)”

OKSANA: Usually no, when we are leaving

BRUA: OK. Um hmm.

OKSANA: uh doctor’s office and um they are saying- but sometimes if they are very old they, (yes), they start arguing with you (right) in (the) office so

BRUA: How do you handle that, then?

OKSANA: Uh, now I know how to handle that. I am just- I’m just trying to explain them (um) that uh there is um- uh medical equipment in America is much better and (uh w-)– to be honest, in Russia, they don’t do this uh properly. And now I am very sure they- they don’t do that properly, I mean, they- uh- they diagnosed people with, I mean, it’s [PAUSE]. For an example, they don’t have right equipment. They um- OK, one example. Um I know so many people who are coming from Russia and they have uh like
uh I forgot (the name of ) ... ( ) forgot the name of, was that uh it’s not disease but, for an example, it’s um when uh they go to a gynecologist, they think they-- forgot it, sorry [LAUGHS]. So but I know they cannot be diagnosed with this kind of- they can’t get this diagnos(is) without having la- la- laparoscopy

BRUA: OK.

OKSANA: which they don’t do in Russia, they don’t provide this kind of procedure in Russia.

(Source tape: ”Oksana-3,” Sept. 23, 2005)

Oksana thus portrayed herself as stepping into a “persuader” role. This move potentially could chill her relationship with her client, and it could also impede the client’s ability to have her own concerns addressed by the doctor, rather than being answered/blocked by the interpreter. Oksana seemed to be acting as a gatekeeper in such instances. We also might argue that during a dental visit described in detail in the next section, Oksana might have been attempting to make her clients conform to a U.S. biomedical scheduling script that they did not want to accept (personal communication from James Lantolf, Steve Thorne, & Amber Huang Navarre, Nov. 15, 2004).

In fairness, however, she did also discuss other ways of handling patients’ concerns about diagnoses:

OKSANA: For an example, if uh (uh/a) patient saying ‘I insist you have to check me with this disease.’ And doctor saying ‘Not you- we don’t have to do that.’ Then I’m asking doctor, ‘Could you explain um why we don’t need to do this procedure?’ and, for an example, that uh- you know that the patient will be hearing that I’m asking doctor and doctor is saying that uh. And uh doctor was um as far as I remember, always doctors were very patient with uh [PAUSE] (y’know) with Russian clients [LAUGHS].

(Source tape: ”Oksana-3,” Sept. 23, 2005)

Such an approach, in which the interpreter puts the responsibility for medical explanations on the medical provider, seems much more ethically sound, and it accords with instructions for “transparency” in the standards of the National Council on Interpreting in Health Care (2005: p. 5).

Interpreter Identity: Interpreters’ Values
In Masha’s data, a very salient value was the importance of high-quality medical communication. For instance, in her discussion of her role as an information clearinghouse, she said: “Because um then better communication, then better problem solves.” A few minutes later, she made an observation that concluded with a similar, almost slogan-like phrase:

MASHA: Sometimes uh people has wrong opinion about doctors because (depends) from um communication and understanding. So if you goes to the appointment with child who speaks English but child can’t discuss about special(t)y problem and explain everything, more detailed, uh how you can understand as much that’s important for you or not. And after that the person can think, Um that’s not real good doctor, he didn’t understand me right, he didn’t give me good care or didn’t pay attention or something you know. Better communication, better understanding, better service.


Masha contended that medical knowledge and medical bilingualism are important resources that interpreters should have—simple Russian-English bilingualism, as found in immigrant teenagers, is not sufficient, she said.

Although mentioned less frequently than the need for good communication, two other values seemed directly relevant to Masha’s sense of herself as an interpreter: She noted that it is a priority to keep her clients’ information confidential, and she mentioned that her dedication as an interpreter was related to a sense of mutuality or reciprocity (Antonucci & Akiyama, 1987):

MASHA: Um I’m trying to be really r- responsible for it because um you never know what- what- what can happen. So. I mean that- that same it would be happen in my family.

BRUA: Hmm.

MASHA: And I would (xx) find uh same attention from another- (sides) from another persons. Like I do, you know.

BRUA: So you would- you would hope to get the same sort of help

MASHA: Yes, of course. Yeah.


Oksana, like both Masha and John, obviously maintained dedication as a value—she mentioned volunteering with many clients, and as seen in the narrative about the injured child,
she was willing to travel long distances to help. She said that one of her duties as an interpreter was to thoroughly understand the medical background of the case and to ask questions of the doctor to clarify areas that were unclear to her. In this way, she said, she would be able to provide maximum helpfulness as a communication intermediary. Also like Masha and John, Oksana talked at multiple points about the need for a high level of medical bilingualism in order for medical interpretation. (After telling about a friend’s daughter who could interpret simple instructions but could not explain to her mother the causes of her illness, Oksana noted: “For an example, if child 8 or even 10 years old goes with you to gynecologist, what she can say?”)

However, one of the most salient values she expressed was one not mentioned by the other two interpreters: a desire to be respected and treated politely by her clients. At one point I asked her whether she mentally took on her clients’ problems as her own, or whether she maintained a mental distance, seeing the problem as the client’s alone. Oksana answered with a finely articulated account:

OKSANA: Uh, what I can say, when I was helping for an example that girl it was like- like my problem, you know it’s, because it’s just child and she was suffering from you know for nothing. And it’s

BRUA: That’s the girl with the ((dangerous object)) in her throat?

[OVERLAP]

OKSANA: Yes, yes. And just. And um no I’m always taking the problem (like) mine, yeah, or if it’s old person, but some person you know, some people are just like ‘I need your help and be there, please’ [SHE IMITATES A RATHER RUDE AND DEMANDING PERSON].

BRUA: [LAUGHS]

OKSANA: Those people I- I’m not trying to be a like take their problem as mine. I’ll w- I’m always trying to be polite and you know to be nice but, I’m expecting in return I want to be polite to me as well, you know. [LAUGHS]


21My question was motivated by an interest in the communal-coping theories of Lyons, Sullivan, Ritvo, and Coyne (1995) and Lyons, Mickelson, Sullivan, and Coyne (1998).
In the second interview, I asked a similar question: whether she began to feel like one of the
family when helping her clients. And she gave a similar answer:

OKSANA: Especially if uh, I already mentioned last time uh if
people just you know like, they talk with me nice, they’re
(doing) like (right) thing, the things that’s uh that they
supposed to do in (the) situation like, “thank you” (and’/d) be
nice, you know [LAUGHS], not like [IMITATES HARSHER VOICE]
“Why’s- why doctor saying that? I don’t want to do that,” you
know, I don’t like to deal with those kind of people.

I then asked whether she encountered clients of the latter kind. She told this story about a dental
visit:

OKSANA: Yeah, absolutely [LAUGHS]. Like um one situation, once we
went uh to um dental- to dentist uh for dental appointment, and
uh I told them, first appointment it will be just they gonna
check uh uh check your mouth to- to make some X-rays and uh
cleaning. That’s basically it for first visit. And uh when uh uh
they were done with that appointment they were (saying) [HIGHER
QUOTING VOICE] “Oh, is that it? And now
we have to wait for an-
other appointment when they’re gonna fix the cavity, it’s gonna
take us uh forever to wait for that appointment,” [DROPS TO LOWER
VOICE] and you know I said, you’re- you(’re)- you are very happy
you know, I mean not- not hap- how can I say it? For an example I
don’t have any kind of dental coverage and I would like to go but
I cannot [SOUNDS AMUSED] and uh (your)- um your medical access is
uh uh is covering the dental, so um. You don’t have to say
anything in this situation [LAUGHS]. I mean you- you’re supposed
to be happy that your- you went for this appointment, (so/uh).

In this dental narrative, Oksana described an initial attempt to educate clients about the scripts of
U.S. dental appointments—during the first appointment, problems are diagnosed and
maintenance cleaning is performed, but major work is generally not done. As discussed earlier,
Oksana also was encouraging her clients to conform to those scripts; she thus may have been
affiliating herself more with the health-care establishment rather than with her clients. These
particular clients, however, do not take the hint and instead complain to Oksana afterward about
the delay they face in having the cavity filled. This delay might, in fact, have been truly
burdensome: Several immigrant participants in my study (including Oksana) complained about
waits of months in accessing medical or dental care. This situation was sometimes exacerbated by
the fact that they could only receive treatment from the few providers who accepted payment via
a government-issued medical access card. Another factor in the dental clients’ reaction might
have been their socialization in the Soviet and post-Soviet health-care systems, in which same-
day treatment was frequent, according to several of my participants.

It is not 100 percent clear from Oksana’s narrative that she actually chided the dental
clients; perhaps she was merely reporting to me what she said silently to herself. But if she
actually did tell them to be grateful because they had better health-care access than she did, this
would be additional evidence that she, like John Smith, sometimes acts in ways that are ethically
gray, ways that a professional medical interpreter would hopefully be trained to avoid (Brua,
2008).

Oksana was also noteworthy for the degree to which she praised the U.S. medical
establishment. On several occasions she portrayed U.S. medical personnel as extremely patient
and thorough toward their Russian-speaking patients, and as noted above, she believed that U.S.
diagnostics were superior to those in the former Soviet Union. As we saw earlier, such affiliation
sometimes led her to enter a “persuader” role—similar to the one described by John—in which
she attempted to convince her clients to agree with the doctor’s diagnosis.

Oksana expressed a high degree of sensitivity to the differences in access to health-care
benefits available to her clients and herself. This was a factor in the dental narrative, where her
clients did not sufficiently (in her view) appreciate their government-provided access to dental
care—access that Oksana did not have. At another point, she spoke sympathetically of people
trying to have their health-care needs taken care of during times when they were covered by
medical assistance programs, since that access would be lost if their income improved above
certain thresholds the next year. She added: “They’re doing um they’re helping a lot of people I
mean (in) welfare with uh those (who with) that kind of help, it’s real good. So I just- I can say
I’m- I’m envy [LAUGHS] because I can’t get this kind of help [LAUGH QUAVER].”

At one point, Oksana noted a difference between people who came under immigrant status and those who came under refugee status:

**BRUA:** Question about the older immigrants and refugees here. Do most of them have relatives in this area?

**OKSANA:** Yes, especially rela- uh I mean refugees. They uh if one family came here they can invite uh their brothers, sisters, mothers, fathers, come as soon as they want to.


She contrasted the refugees’ situation with the one faced by people who came under immigrant status, who experienced a multi-year wait before they could bring their parents to the U.S. And at another point, after saying that the government should provide trained interpreters for medical appointments, she then said:

**OKSANA:** Anyway you know, I think uh government is helping them a lot, I mean through welfare. They are getting enough help, I mean, medical help to pay medical bills I mean. So (and) (folks payin?) something like that.

**BRUA:** Now when you say they are getting help, you’re talking more the refugees.

**OKSANA:** Yes, absolutely.


Two additional points should be mentioned. One, in the interest of fairness, is that I re-invoked the topic of differences between Baptist refugees and other Russian-speaking immigrants at various points during the interview, thus possibly keeping the issue in the foreground. Another is that Oksana had a tendency to offer mild critiques of U.S. health-care practices (for instance, the long wait for appointments or the lack of trained interpreters provided by the government) and to almost immediately follow up with a statement saying that the government was providing a lot of help to Russian speakers via welfare. Perhaps she was trying to guard against sounding ungrateful, since that was a trait she disliked in her clients.
In John’s data, two values that seemed especially salient were his sense of empathy, and a resulting sense that he should take action to improve the immigrants’ situations. In Medical Narrative #3 above, we saw John’s empathetic response to the injured worker. As noted, John asked himself, “How would it be for me if I were going through these things in- in Russia?”

As noted previously, John also mentioned feeling “compelled” to help the injured worker, and his commitment as a volunteer on behalf of the immigrant community has been substantial—learning Russian, helping as a language intermediary, establishing an advisory group to successfully lobby for use of the Language Line in five locations, and acting as an “advocator” for clients including the injured worker. Thus, another of his values was direct action. It seems reasonable to speculate that his sense of empathy might have been a primary motivator behind his willingness to take direct action.

To introduce a contrary possibility, though, it seems important to mention that John also seemed to adopt/value an “other” orientation when talking about Russian-speaking immigrants. At several points, he portrayed them as suspicious or distrustful. For instance, discussing the use of the Language Line telephone interpreting service, he said:

**JOHN:** And even the, the Russian person who’s using it, they always wonder who that person is who’s translating because it’s very, you know, personal matters and- and information that- that shouldn’t be out there (but/really). (And) as it goes, you know, people of other nationalities, it’s difficult for them to trust another nationality (just) you know, totally....


At another point, he said:

**JOHN:** And too, Russians tend to be secretive, so they don’t always divulge [LAUGHS]

**BRUA:** Sure, (yeah)

**JOHN:** you know, things


(We should also note that my back-channel in the preceding excerpt affiliated with John in his
“othering” of the immigrants.

He also portrayed the Russian-speaking community as distrustful of doctors:

JOHN: So they would always be leery of a doctor giving any diagnosis. They would think they would know better. And I mean, there are Americans that are that way [LAUGHS]...

Distrust and lack of respect toward doctors by people from the former Soviet Union has been attested in the literature (Barr & Field, 1996; Cassileth, Vlassov, and Chapman, 1995; Duncan & Simmons, 1996; Tulchinsky & Varavikova, 1996).

A discussion about Russian-speaking immigrants’ attitudes toward medications was noteworthy for the way in which it spotlighted John’s willingness to take very direct action, as well as tensions between his health-care beliefs and those of his clients. I had asked John what advice he had for medical personnel wishing to improve the health-care access of Russian-speaking immigrants. One of his suggestions was to be cognizant of drug interactions and the immigrants’ medication practices:

JOHN: Because they, they come with just treating themselves because that’s what they had to have done through the years. And they have herbal treatment for every- almost every symptom and um when you mix the two is when it gets um, (y’know), kinda dangerous. I know um pharmacists can look up on computer what- if there are any reactions with, y’know, any other herbs, but um they really need to hear it from the doctor. What is most frustrating for the- for the doctor is when they do prescribe medication for them, Russians they take the medication and- until the symptoms (have) disappeared. Then they dispose of the rest of the medicine. They feel if you live- or if you- you’re on medication for any extended period of time, you’re doing some- you’re doing harm to your body, and I’ve told them many times that we have blood tests for that, to make sure your liver’s OK, you know, all the organs are functioning properly. But still they feel uh you’re doing- you’re harming yourself chemically because (of the) drugs’ (uh) chemicals. So to take them out of that herbal culture is very difficult and- and also on the other extreme they tend to save medicine and use it later or help someone else later, which is- that’s [COUGHS OR LAUGHS]

BRUA: Oom

JOHN: a big no-no. And one time I, right in front of a lady, threw the medicine down the toilet and she got very upset with
John’s one-sentence narrative about flushing the medicine down the toilet followed a series of turns in which he detailed his perceptions of the immigrants’ attitudes toward medicine and their “herbal culture.” His portrayal of the immigrants in this narrative can be summed up as: a) They self-treat because they had to be self-reliant in their country of origin; b) They use herbal medications extensively; c) They distrust long-term use of medication; and d) They also retain or share medicine in ways that conflict with U.S. biomedical guidelines. John’s portrayal, which does find support in the research literature (e.g., Ivanov & Buck, 2002; Resick, 2008; Shpilko, 2006; Smith, 1996), reveals two ways in which he again diverged from an interpretation-only role: He tried to persuade clients to follow the prescribed medication regimen despite their concerns about long-term use, and he was willing to act very directly to carry out what he believes is best, even against his clients’ wishes. Such action took him into an ethically cloudy situation that certainly would be off-limits for a professional interpreter. It may be that this “othering” of the immigrants, whether accurate or not in any particular instance, was another motivator of John’s willingness to take very direct action.

While John sometimes portrayed himself as a sort of representative of the U.S. health-care system, it is important not to oversimplify his stance. After noting, “And I am of course trusting the doctor and in what he or she is saying,” he went on tell the story of a client who had been misdiagnosed by an English-speaking doctor. The client was told he would need to have surgery, but he decided to consult a Russian-speaking doctor based 60 miles away but who periodically swings through a town 30 miles away from the study community. She found that the patient had an infection caused by drinking bad water at a motel where his construction crew had been billeted. John added a bit of advice for U.S. health-care providers:

JOHN: They need to—this I guess is for (the) doctors to realize what they’re working with, you know, these are construction guys who are, you know, in, n—not only bad condition(s) they came from
By mentioning the fallibility of U.S. medicine, John levels the playing field again and returns to a position that seems more grounded in empathy than in “othering.”

**Interpreter Identity: Non-Professional, Non-Naïve Interpreters**

This category focuses on the three volunteer intermediaries’ in-between status in comparison to professionally trained interpreters on the one hand and naïve interpreters (such as minor children), on the other. Some of the salient points in this category have been addressed above, but a few bear reiterating.

Compared with a naïve interpreter, Masha had a number of strengths. She had worked for three years in a medical facility in the former Soviet Union before immigrating to the United States. In the U.S., she had taken a medical terminology course and had become a Certified Nursing Assistant. She brought this background to her volunteer work as a medical interpreter.

She also emphasized the responsibilities of acting as an interpreter:

MASHA: Of course uh that’s really um gives me responsibility so I’m not- I’m- I shouldn’t talk about that- of s- I mean about somebody’s problem (or) somebody’s condition- health condition with another people or um to show something you know like that’s really confidential. Of course.


In terms of a potential difference from a professionally trained interpreter, Masha’s English was quite good but contained fairly frequent grammatical irregularities or non-idiomatic usages that potentially might interfere with communication.

Of the three interpreters, Oksana was the only one who reported doing any interpreting work on an official basis—she was hired on a contract basis by a state agency to interpret for
Russian clients on the one day a month when they were scheduled for appointments.\textsuperscript{22} (Most of her interpreter activities, however, were on a volunteer basis.) Her non-naïve strengths included highly developed medical vocabulary in English: “Soft tissue,” “laparoscopy,” and “trachea” were among the terms she used during the interviews. As noted above, she also mentioned that she makes determined efforts to have the doctor explain to her the causes of the patient’s condition, so she can provide effective interpretation. However, when asked whether she had any medical training, she made a statement that might be cause of some trepidation:

\textbf{OKSANA:} Not really. But um I read ((past tense)) lots of uh medicine books just for myself, for my knowledge. And I can (even) say what kind of problem if people saying what kind of problem(s) they have I can figure out what it might be [LAUGHS], what kind of disease or you know.


There could be some danger of distortion of meaning if she ever relied on her own views about medical conditions, rather than interpreting the statements from the provider or patient. While I have no evidence that she inadvertently relied on her own knowledge rather than information from the doctor or patient, I also cannot rule out such a possibility. She also mentioned sometimes attempting to persuade patients that the doctor was correct. Such actions would be ethically off-limits to a well-trained professional interpreter.

John’s advocacy work demonstrated his ability to challenge the health-care reimbursement system on behalf of his client—a stance unlikely to be available to a naïve interpreter if the person had limited understanding of the system. However, like Oksana, John sometimes mentioned potentially problematic activities that would hopefully be less likely from a professionally trained interpreter. For instance, John threw out a patient’s outdated medicine against her wishes, and he also mentioned attempting to persuade patients to trust their doctors.

\textsuperscript{22}However, while Masha’s duties as a Certified Nurse Assistant would not seem to primarily focus on language accommodation, it is possible that she also acted as a language intermediary in that role.
Language Proficiency

Issues of language proficiency, language learning, and language attrition have been raised numerous times already in this chapter, but a few of the most salient points bear repeating, and some additional issues can also be mentioned.

As noted, all three of the volunteer interpreters said that medical bilingualism, and not just the ability to speak English or Russian in everyday situations, was crucial to successful health-care communication. All three portrayed themselves as having attained such bilingualism via laborious processes of language-learning as adults, but two of the three (John and Oksana) also suggested that there were limits to their own proficiency. For instance, John noted that he sometimes made mistakes in Russian, with his clients chuckling but still valuing his help. Oksana said that in unexpected situations, such as interpreting for accident victims, she sometimes became flustered and had difficulty finding the right words. Still, all three interpreters portrayed their help as superior to that provided by naïve interpreters.

All three interpreters also mentioned age as a factor affecting Russian immigrants’ ability to communicate with medical providers. For instance, all three cautioned against the use of children as medical interpreters. In discussing the interpreting abilities of a friend’s child, Oksana said that the child could convey dosage instructions but not underlying medical concepts:

OKSANA: Daughter uh will always say you have to take two pills, but she couldn’t explain her mom what- what’s wrong with her, what kind of disease she has, and those kind of things.

Conversely, though, younger age did have its benefits in communication: Masha said that younger immigrants generally speak English better than older ones, and Oksana described the following constraints on older members of the community:

BRUA: Is there a difference in what people do in terms of getting medical help or just getting help from their friends with medical
problems as they learn more English? Does that change things?

OKSANA: Hmm, not really because you know as I already mentioned, some people are old, they are 65 and older and they’re tryin’ to learn English, they have classes at that place twice a week, but no their memory. (x) They tryin’ their best but

BRUA: But their memory’s not (so).

OKSANA: Yeah. Absolutely. And uh they’re- they focused on um citizenship test because they know they need to go and pass that test and uh what they’re tryin to learn, they try during five years they’re trying to learn [LAUGHS] you know American history. (Source tape: “Oksana-1,” Oct. 26, 2004)

Two other factors were mentioned as having an effect on ability to speak English: gender and job status. John discussed them as intertwined factors:

JOHN: But what was difficult um for the men of (the/that) home to- to learn the language because after working all day they’re just exhausted, to go to class I mean it was sometimes three times a week (uh/or) two or three times. It was just too much, and to, you know, retain that knowledge (when) they’re going through it, and you’re going through just too much so (it’d) end up with the wife usually knows more English than (her/the/your) husband.


In the medical-site interviews, the clinician Jason made a similar comment, adding that women in the Russian-speaking community tend to have jobs with more interaction with English speakers (such as seamstress or housecleaner) while many of the men work at a construction company where Russian is spoken so widely that there is less need to use English on the job.

Masha also addressed the intersection between employment and language learning. I had asked whether, with her highly developed English abilities, she considered herself a typical immigrant. She replied that she was, and our conversation proceeded as follows:

BRUA: So that most of them learn more and more English as they’re here?

MASHA: Yes. Yeah. Um, it just um- differences between people um how soon they can do that, they can improve their language. Um depends what kind of job do they have and as much they have communication, uh (which) you can have good with good pay but not good communication you can be almost alone all day long, right?
BRUA: um-hmm um-hmm

MASHA: So how you can do that? Um. So everybody in different ways. But what I can say about that small town uh over here kinda limit what uh working positions you know, most of the people with their language barrier do kinda job with extremely low English or no English (xxx xx).


She went on to say that in a larger city, immigrants would have more opportunities to find work that, even if not well-paying, might allow more opportunities to develop specialized language skills (such as the vocabulary of particular industries).

The points made by Masha fit in well with a discussion of “truncated multilingualism” in Blommaert, Collins, and Slembrouck (2005: p. 199). Discussing social and linguistic practices in a Belgian city’s immigrant zones, those researchers note that the communicative success or failure of multilingual encounters is often portrayed as dependent on individuals. They argue, however, that this kind of focus can mask the actual state of affairs, in which “multilingualism is not what individuals have and don’t have, but what the environment … enables and disables” (p. 197). Interestingly, in the excerpt above, even though Masha used the phrase “most of the people with their language barrier,” which located a problem in individuals, she simultaneously discussed ways in which location can either limit or help speakers who wish to improve their English. In her present location, immigrants have fewer opportunities to get jobs that will allow them to improve their English.

**Portrayal of the U.S. System**

Masha had praise for certain aspects of the U.S. system, in particular the use of hospice care. She also seemed pleased with the care provided by medical personnel:

MASHA: As much as I can tell about doctors and nurses um um they trying to explain (real wide) about some problems about some real
important things to prevent some situation. Um I think they doing (a) good job. Of course. Um. Sometimes uh d- they not uh decide by themself, try to communicate with another doctors or professors to give uh really right opinion for special diagnosis or you know. Uh- uh- I think that’s real good, that’s right.

However, she did portray the U.S. payment system as presenting challenges that decreased immigrants’ access to health care. For instance, she noted:

MASHA: If person knows he doesn’t have any insurance he’s (then/sent) home and h- he doesn’t know how to- how to decide. To be sick then or get for some help. (You know). And most of the time when condition gets worse and worse even it’s threats your life, then neighbors or relatives will call to emergency because that’s between or or [INDICATING THE CHOICE] save life or leave person just...

On several other occasions during her interview, Masha mentioned high costs and insurance issues as challenges facing immigrant patients. Near the end of the interview, when asked if she had any further comments, she said:

MASHA: We need more opportunity for um more health insurances, more choices. And um for appropriate prices because middle of working class, it’s really hard.

Oksana similarly noted that payment issues restricted health-care access. When asked how immigrants know which doctors are good or bad, she replied that since only a few doctors accepted Medicare or the government-issued health-care access card, there was no way for immigrants to compare—they simply had to go to those doctors who accepted these types of reimbursement. She added that dental coverage could be difficult for the same reason:

OKSANA: And um most important thing is dental insurance. Lots of people who came from Russia, they have lots of problem, lots of dental problem. And uh welfare I mean medical assistance cover it but you have to pay co-pay (too), you have to make co-payments. And uh almost just one office in ((Town Name)) will acs- uh accept (the- with) those kind of cards.

She said that another dentist in a town 40 miles away also accepted the medical assistance card.
As discussed previously, Oksana was quite complimentary of the care provided by U.S. medical personnel, as well as the diagnostic superiority of U.S. care. At several points, she also said that the U.S. was providing substantial help for members of the refugee community (although she portrayed access under immigrant status as less good). However, at the end of the first interview, after the tape had been turned off, she asked that it be turned back on so she could add another comment. The following interchange then occurred:

OKSANA: Some people who come from uh from- (come) from Russia, they um they were wondering- it’s- it’s completely different system. In Russia you can just, if you’re g- uh if you(’re) sick you could- uh you can go to doctor right away, you don’t need to make an appointment or anything. Or if you make an appointment, you don’t have to wait such long. So maybe I have to t- to say to doctors [LAUGH QUAVERS] could you, could you like- we need to get your help as soon as possible and why we have to wait such long to get you know to get your help?

BRUA: Now when you say wait that long, do you mean in the waiting room or maybe a couple days you have to wait?

OKSANA: Yes. Not couple days, couple of months

BRUA: Uh-hmm

OKSANA: Sometimes. It depends what kind of specialist you making an appointment to.

BRUA: So in Russia it was easier to just get access.

[OVERLAP]

OKSANA: (   ) Go right into doctor’s room, that’s it, (we) don’t have to wait.


She thus pinpointed an important form of health-care socialization and its effect on the satisfaction of Russian-speaking immigrants seeking care in the U.S. health-care system—whose providers (and patients) have been socialized with a different model of “acceptable wait before an appointment.” However, even people socialized under the U.S. health-care system might experience such wait times as burdensome.
John’s portrayal of the U.S. health-care system was, like the other two interpreters’, somewhat ambivalent. While he tended to affiliate with the tenets of mainstream U.S. medicine rather than what he called the Russian speakers’ “herbal culture,” he also noted that U.S. doctors sometimes make misdiagnoses. In addition, he seemed disgusted by the treatment accorded the injured worker whose therapy had been terminated and whose health-care coverage claims were being denied, and this sense of outrage motivated his intensive advocacy on behalf of the worker.

And at several points, he portrayed language accommodation as less than adequate. Speaking about use of the Language Line telephone system, he noted:

**JOHN**: So it gets rather costly to the provider and because of that um (x) the hospital had taken it on but um some health providers could not bear that expense, and so I was- I became frustrated sometimes because some appointments I just couldn’t be (at), I even took my own uh cordless phone in, so because they don’t have phones in the uh actual rooms that the patients are in, which I- I- I feel (uh/a) health provider(s) should have one room that has a telephone where the- if they need the(ir) Language Line or uh- well because they couldn’t afford the Language Line we came up with a group of people in the area who know Russian and would be able to translate, so (a/they), you know at no cost, so all they would need would be a telephone in a room or a cordless phone with them or a speakerphone. And they were not willing to do that. And even if somebody took in they did not even use

**BRUA**: (OVERLAP) (They would x x x) providers, the health providers?

**JOHN**: Right.  

Thus, while he could sympathize with providers who are concerned about the cost of professional telephone interpretation, John also made critiques of providers: 1) Their exam rooms do not always include phones, a fact that impedes patients’ access to confidential telephone interpretation; and 2) When less expensive phone interpretation was offered by John’s corps of volunteers, the help was sometimes refused. John portrayed the lack of telephone interpretation support as a risky decision on the part of the medical facilities.
When some providers refused to use the corps of interpreters established by John’s advisory group, the providers might have feared distortion of the information being conveyed (Angelelli, 2004; Dysart-Gale, 2005; Office of Minority Health, 2001; Singy, 2003; Singy & Guex, 2005). Such a fear could involve ethical dimensions (protecting the patient from the mistakes of a non-professional interpreter, and protecting the patient’s confidentiality); wariness of lawsuits; or a wish to preserve his/her authority (Barry, Stevenson, Britten, Barber, & Bradley, 2001; Raval, 1996; Singy, 2003; Singy & Guex, 2005).

**Conclusion**

The three volunteers who are the focus of this chapter are “in-between” in a number of ways. In terms of *types of help* given, the three volunteers are more actively involved in their clients’ lives than institutionally based professional interpreters would be. This higher degree of involvement has both potential positive and negative effects. On the positive side, the volunteer intermediaries are available in situations other than just the medical appointment; act as information clearinghouses; take on strong advocacy roles in which they shepherd clients through legal challenges (at least in the case of John); and provide clients with transportation to medical appointments in other cities. On the negative side, they sometimes enforce their own judgments, based on their values, as to whether clients are misusing their medicines (for instance, by discarding medicine against patients’ wishes) and attempt to persuade clients that the doctor really does know best. Both of the latter two activities encroach on the patient’s decision-making abilities. Compared with naïve relatives, the three volunteers inhabit less of a caretaker role. They do not spend as much time with the patient and are not financially responsible for (or dependent on) the patients.
In terms of values, the three volunteers inhabit a space in between the health-care socializations of patient and provider, having devoted considerable thought to the differences between the attitudes and experiences of people raised in the former Soviet Union and medical staff trained in the U.S. system. It seems likely that the three volunteers understand the U.S. system better than most of their Russian-speaking patients and understand the former-Soviet system better than most of the English-speaking medical providers. At any given moment, the volunteers might affiliate with the patient (as John did when he challenged the reimbursement system) or with the biomedical establishment (as John did when he discarded outdated medicines that his client had wished to keep).

In terms of language proficiency, the three volunteers seem to possess a degree of medical bilingualism that is in between naïve interpreters and professionals. With better English abilities, they have more access to social capital than would many of the naïve interpreters, and this capital can be used to assist their clients (at least for John, who challenged the termination of his client’s physical therapy when the client himself was ready to give up). For these reasons of types of help given, interpreters’ values, and language proficiency, I consider the three volunteers to be non-professional but non-naïve interpreters.

Another important factor considered above was the volunteer intermediaries’ ambivalent portrayal of the U.S. health-care system—described as highly skilled care, but difficult to access because of high costs or a sometimes-hostile insurance system. At the same time, the volunteers John and Oksana also displayed a tendency to affiliate with the U.S. system (as when they adopted a persuader role to convince patients to trust the doctor). Interestingly, John and Oksana both expressed ambivalence toward their Russian-speaking clients, as well: John had a tendency to “other” his clients because of their health-care beliefs, and Oksana expressed her dislike of rude clients and her envy of clients who seemed to have better health-care access than she did.
As I hope will have become clear from the data and discussion in this chapter, the three volunteers are quite dedicated in their service as intermediaries for the Russian-speaking immigrant community and the English-speaking medical community. In the absence of professional interpretation support—which is itself not immune to ethical challenges, per Angelelli (2004), Davidson (2001), and Greenhalgh, Robb, & Scambler (2006)—they play a vital role, and some of their services go beyond those that could be provided by institutionally based interpreters. It is this last fact that gives the three volunteers the potential to be so beneficial—and makes some of their activities potentially problematic from the standpoint of ethics and patient welfare.

In the discussion chapter that follows, I consider ways in which the insights from the volunteer intermediaries, the immigrant patients, and the medical staff data might be used to inform the stakeholder groups and to promote better health-care access for the Russian-speaking community.
Chapter 7

Conclusion: Language, Culture, and Access to Health Care

Introduction

In this chapter, I first discuss the overall findings across the three stakeholder groups, with a focus on both the convergence and the tensions in the ideas expressed by the participants in regard to two overarching concepts: 1) language accommodation and 2) the health-care socialization of the immigrant and medical communities, and the related beliefs and behaviors. Next will be a discussion of potential ways of improving the situation via cross-community efforts. The chapter concludes with consideration of implications for wider applicability of the findings; limitations of the study; and directions for further research.

Convergence and Tensions in the Data

Based on the coding and analysis of the data from all three stakeholder groups, a number of topics emerged as most salient. In the discussion that follows, I will group them under two general umbrellas: issues related to language accommodation, and issues related to health-care socialization (beliefs and behaviors). In regard to language accommodation, I will consider the following questions:

• What kind of language accommodation is portrayed as desirable?
• Who is responsible for providing the interpreter?
• What roles do non-professional/non-naïve interpreters take on?

In regard to health-care socialization, I will address the following issues:
• What makes for a good doctor?
• What makes for a good patient?
• How is use of medications portrayed?
• What effects are associated with divergent logistics of the medical systems?
• What attitudes surround prices, payments, and quality of care?

Issues Related to Language Accommodation

What kind of language accommodation is portrayed as desirable? People from all three stakeholder groups spoke of the need for medical bilingualism, rather than “garden-variety” bilingualism, for successful communication in health-care interactions. We might think of medical bilingualism as a combination of high-level language proficiency and knowledge of medical terminology in both languages, as well as fairly well-developed knowledge of medical concepts.

The immigrant Katya, for instance, told of a situation in which communication failed repeatedly because the naïve interpreters (an adult friend and the friend’s minor child) did not have either the medical/life knowledge or the bilingual acumen to communicate between a Russian-speaking patient and English-speaking doctors. In that case, the adult friend sometimes had to guess what the doctors meant, and the friend’s child was unable to understand questions in Russian (because of low levels of skill in that language) and the doctor’s conceptually and terminologically complex English terminology.

Staff at the medical facility also made note of the need for medical bilingualism, as when the social workers Trina and Vanessa each commented on the dangers of using interpreters who lacked medical knowledge or terminology—such as a minor child accompanying a parent, or
would-be volunteers from a college’s language classes. In the case of the minor child described by Trina, he was actually being used as the interpreter for a relative; in the case of the college students, they were not used as medical interpreters.

The three volunteer intermediaries similarly commented on the need for medical bilingualism, as when John called medical terminology “a whole ’nother language,” Masha distinguished between the interpretation skills she provided and those a naïve teen could provide, and Oksana noted, “If child 8 or even 10 years old goes with you to gynecologist, what she can say?”

Thus, members of all the stakeholder groups spoke of the value of having interpreters with medical bilingualism. However, as we have seen throughout the data chapters, the actual situations described by participants often involved the use of children and adult family members/friends with limited general English or Russian skills and very limited command of medical terminology.

**Who is responsible for providing the interpreter?** The situation described in the preceding section—which entails risks for both the patient and the provider—seems primarily to be an outgrowth of medical facilities’ stance toward providing language accommodation for Russian-speaking patients: Supplying an interpreter apparently is generally viewed as the patient’s responsibility. Certainly we saw this attitude expressed numerous times by staff members at the Free Clinic discussed in Chapter 5. That facility, which was small and overburdened financially and logistically, was not required under federal law to provide language accommodation, because the site did not accept federal reimbursements. However, immigrant participants spoke of going to other facilities but still having to provide their own interpreters. The immigrant Zhenya, for instance, told of seeking care at a facility—which under Title VI (U.S. Department of Health and Human Services, 2003) and the CLAS Standards (Office of Minority Health, 2001) is required to
provide language accommodation—and asking for a Russian-speaking interpreter; none was available, she said, so she called a medically trained friend in a distant state and had her friend act as a telephone intermediary. Another immigrant, Klara, mentioned that when her teenage child was undergoing follow-up treatment at another facility, the child acted as the communication intermediary between the doctor and Klara. While Klara did not seem dissatisfied with this situation, I wondered about the wisdom of children serving as interpreters in their own treatment—for example, what is to prevent the children from “editing out” any directives they find embarrassing, overly constraining, or frightening? (Flores, 2005)

While I cannot attest to the beliefs that motivate language policy at facilities where I did not conduct interviews, I do feel comfortable in examining the approach taken by the Free Clinic examined at length in Chapter 5. Overall, it seems there was an internal contradiction in the facility’s stance. Staff expressed awareness of the difficulty of accurate medical interpreting (as evidenced by repeated references to the dangers of using children as interpreters and the need for medical bilingualism). And yet, in assessing the effectiveness of their communication, they relied on potentially unreliable approaches: They asked patients to provide interpreters who knew medical terminology, and the doctors then “had to trust” (as noted by Vanessa, a social worker) that the interpreters actually knew the terminology. They asked interpreters, “Are you clear on what we’re saying?” (Vanessa/social worker). They “just kinda try to get a feel … for their [patients’] level of understanding with the family member” serving as an interpreter (Gail/clinician). And they also use patients’ compliance with prescribed regimens to assess communication (Gail/clinician).

While all of these approaches are in some sense understandable because of the funding and logistical challenges facing this small clinic, they still seem quite risky to patient and provider. As the volunteer language intermediary John noted:
JOHN: But unless you had the Language Line or some other (trained) setup, you’re always gonna be wondering, Well am I understanding the symptoms of this person fully? And um just in running a business I think it’d be crazy not to, if not the Language Line, have some type of group or, you know, people set up to able to come in and translate.


While John’s comment was not directed at the Free Clinic, it seems like a cogent argument in the case of that facility as well. In the event of a malpractice lawsuit arising from cross-linguistic misunderstanding (as described in Carter-Pokras, 2004), it seems possible that a small site of this kind, operating under considerable financial stresses, could be completely shut down.

What roles do non-professional/non-naïve interpreters take on? As discussed at length in Chapter 6, I see the three volunteer intermediaries (Masha, Oksana, and John) as being in a category between a) naïve interpreters with low levels of medical bilingualism and/or medical knowledge and b) interpreters with professional training in interpreting, medical knowledge, and connection to some system of oversight.

In terms of Hsieh’s (2006) taxonomy based on degree of training, the volunteer intermediaries would fit most closely with the category untrained interpreters, that is, people with some degree of medical bilingualism (such as hospital staff) who have not been trained as interpreters (p. 179). However, Hsieh portrays such interpreters as receiving payment for their services, which is not generally the case for the three intermediaries in my study.

In terms of the taxonomy discussed by Dysart-Gale (2005, p. 94), which focuses on operational roles, the three volunteer intermediaries described acting as culture brokers (providing cultural information to help patients and possibly medical staff understand the other’s worldview) and patient advocates (helping the patient outside the context of the medical appointment, including in ways that challenge perceived systemic injustices). In terms of their language-interpreting function, it is less clear to me whether they function as conduits (i.e., performing strict word-for-word “transmission” of information); it is possible that they do, but
without data showing them in action during medical appointments, I cannot confirm this. Also, none of the three intermediaries stressed exact, word-for-word interpretation as a priority. My sense was that they made more general attempts to convey meaning, including cultural background. Such a role would be closer to the clarifier role discussed by Dysart-Gale, although she portrayed the paraphrases used in that role as a work-around step needed when no exact equivalent for an utterance existed in the two languages. In their activities, they also often take on the “ritual view of communication” functions described by Dysart-Gale as contributing to solidarity and interpersonal relationships (p. 99).

Thus, in terms of the Beltran-Avery (2001) taxonomy from which Dysart-Gale derived some of her concepts, the volunteers would certainly act as communication managers (p. 7) and incremental interventionists (p. 9), but probably would not function as conduits. It also did not seem that they functioned as what Beltran-Avery called embedded interpreters (p. 11), because while Masha and Oksana were members of the Russian-speaking community, they did not emphasize roles as protectors of in-group norms related to gender, religion, cultural values, etc.

Leanza’s (2005) taxonomy is perhaps the most helpful in describing the three volunteer intermediaries in my study. At times they operate as system agents (“the interpreter transmits the dominant discourse, norms and values to the patient,” p. 186), as when Oksana and John attempt to persuade their clients to trust the doctors’ expertise, to be abide by the dental-appointment script in the U.S., or to discard old medicines. At times, their activity in this role possibly takes them into the gatekeeper status described in Davidson (2001), Angelelli (2004), and Greenhalgh, Robb, and Scambler (2006)—a person whose actions block the patient from empowerment.

The volunteer intermediaries—or at least John among them—also sometimes act as what Leanza calls community agents (“the minority [migrant] norms and values are presented as potentially equally valid,” p. 186). John’s empathy for the Russian-speaking immigrants as people who deserve fair treatment seems closely related to a community agent role, and he
described taking direct and sustained action to help an injured worker challenge the health-care
reimbursement system. Oksana and Masha both voiced mild critiques of the U.S. system from the
point of view of immigrants, in regard to long waits for appointments and high costs for care, but
it is unclear whether they expressed these concerns to representatives of the medical system or
just to me.

Continuing with Leanza’s taxonomy, all three volunteers report acting as *integration
agents* (“the interpreter finds resources to help migrants [and people from the receiving society]
to make sense, negotiate meanings and find an ‘in-between’ way of behaving,” p. 186). Masha
described herself as able to refer her peers to people who could help them with various problems,
Oksana described attempting to educate her peers so that they could handle their own medical
interpretation, and John reported that he had established a short-lived group of interpreters as well
as having successfully pushed for use of the Language Line telephone-interpreting system at five
sites.

Finally, still using Leanza’s taxonomy, is the role of *linguistic agent* (“the interpreter has
to find the proper translation on the fly,” p. 187). Certainly all three of the volunteers reported
doing this, although Leanza also portrays this role as requiring some degree of impartiality. It is
unclear to me to what degree the three volunteers valued impartiality; to get a clearer sense of this
question would require analysis of their actual medical interactions.

In the diagrams that follow, I attempt to illustrate the in-between status of the volunteer
intermediaries. The label *professional* is shorthand for “professionally trained, institutionally
employed interpreter”; the label *V.I.* is shorthand for “volunteer intermediaries,” i.e., Masha,
Oksana, and John; and the label *family* is shorthand for “family or friends in the patient’s circle of
intimates.”

*Increasing level of medical bilingualism*

family V.I. professional

![Diagram of increasing level of medical bilingualism]

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*Diagram of Increasing level of medical bilingualism*

- **Family**: Represents family or friends in the patient’s circle of intimates.
- **V.I.** (Volunteer Intermediary): Includes Masha, Oksana, and John.
- **Professional**: Represents professionally trained, institutionally employed interpreters.
Increasing level of ethical awareness re: interpreting

family V.I. professional

Increasing knowledge about health-care system in U.S. & F.S.U.

family V.I. professional

Increasing alignment with interests of health-care institution

family V.I. professional

Increasing availability to patient

professional V.I. family

Increasing alignment with patient’s interests

professional V.I. family

As noted in Chapter 6, the volunteer intermediaries’ activities sometimes take them into ethical gray zones (Brua, 2008) in which they try to persuade recalcitrant clients or override clients’ wishes in regard to keeping old medicines on hand. Unlike professionally trained interpreters in a well-run program, the three volunteer intermediaries are unmonitored for accuracy and for ethical behavior. Thus, there are some dangers in their roles in the community. However, I would argue that in a context with very few professionally trained Russian-English interpreters, the three volunteer intermediaries play a vital role in providing language accommodation that is more proficient than the naïve interpretation of minors or adults with limited English proficiency. In addition, as noted briefly above and at length in Chapter 6, the
three intermediaries provide services that a professional trained interpreter would not (transportation, help finding other sources of information in the community, etc.).

**Issues Related to Health-Care Socialization (Beliefs And Behaviors)**

*What makes for a good doctor?* One of the recurring themes brought up by immigrant participants was the difference between doctors who actually seemed interested and those who conducted examinations in a perfunctory manner. The immigrant Katya, for instance, disapprovingly mentioned both a doctor and a dentist who said, “This is nothing,” when she and a relative sought help with problems. Katya said that her own longtime experience as a clinician in the former Soviet Union told her that the problems were not “nothing.” The immigrant Veronika compared the treatment she and her family received from one thorough doctor and another whose exams were cursory unless there was a known problem. She much preferred the thorough doctor, whose style, she said, resembled the approach used by doctors in Ukraine. The immigrant Zhenya told a narrative that portrayed U.S. doctors as uncaring (or caring more about unpaid bills than the health of an injured child), but she did also recount one situation in which she encountered a very thorough physician’s assistant and a series of caring physicians. Her dealings with this last group of clinicians reassured her somewhat that “the doctors here are good if they are really interested in finding out about the cause.”

The immigrants’ perceptions seem somewhat similar to those mentioned by some of the participants in Ivanov and Buck (2002): “One woman added that ‘Here you walk in, they quickly look at you, and tell you that you are okay’” (p. 25). However, I must add anecdotally that I have heard people born and raised in the United States make very similar statements about doctors and
have occasionally experienced such feelings myself. One potentially fruitful direction for future research would be to examine whether perceptions of cursory or uncaring treatment are more common among older members of the U.S. populace, since we were originally socialized in an era of comparatively unhurried medical care.

Another part of the same quote just cited from Ivanov and Buck (2002) may also bear on the immigrants’ perceptions: “This group also voiced that with all the equipment and technology the quality of care was good [in the U.S.] but they still felt that their physicians in the former Soviet Union were more thorough because they depended on touching their bodies and blood analyses to diagnose illness” (p. 25). A number of participants in my study, when asked to compare U.S. and former-Soviet medical care, similarly said that U.S. diagnostics are superior, although this perception did not always assuage their concerns.

A factor potentially related to the preceding themes—and to issues of language accommodation as well—is the degree to which doctors clearly communicate their rationales. Zhenya, for instance believed that in general U.S. doctors did a poor job of explaining why they were taking particular actions. The immigrant Klara—who thought American doctors were well-trained but that their training made them “very restricted” in terms of the treatments they prescribed—made this remark: “Maybe doctor can explain why- better why um she gives (us) some strong treatment at first.” Overall, though, Klara had been generally pleased with the willingness of her U.S. doctors to explain and to negotiate treatment.

Two comments from other stakeholder groups bear repeating at this point. One is from the volunteer language intermediary Masha, who said:

MASHA: If you goes to the appointment with child who speaks English but child can’t discuss about special(t)y problem and explain everything, more detailed, uh how you can understand as much that’s important for you or not. And after that the person can think, Um that’s not real good doctor, he didn’t understand me right, he didn’t give me good care or didn’t pay attention….
The clinician Jason addressed the situation from a different angle. Speaking of a patient from the former Soviet Union, he said:

JASON: Many of my encounters have extended well past an hour, because that’s the problem with the-a complex storyline with going through an interpreter. And I don’t know whether you want to include this, but I think this is a lot of the problem he had with dealing with the system. I think for instance even ER visits (and) other evaluations, people were not patient enough to get an accurate story. ‘Cause the story was complex and y’know just- y’know it takes a long time to go through a complex story through an interpreter.

(Source tape: “Jason,” Nov. 22, 2005)

It seems very possible, then, that part of the immigrants’ perceptions of U.S. doctors not communicating their treatment rationales may be related to the providers’ and patients’ divergence in available languages. Many of the immigrants, medical staff, and volunteer intermediaries said that having better interpreters would be beneficial, and it undoubtedly would be—but as the comments from Masha and Jason suggest, clinicians and patient face an interesting dilemma: Without an adequate interpreter, communication often fails; however, with an interpreter, time pressures may also result in impaired communication.

What makes for a good patient? As we consider this question—and especially in light of the discussion about “what makes for a good doctor?”—we will see additional ways in which the socialization of patient and provider might come into conflict.

For instance, three of the clinicians at the medical facility told narratives about the same patient, described by one as “everybody’s wonderful grandmother.” However, while one clinician told a story of success, the other two told a more mixed story, in which some of the patient’s problems had been successfully treated but her health was still being endangered by her noncompliance with the medication regimen for a different, potentially deadly, problem. Communication in that case was handled both through the patient’s relatives (including an adult and a minor) and at times through a highly proficient volunteer at the clinic. The clinicians
wondered whether the patient did not understand the cost/benefit ratio, or whether she did not trust them—although all three clinicians also portrayed the patient as having a very warm relationship with the medical staff.

From these narratives, we can glean a few descriptors of an ideal patient. Such a patient is grateful for the help received (although everyone who mentioned this trait also said that while they appreciated patients’ gratitude when it was expressed, they did not expect it from patients). More importantly, the ideal patient trusts the medical staff and follows their recommendations—especially in cases where the patient’s health is endangered by noncompliance. While there may have been other motives such as a wish to maintain clinical authority (Barry, Stevenson, Britten, Barber, & Bradley, 2001; Singy 2003; Singy & Guex, 2005), I believe based on my conversations with the staff that their major motivator was their concern for patients’ welfare.

While I do not know the motivations that led the “wonderful grandmother” to deviate from her medication regimen, it is possible that the medical staff’s desire for compliance may sometimes be in conflict with patients’ attitudes toward long-term use of medication. We now turn to that topic.

*How is use of medications portrayed?* As noted in Chapter 2, immigrants from the former Soviet Union often mistrust the long-term use of medications, believing that such chemical agents cause damage to a person’s health (Resick, 2008; Shpilko, 2006; Smith, 1996). Herbal medications—apparently not perceived as chemicals—are often a preferred route of treatment (Ivanov & Buck, 2002; Shpilko, 2006). The volunteer language intermediary John in my study described similar attitudes in immigrant clients he has known.

Attitudes toward medication may be involved in patients’ evaluations of medical personnel, as Resick (2008) writes:
Participants believed that Americans considered doctors “good” if the doctors gave pills to do the healing. In contrast, in the Russian culture, doctors were considered good if they did not use pills to do the healing. Fekla [a participant] said, “In Russia, if the doctor is good, he will give you less medicine. Here the opposite, here pills ... if the doctor gives you pills, he is considered a good doctor” (p. 251).

Resick also noted that many of her participants followed doctors’ medication regimens to whatever degree made sense to them, based on their concerns about or actual experience of side effects. In a related vein, numerous participants in my study commented on the medication choices of U.S. medical personnel. Several participants portrayed U.S. doctors as too quick to resort to strong antibiotics, which were seen as potentially damaging to the patient’s health.

Conversely, however, several immigrant participants actually desired more access to antibiotics than U.S. medical personnel recommended. Kirill (whose wife, Filippa, spoke harshly about perceived U.S. overuse of antibiotics) mentioned needing antibiotics and not being able to procure them without a prescription and an expensive visit to the doctor—whereas in the former Soviet Union, such drugs were available over the counter. The immigrant Zhenya told a story in which U.S. doctors prescribed three days’ worth of antibiotics; through the study interpreter, she said: “In Russia you learn that you should take all antibiotics longer, so it doesn’t make any sense to stop after three days.” When she asked for five days’ worth of antibiotics, the doctors refused. Zhenya reported that the illness came back until she received successful treatment during a visit to the former Soviet Union. Zhenya, as noted above in the section about doctors’ explanations, also said that communication played a role:

INTERPRETER: Here the doctors didn’t explain the (core) of the— the essence of the problem. They just gave the prescription, and they didn’t tell her about any follow-ups. They— they said it’s a very light case, nothing- easy case, you just take the drugs for three days and then it will be over.  

In the former Soviet Union—where Zhenya and her doctor could speak together in Russian—communication was much easier for both parties.
What effects are associated with divergent logistics of the medical systems? Access to providers and scheduling of appointments were a point of tension in the immigrant and medical-staff narratives. These concerns were often entangled with issues of payment, which will be considered in the following section.

A number of immigrant participants expressed concerns about wait times of a month or more for medical and dental services in the study community. The volunteer intermediary Oksana noted that “it’s completely different system” in the former Soviet Union and that immigrants’ experiences in that system had not prepared them for the logistics of access that they were encountering in the United States:

OKSANA: Some people who come from uh from- (come) from Russia, they um they were wondering- it’s- it’s completely different system. In Russia you can just, if you’re g- uh if you(’re) sick you could- uh you can go to doctor right away, you don’t need to make an appointment or anything. Or if you make an appointment, you don’t have to wait such long. So maybe I have to t- to say to doctors [LAUGH QUAVERS] could you, could you like- we need to get your help as soon as possible and why we have to wait such long to get you know to get your help?

BRUA: Now when you say wait that long, do you mean in the waiting room or maybe a couple days you have to wait?

OKSANA: Yes. Not couple days, couple of months

BRUA: Uh-hmm

OKSANA: Sometimes. It depends what kind of specialist you making an appointment to.

BRUA: So in Russia it was easier to just get access.

OKSANA: ( ) Go right into doctor’s room, that’s it, (we) don’t have to wait.


In speaking about the Free Clinic in my study, two immigrant participants said that long lag times before obtaining an appointment had discouraged them from seeking treatment there, and another mentioned disappointment about the length of time needed to obtain a test result, although she was otherwise very satisfied with her treatment through the clinic.
The clinician Andrea addressed the situation from a different viewpoint. She said that even with established patients, the clinic was not set up to handle walk-in patients; however, if patients telephoned and had an urgent situation, she would attempt to get them onto that day’s schedule. She also described patients from the former Soviet Union in this way:

ANDREA: I notice in general with them that they never really feel well when they’re here. Y’know I’ve yet to have someone come in and say, I feel really good. There’s always- y’know there’s always- a lot of (ti-) what I call [LAUGH QUAVER] multiple somatic complaints.

BRUA: Um hmm

ANDREA: There’s a lot of complaints. And you really- you just- they never say, I really feel good today.

BRUA: Um hmm. [SOUNDS AMUSED]

ANDREA: Y’know, there’s always- like last week a lady came in, we hadn’t seen her in a year. She just walked in, and she didn’t speak very much English, and she said, I need a blood test. Well, we haven’t seen her in over a year and y’know trying to tell her that I just couldn’t order the blood test, the doctor has to order the blood test, she has to come in and get the blood test, and really just didn’t- didn’t understand that. The- the- sometimes they just- they leave- I feel like they leave and they’re not really happy with us because we haven’t told them what they wanted to hear, I guess.

(Source tape: “Andrea,” Nov. 22, 2005)

Andrea’s narrative encapsulated a number of differences in health-care socialization between the former Soviet Union and the United States, and in particular the logistics of the study clinic.

Whereas much of the health care in the former Soviet Union was on a same-day, walk-in basis (as described by the interpreter Oksana and the immigrant Yakov), walk-ins are less common in the United States, except in emergency room care. In Andrea’s narrative, the would-be patient’s demand for a blood test might also echo the situation Yakov described at the common neighborhood polyclinics in the F.S.U.: Patients would go to the reception desk and tell staff what kind of doctor they needed to see, at which point they would receive a same-day appointment to that kind of specialist.
There is quite possibly a cultural component in Andrea’s observations that her Russian-speaking patients typically do not say they feel good. Early in the interview process, the study interpreter, Nina Vyatkina, told me that it was less common for Russians to describe their health as *khoroshó*—“good”—than to say it was *normál’no*—which can be translated as “normal,” “not bad,” “sound,” or “fine.” She noted that people might not want to tempt fate by bragging about their health.

*What attitudes surround prices, payments, and quality of care?* The high prices charged for health care in the United State were mentioned frequently by immigrant participants and were mentioned as well by volunteer intermediaries and by members of the medical staff. (We should remember that the medical site made it a primary mission to provide free care for people who had no health insurance.) As with the former-Soviet participants in Ivanov and Buck (2002), some of the immigrants in my study reported that they delayed seeking treatment because of high costs. Some also said they planned to return to the former Soviet Union if they needed serious care, because they could not afford the prices in the United States.

Issues of cost and payment system also seemed related to immigrants’ evaluations of the quality of care received. Of the four participants who were not affiliated with the area’s university (and thus had decreased access to high-quality health insurance), three implied or said explicitly that the care they received was substandard because of their payment method (oftentimes the government-issued medical access card). They suggested, for instance, that their choice of doctors was constrained in ways that prevented them from seeing the best doctors, or that materials used during an insured dental visit were inferior to situations in which “real money” was paid. One immigrant, who used the English term “bloodsuckers” to describe American doctors, echoed attitudes mentioned in Resick’s (2008) article on former-Soviet immigrants: “Another reason for distrust of American healthcare professionals was the perception that
medicine is a business and that physicians are focused on making money rather than caring for people” (p. 251). However, some of Resick’s participants emphasized that they did not trust their doctors in the former Soviet Union, either, although for different reasons.

Summary

In discussing the participant narratives across the three stakeholder groups, we have seen that there are areas of convergence—for instance, in a shared sense that medical costs in the United States present a barrier to access for low-income patients, or in stated recognition of the need for medical bilingualism in interpreters. (The actual use of high-proficiency medical bilinguals is another matter, however.) We have also seen a number of potentially significant divergences, especially around attitudes toward medical compliance and use of medications, and the logistics of approach to medical care.

Interestingly, while the two subsets of Russian-speaking participants—university-affiliated and non-affiliated—differed in their access to quality health care, there did not seem to be much, if any, difference between the attitudes of the two groups. Instead, they expressed strikingly similar attitudes.

Potential Ways of Improving Health-Care Access

In this section, I discuss my recommendations for ways in which the stakeholder groups might address issues of language accommodation and health-care beliefs/practices in an attempt to increase the health-care access of the Russian-speaking community. In the following
discussion, I draw on the research and policy literature as well as suggestions made by participants in my study.

**Improving Language Accommodation**

As I have attempted to show, language accommodation in the study context contained a number of potentially dangerous gaps. While members of all three stakeholder groups said that medical bilingualism was desirable, the frequent use of naïve interpreters such as minor children meant that medical bilingualism was often not available as a resource. The Free Clinic’s default stance of relying on patients to provide interpreters contributed greatly to this problem. Thus, my overall recommendation would be that *the clinic—and other medical providers serving patients with limited English proficiency—should make language accommodation a priority instead of an afterthought.* While the immigrant community may have an important role in fielding interpreters or other improvements, as discussed below, I believe that the overall medical community must be the driving force behind the effort, because the medical community has greater institutional resources and an extensive logistical infrastructure that can be used to coordinate the efforts. The following are some language-accommodation efforts that I believe strongly deserve consideration and further exploration by the providers and others in the study context:

1) *Partner with other sources of language-accommodation resources.* Obviously, and as pointed out to me by staff at the Free Clinic, a major difficulty lies in finding money or energy to push language-accommodation efforts ahead. However, partnering with “local hospitals, managed care organizations, community-based organizations, community colleges, and former patients and their family members” might lessen the burden on the clinic or other single-facility medical establishments (Youdelman & Perkins, 2005, p. vii). For example, as Youdelman and Perkins note in their Commonwealth Foundation report on “Providing Language Services in Small Health
Care Provider Settings: Examples from the Field,” small facilities seeking to purchase professional telephone interpreting services might be able to join forces with “nearby hospitals and providers who may be interested in partnering to purchase volume, discounted packages of services” (p. 8). The U.S. Department of Health and Human Services (2003) similarly suggests combining of resources:

Resource and cost issues, however, can often be reduced by technological advances; the sharing of language assistance materials and services among and between recipients [i.e., medical providers], advocacy groups, and Federal grant agencies; and reasonable business practices. Where appropriate, training bilingual staff to act as interpreters and translators, information sharing through industry groups, telephonic and video conferencing interpretation services, pooling resources and standardizing documents to reduce translation needs, using qualified translators and interpreters to ensure that documents need not be “fixed” later and that inaccurate interpretations do not cause delay or other costs, centralizing interpreter and translator services to achieve economies of scale, or the formalized use of qualified community volunteers, for example, may help reduce costs. (p. 47315)

Pooling resources to make the Language Line (or a similar telephone interpreting service) available at the Free Clinic and elsewhere seems like an extremely valuable idea.

2) Designate a staff person who is in charge of language accommodation. Youdelman and Perkins (2005) note: “Most providers interviewed for this project have designated a staff member to coordinate language service activities” (p. vi). Having a point person for language issues seems wise, since without a designee for this role, the problem of providing language accommodation becomes everyone’s responsibility—or no one’s. At the clinic where I conducted interviews, no one was identified for me as the person in charge of language accommodation. And while all the staff members were interested in improving their program’s language accommodation, the level of coordination related to language did not seem high—which leads to my next recommendation.
3) Attempt to schedule Russian-language resources and Russian-speaking patients at the same times. The volunteer intermediary Oksana mentioned to me that she served as a contract interpreter at an agency in her town on one day a month when Russian-speaking clients were scheduled. More clustering of Russian-speaking patients might also make sense at the Free Clinic. Some medical problems obviously occur on their own unpredictable schedule, but many appointments at the Free Clinic involved treatment for chronic conditions, doing tests and providing results, and doing non-emergency exams. It thus seems possible that the clinic could make more efforts to schedule Russian-speaking patients in clusters, at times when high-proficiency interpreters were available. As with any change, there would be a potential downside: Patients from the Russian-speaking community would be more likely to encounter one another at the clinic if linguistically clustered scheduling were used, and thus patients’ privacy within the Russian-speaking community might be decreased.

Even if clustered scheduling were not used, it seems that more might be done to thoughtfully coordinate the use of Russian-speaking volunteers. For instance, the clinician Andrea and I had the following interchange:

BRUA: And she [ANOTHER STAFFER] had said that you have some Russian-speaking volunteers here (right)?

ANDREA: We do. We do have a couple. It just- if they coincide with a Russian patient’s visit, if- that would normally- that’s not planned, that would just be coincidence, that they’re here, so.

(Source tape: “Andrea,” Nov. 22, 2005)

In fairness, I should note that we were talking about volunteers with limited English proficiency who helped out with non-interpreting tasks such as filing of forms. However, even with the limitations of those volunteers’ English proficiency, the apparent lack of alignment between their shifts and the visits of Russian-speaking patients seems like underutilization of a potential resource. If nothing else, they could serve in the role Leanza (2005) calls “welcomers”: “As confirmed by participant observation, both parents and children felt more welcome in an
institution that hired people from their own community and in this way showed some acknowledgment of their difference” (p. 178).

4) Work with the other stakeholder groups to cultivate high-proﬁciency interpreters. As both the U.S. Department of Health and Human Services (2003) and Youdelman and Perkins (2005) point out, community volunteers can sometimes be used as interpreters in the absence of professional interpreting help. In such instances, it is important to have a reliable way of assessing the proﬁciency of the interpreter (U.S. Department of Health and Human Services, 2003). At the Free Clinic, assessment would require the help of trained resource people—possibly from the local university or through partnering with other local, state, or federal programs. (As Youdelman and Perkins note, one of the duties of a designated language policy coordinator would be to seek out potential avenues for this kind of fruitful collaboration.)

In my study context, the clinician Jason expressed frustration because he saw the Russian-speaking immigrants’ churches (the Russian Baptist and Orthodox denominations) as underused community resources:

JASON: A large church, the Baptist church— {it/just } was built. Y’know somebody here- it should be Dominika, or { (name of another Russian-speaking volunteer)}, needs to go to their church community and say, We need interpreters. We need— we need a staff of volunteers we can call, and this was the most obvious one since we first started, and why that hasn’t happened, I don’t know. Gail [CLINICAL DIRECTOR] or Wanda [EXECUTIVE DIRECTOR] needs to be asked that question... I just don’t have enough energy left over taking care of patients to try to keep pushing and pushing these agendas. But that seems obvious to me, because there’s a particular(ly) - so many of them are churched. Churches are great organizations for looking after- y’know helping people, y’know, and particularly their own people. So I don’t know why Dominika’s the only face I see in here that comes in as a volunteer.

(Source tape: “Jason,” Nov. 22, 2005)

The clinician Gail mentioned another way in which partnership with the Russian-speaking community might help the facility provide services:
GAIL: We’ve talked even that with fund-raising—because there are some very successful Russian-immigrant-owned businesses in this community, like ((name of company)), and they just built the new Russian church off ((street name)) there, y’know of—we’ve talked very lightly about identifying ways to really reach out to some of those successful businesses as a relationship for them to make contributions to help support the care that we’ve provided to the Russian community. Just like we go to ((the local university)) and say, OK … we’ve taken care of some of your part-time employees and family members of grad students who are in the community with them that y’know obviously ((the local university)) doesn’t provide care for. Y’know and we’ve asked for donations to help support that, and have tried to identify ways to do that within the Russian population but haven’t had great success with that, so.

(Source tape: “Gail,” Nov. 22, 2005)

In addition, I believe that more training for volunteer interpreters from the community would bring benefits. The intermediaries Masha, Oksana, and John, for example, might be able to provide improved help if they received additional training about interpreter roles and the ethics of choosing among roles. There may be other frequently used intermediaries in the community who also would benefit from additional training in medical bilingualism, culture brokerage, or the ethics of interpreting.

In addition, the immigrants Raisa and Katya, who had worked as medical providers in the former Soviet Union, would likely benefit from sustained and well-focused instruction in medical English as a Second Language. Their medical knowledge and proficiency in medical Russian—and similar skills of other medically trained immigrants in the community—would be an invaluable resource, which brings us to my next recommendation.

5) Make use of the skills of bilingual medical personnel who live in the area (or who might be recruited to the area). Youdelman and Perkins (2005) point out that the use of “bilingual mid-level practitioners” or “dual role bilingual staff” can be valuable in language accommodation (p. vii). They make an important distinction about appropriate roles for bilingual staff: “[I]ndividuals with conversational proficiency in a second language may provide limited
services at the front desk (e.g., answering phones, scheduling appointments) while those with medical proficiency may interpret for patients during medical or clinical visits” (p. vii). The Free Clinic did make this valuable distinction in assigning its Russian-speaking volunteers, although as noted earlier, coordination of volunteers on the basis of a common language with Russian-speaking patients was not high.

Youdelman and Perkins (2005) note that it may be easier to recruit mid-level staff, such as a bilingual certified nurse practitioner, than to recruit a bilingual physician because bilingual doctors are rare and in great demand. Still, the American Medical Association (2008) notes that internationally trained medical graduates (IMGs) are an underused resource: “[A]t any given time there are 5000 – 7000 IMG physicians who are unemployed in the U.S.” (p. 4). The AMA additionally contends that IMG physicians often are willing to work in remote and rural areas that domestically trained physicians may try to avoid.

Medically trained immigrants may nonetheless require—or as in the case of Raisa, desire—additional training before they can function successfully in the U.S. medical context. Models do exist for retraining of immigrant physicians seeking work in North America. One example is the University of Calgary’s Language Communication Assessment Project, which used a 16-week combination of instruction and clinical practice to prepare immigrant physicians to deal with Canadian patients (Watt, Crutcher, & Lake, 2006). The program included training in medical English as a Second Language and in North American pragmatic/cultural expectations regarding appropriate communication during medical exams.

Another potential training model, targeted toward nurses, can be found in Baj (1995). That program in San Francisco retrained nurses from the former Soviet Union so that they would be employable in the United States. Baj notes that before the program, former-Soviet nurses in San Francisco often did well on entry exams but then lost their jobs because of poor language skills or dangerous violations of clinical procedures (such as attempting to sterilize and reuse
needles—a common practice in former-Soviet medicine). Baj reports that a 420-hour program of linguistic and clinical retraining helped the nurses to substantially improve their skills and employability. That program involved partnering between two universities’ medical programs and a community-based Jewish resettlement agency. In my study context, it seems possible that similar partnerships could be formed between the medical program of the area’s large research university, community organizations, and the region’s medical facilities. As noted in the chapter on immigrant participants, the local Russian-speaking community includes immigrants with various levels of clinical training from the former Soviet Union. I believe, therefore, that such training programs and potential partnerships deserve further investigation by stakeholders in the study, especially medical providers, who would have the most social capital in making a training program a reality.

6) **Improve the medical-ESL instruction available to immigrants.** One immigrant participant portrayed current ESL programs via the local school district and the Russian Baptist church as ineffective, although I do not know how widely her opinion is shared. It may be that additional partnership with the area university’s welcoming program for international residents, or the school’s applied linguistics or communication arts and sciences departments, could bolster the programs currently in place. Such university participation might have benefits to the university as a source of good public relations in the larger community. In addition, an ESL outreach program by the university might provide a source of teaching-assistantship placements; if state, federal, or local match funds were procured, the financial burden on the university might be minimized.

7) **Supplement patients’ naïve interpreters with highly proficient bilinguales.** The research literature has shown that patients sometimes prefer family members and friends as their
interpreters for reasons of confidentiality or because the patient does not trust the institutionally provided interpreter (Edwards, Temple, & Alexander, 2005; Morales & Hanson, 2005; Raval, 1996; Rhodes & Nocon, 2003; Robinson & Gilmartin, 2002). The U.S. Department of Health and Human Services (2003) requires that federally funded providers at least offer patients an institutionally provided, free interpreter; the patient’s choice of interpreter should then be used, the department says, unless the provider suspects incompetence or an abusive relationship. Youdelman and Perkins (2005) suggest that when family members serve as medical interpreters, the medical facility should have “a trained interpreter sit in during the medical encounter or follow up with the family within 24 hours to verify the patient’s condition” (p. viii). For a small facility with few highly skilled interpreters, such as the Free Clinic, telephone follow-ups using skilled interpreters might be a very fruitful approach.

8) **Institute a Russian-language message option on the clinic’s phone system.** At the Free Clinic, the telephone was often the first point of contact (and as noted in Chapter 5, for scheduling of medical appointments it was the clinic’s preferred medium, since walk-ins were difficult to accommodate). The clinician Gail expressed a wish for a phone system that would allow patients to select messages in English, Russian, and some of the Asian languages that were locally prevalent. While such a system would not be a panacea, it might be useful in allowing patients to leave a non-emergency message that could be followed up within a few hours or a day by a Russian-speaking volunteer. As noted in the preceding recommendation, some of the facilities mentioned in Youdelman and Perkins’ report do something similar when interpreting assistance is not available during live interactions.

9) **Continue to expand the facility’s archive of high-quality medical documents available in Russian.** The Free Clinic reported having Russian-language education materials on about 30
topics. The social worker Vanessa also reported that a volunteer at the clinic had translated the phone intake form into Russian so that Russian-speaking walk-ins could fill it out. I believe that the facility and its Russian-speaking patients would benefit from having additional materials available in Russian. Shpilko’s (2006) article contains URLs for many Russian-language materials about health and social-services topics, produced by U.S. government agencies, U.S. states, Russian government agencies, and other entities. Shpilko’s article thus is a potentially valuable resource for the staff at the Free Clinic, and I will bring it to their attention. If a community-provider-university partnership were to emerge in the future around health-care access for Russian-speaking patients, I believe that native speakers of Russian in the applied linguistics program or other departments at the local university might have a valuable role in locating high-quality health-education materials written in Russian.

The Ethnomed Web site (University of Washington Harborview Medical Center, 2009) also contains links to potentially helpful language-accommodation and cultural materials. For instance, one page includes printable files of low-level questions that nurses can use in performing an exam on Russian-speaking patients. The nurse points to a question or instruction written in English and Russian, and the patient then points at a yes/no answer (again written in English and Russian). The questions include “Do you have pain? Point to pain,” and “Is it hard to breathe?” The ability to read is necessary for the form to be useful, and in fact, two of the first questions are “Do you read?” and “Can you see?” Because literacy levels are high among immigrants from the former Soviet Union, Ethnomed’s list of questions might be helpful for the Free Clinic. Still, the Ethnomed Web site emphasizes that the form is only a stopgap measure, not a substitute for the participation of a high-proficiency interpreter.

Recommendations related to health-care attitudes and behaviors

Immigrants from the former Soviet Union and non-F.S.U. medical staff in the United
States have been socialized into different health-care systems, As my data have shown, tensions often emerge because of the resulting divergent expectations about medical care. In order to mitigate these tensions, I make the following recommendations:

1) Medical providers should educate themselves about the health-system conditions that their former-Soviet patients have experienced. In other words, the providers should first be aware that in a general sense, health-care conditions in the former Soviet Union have differed substantially from those in the U.S. Potential resources might include the health-care socialization section of Chapter 2 in the current project, as well as specific research articles cited there; the brief overview provided by the Ethnomed Web site (University of Washington Harborview Medical Center, 2009); and the overview provided in Shpilko (2006).

   However, in order for providers to personalize their knowledge and avoid stereotypes, it will also be important for them to gain as much information as they can from their own particular patients. While questionnaires might be of some help, they might also yield limited information if the patient has a low level of trust for doctors, as found in some people from the former Soviet Union (e.g., Resick, 2008) and as evidenced by some participants in my study, such as Zhenya. Building a mutually trust-filled relationship will take time, and the providers’ communication style seems crucial in this regard, bringing us to my next two recommendations.

2) Medical personnel should provide careful explanations of “why,” and not just “what.” In my data, the immigrant Zhenya criticized what she saw as inadequate explanations by U.S. doctors during one medical problem she had experienced:

   INTERPRETER: Here the doctors didn’t explain the (core) of the—
   the essence of the problem. They just gave the prescription, and they didn’t tell her about any follow-ups. They— they said it’s a
very light case, nothing—easy case, you just take the drugs for three days and then it will be over.

Zhenya advised that doctors should “explain the causes of the health problem. Not only prescribe treatment, but also explain the causes.” The immigrant Klara, saying that former-Soviet patients were startled by the use of strong antibiotics as a first course of action in the U.S., similarly suggested: “Maybe doctor can explain why—better why um she gives (us) some strong treatment at first.” Of course, such explanations become doubly difficult or burdensome for the provider when communication with the patient is impeded by lack of a shared language. As the clinician Jason said, many providers may lack the patience (or more charitably, the appointment time) to deal with a complex narrative through an interpreter, and reluctance to use available interpreters is attested in the literature (Diamond, Schenker, Curry, Bradley, & Fernandez, 2008). I believe the situation points up the need for 1) better language-accommodation services; 2) better education of providers about giving culturally competent care; and 3) reservation of longer appointment times for LEP patients, a strategy used by some of the sites in Youdelman and Perkins (2005).

It might also be helpful for providers and patients to discuss their divergent expectations around logistics of access—waiting periods for appointments, pricing structure, and so on. While the providers and patients likely have limited ability to transform the logistics of access in the study context, a frank discussion might at least humanize the two sides for one another.

3) Providers, patients, and intermediaries should pay special attention to attitudes and communication concerning the use of medications and herbal treatments. Many people from the former Soviet Union distrust the long-term use of pharmaceuticals (e.g., Resick, 2008; Shpilko, 2006; Smith, 1996), but mainstream U.S. medical practice relies heavily on pharmaceutical interventions. Thus, I believe it would be valuable for providers to clearly and patiently explain to
patients why particular medications are being prescribed, what gains can be expected, to what
degree the gains outweigh the risks or side effects, what measures will be taken to monitor the
patient’s health for problems caused by the medication, and whether non-pharmaceutical
alternatives might be used instead. (While suggesting that physicians emphasize compliance with
pharmaceutical regimens, Shpilko [2006] also argues that providers should deal respectfully with
patients’ attitudes toward herbal and alternative treatments. Taking a mocking or dismissive tone
is likely to alienate the patient—who may continue using the herbal substances but simply
conceal that practice from the doctor. Communicating in a respectful way is more likely to create
openings for discussion of potentially dangerous interactions between biomedical medications
and the herbs being used by the patient.)

Attempts at communication around medications might still be unsuccessful, since
according to two clinicians at the Free Clinic, their discussion of costs and benefits failed to
promote medication compliance in the “wonderful grandmother” described in Chapter 5. Further
research with populations from the former Soviet Union will be valuable in determining what
kinds of health-communication appeals would be most effective, e.g., “fear appeals” (Hale &
Dillard, 1995), appeals to caregivers’ sense of responsibility to their families (Guttman, 2000), or
some other approach. As Borovoy and Hine (2008) and Guttman (2000) argue, providers should
also recognize that patients might have different values than do representatives of the biomedical
establishment (for instance, about what constitutes quality of life).

Patients have their own responsibility to ask questions and to provide complete and
accurate information to medical staff members who are treating them. Allowing high-proficiency
interpreters to act as intermediaries, when available, also seems like a positive strategy for
patients to pursue. However, I believe medical providers have the most responsibility in
promoting or allowing effective communication, because of their greater power over the medical
appointment. Without the cooperation of providers—by being open to questions, allowing enough
time for a cross-linguistic interaction, and providing sufficient language accommodation—the patient will have little ability to communicate his/her needs. The cooperation of interpreters is also crucial, since the interpreter can easily block the patient and the provider from communicating (Davidson, 2001; Edwards, Temple, and Alexander, 2005; Greenhalgh, Robb, and Scambler, 2006; Leanza, 2005). I would urge the volunteer intermediaries in my study to monitor themselves carefully to avoid drifting into a “persuader” role in which they attempt to convince the patient to adhere to the doctor’s instructions.

4) Providers, with the help of other stakeholder and community groups, should consider collaborative education strategies. Borovoy and Hine (2008) discuss a 1993 study by Wheat et al. in which a doctor and her Russian-speaking patient were able to educate each other about their rationales for promoting or refusing certain treatments; Borovoy and Hine suggest that such attempts at mutual education might provide a way to improve care. In addition to individual interactions of that type, I believe that a potentially valuable approach would be something like the Indian Family Stories Project formerly conducted at the University of Minnesota, in which researchers interviewed families to better understand the concerns and barriers they experienced in providing care for children with chronic illnesses (Garwick & Auger, 2003; Rose & Garwick, 2003). The researchers explicitly call for health-care providers to learn from the families as well as the other way around, and I believe such mutual education would be important to health-care providers and patients in my study context as well. One crucial aspect of the Indian Family Stories Project was that it followed a participatory action research (PAR) format in which members of the American Indian community helped to choose the direction of the research. Although my own project has not been in the PAR format, I believe that future research and interventions designed by members of all three stakeholder groups—providers, immigrants, and intermediaries—would be valuable in increasing health-care access in the study context. I discuss
this kind of project further in the “Next Steps” section below.

Additionally, the Free Clinic and other medical sites in the area should continue to disseminate educational information, both to patients during appointments and via outreach efforts. The Russian-speaking volunteers at the study clinic, as well as any other Russian-speaking health personnel working in the area, might be key partners in such outreach efforts because of their language skills and their potential to serve as culture brokers.

Throughout my interviews with immigrant participants, I asked how medical providers might efficiently disseminate information to the entire local Russian-speaking community. The following pathways were suggested: via the Russian Baptist church; via the Russian Orthodox church; via the campus-based L-CCCP listserv for people from the former Soviet Union; and via flyers at an East European grocery store that is frequented by immigrants from the former Soviet Union. In all cases, having the buy-in of “insiders” to each particular community would be helpful in gaining access or sustaining access. For instance, the non-Baptist participant Klara portrayed the Russian Baptist community as having “very restrictive rules” about clothing styles and similar matters. She added: “That’s why I’m trying to keep out.” Regardless of the accuracy of her portrayal, it seems likely that a Russian Baptist partner would make better inroads with the Baptist community than would a skeptical outsider like Klara.

5) The medical community should consider the use of community health workers or “promotoras.” A related approach deserving further thought is the use of community health workers, sometimes referred to as “promotoras.” Such workers have been successful in a number of cities in dispensing information on topics such as breast self-exam education, nutrition education, compliance with chronic-illness management, community-organizing to improve the quality of grocery stores, and so on (Mack, Uken, & Powers, 2006; Perez, Findley, Mejia, & Martinez, 2006; Reinschmidt, Hunter, Fernández, Lacy-Martínez, Guernsey de Zapien, &
Meister, 2006; Schulz, Parker, Israel, Allen, Decarlo, & Lockett, 2002). Again, medically trained immigrants in the Russian-speaking community might be leading candidates for such roles. In any case, thorough training for the community health workers—in culture brokering, patient advocacy, and the goals of whatever health-promotion project were selected—would be vital. Also crucial would be training for medical providers on how to collaborate with such workers.

Next steps

Following the completion of this project, I will share executive summaries of my results with the staff at the medical facility where I conducted interviews, as well as with a larger facility that also deals with many Russian-speaking patients. Basically, my summary will address three issues: 1) “Here are some perceived gaps in the study area’s language accommodation policies—gaps that might put patients and providers at risk”; 2) “Here’s what the Russian-speaking community finds puzzling about the way U.S. medical providers conduct themselves”; and 3) “Here are some resources from the research and policy literature that might help you better serve patients from the former Soviet Union.” As discussed in detail above, the literature I will forward to the providers will include the reports by Youdelman and Perkins (2005) and Shpilko (2006). Additional sources of information might come from the Ethnomed database entries about Soviet-Jewish and Ukrainian immigrants in Seattle (University of Washington Harborview Medical Center, 2009); Barrett, Puryear, and Westpheling’s (2008) report on promising health-literacy practices; and the guidelines for fielding and paying for medical interpreter services discussed in a “Language Services Action Kit” by the National Health Law Program and The Access Project (2004).

I will also strongly suggest to the providers that they attempt to form an advisory panel consisting of representatives from the medical community; the Russian-speaking community (Baptist, Orthodox, and university faculty/students); volunteer interpreters; and university experts
on health-care access and language accommodation. The task of the panel would be to solicit input from each of the stakeholder groups about barriers to quality health-care access. If I were going to be involved with the panel, my own suggestions would obviously be that the stakeholders look at issues of language accommodation and divergent health-care socialization. However, as I noted in recommendation #4 above, if the stakeholders decide to carry forward a project addressing health-care access, crucial input will need to come from members of the Russian-speaking and medical communities and from people working/volunteering as medical interpreters in the area. Without the buy-in of the stakeholder groups that are most affected, there is little hope of success for such community-based projects (Garwick & Auger, 2003; Stringer, 1999).

It is my hope that with representation and buy-in from the stakeholder groups, the proposed panel would be able to identify helpful courses of action: gathering information from other geographic areas about ways in which health-care access is augmented there; investigating what kinds of grants or other funding sources are available to improve language accommodation or cultural competency at medical sites in the study area; bundling of resources to provide more widespread access to the Language Line or a similar telephone interpreting system…. There are likely many other potentially helpful courses of action—for instance related to the thorny issue of health-care costs—that only the stakeholders might currently be aware of, e.g., particular grants that might be sought.

In regard to sharing my study information directly with the Russian-speaking immigrant community, I would first seek advice from experts on health communication in cross-linguistic contexts. Possible resources would be refugee and immigrant advocacy agencies in cities such as Philadelphia, or Sacramento, where large numbers of Russian-speaking immigrants have established communities. I would also hope to seek the expertise of participants such as Raisa and Katya, who had medical training in the former Soviet Union and who had connections with two
different subgroups: the university-affiliated Russians and the Baptist Russians. My concerns would be 1) how best to communicate information with members of the Russian-speaking community in my study context; 2) how to assure that information is conveyed accurately and ethically, since (like the medical providers in my study) I will have to rely on interpreters or translators; and 3) how to minimize my own legal liability. It may be that the best way of communicating suggestions to the Russian-speaking community is through pre-existing agencies or medical facilities. If possible, my executive summary would address these topics: 1) “Here are the things that puzzle U.S. doctors about how Russian-speaking immigrants behave in regard to health care” and 2) “Here are some suggestions from U.S. doctors about how Russian-speaking immigrants might gain better access to health care.”

In terms of sharing my study results with the three volunteer interpreters, the best course might be to contact them individually. Issues that could be addressed might include: 1) “Here are some potential areas of misunderstanding that might emerge between Russian-speaking patients and English-speaking doctors” and 2) “Here are some ethical gray zones to be aware of as an interpreter.”

I will also continue to share my findings with the larger community of researchers interested in medical communication, intercultural communication, and health-communication campaigns. The feedback that will result from such dissemination of the findings will undoubtedly deepen my understanding of the issues.

Ethical Dilemmas

Parrott, Kahl, and Maibach (1995) critique health-communication campaigns that prescribe individual action but that ignore national, state, or local barriers preventing individuals from successfully changing their health situations. In a discussion of ethical considerations, they write:
These barriers have little to do with whether or not individuals understand particular health messages and far more to do with the activities of those who make and enforce policies. Thus, the issue for the message designer becomes: Who should be the target of messages? (p. 281).

And in a related vein, Guttman (2000) discusses a tendency for large structures such as governments to abdicate responsibility for social problems—with small-scale, often volunteer efforts then becoming responsible for fixing the problems. She questions the ethics of health-communication campaigns that ignore systemic injustices in favor of a focus on individual behavior.

Such ethical issues certainly seem relevant in the present study context, and in fact the provider Jason said that his clinic’s free care for the poor was a “Band-Aid” in the absence of better health-care policies at the national level. The recommendations I have made in the preceding sections might be critiqued along similar lines, since overall I have targeted individual providers, and sometimes individual patients and interpreters, as being responsible for change. However, I have also tried to emphasize the potential benefits that could arise if the three stakeholder groups work together to promote changes in their local context. Such attempts, while constrained by problematic policies at levels outside the control of individuals or even small coalitions, still might have value: While health-care reform is being talked about more and more at the national level, it still seems that without small-scale efforts like the coalition I am suggesting, the problem of health-care access for LEP patients in specific locales will not be improved anytime soon.

Another ethical consideration is crucially important to consider when weighing the recommendations I have made: No intervention or attempt at change is ethically neutral (Parrott, Kahl, and Maibach, 1995; Guttman, 2000). Any attempt at change will bring gains and costs, both anticipated and unexpected ones. For instance, while I believe that providing better interpreting services is a laudable goal in the study context, implementing such services would not be an
ethically black-and-white matter. A conversation with the immigrant Tatyana (who took part in my M.A. research) made this clear to me. Tatyana generally supported my research on language accommodation but said that if better interpreters were provided by institutions, members of the Russian-speaking community would lose some of their community cohesion. They would, she said, not help one another as much and would become like Americans, who do not even know their neighbors. I cite her concerns both to illustrate the ethical complexities involved in attempting to improve health-care access and also to reiterate the need for involvement of all stakeholder groups in planning and implementing change. Without true buy-in from the immigrant, medical, or interpreter communities, any intervention will be of dubious legitimacy, as well as unlikely to succeed in the long run.

**Implications**

Few studies have investigated the health-care access of Russian-speaking immigrants beyond large metro areas such as New York, Boston, or Sacramento (Aroian, Khatutsky, Tran, & Balsam, 2001), a gap that I have attempted to fill via the current project. As my data suggests, the situation faced by Russian speakers—and, by implication, other linguistic-minority immigrants—in areas distant from major population centers can be quite challenging, since such areas may have minimal resources for dealing with the needs of those with limited English proficiency. At the same time, compared with members of an urban immigrant population, immigrant communities in smaller areas might have access to fewer social support allies from within their own cultural background, which can lead to stress as well as difficulties managing the needs of everyday life (Simich, Beiser, & Mawani, 2003).

While details will vary between different linguistic-minority groups and between different locations, the topics of *language accommodation* and *health-care socialization* seem
important to consider anytime a linguistic- or cultural-minority patient seeks care. Thus, I believe that the findings from my project might be valuable to patients, providers, or interpreters in other contexts as a source of comparison with their own situations.

Additionally, one of the strengths of my project has been the gathering of data from three stakeholder groups—immigrants, medical-site staff, and volunteer intermediaries. The three groups’ overlaps and divergences of viewpoint proved to be a useful lens for examining the situation, and I believe such an approach could fruitfully be applied in studies of other linguistic- or cultural-minority groups as well.

**Limitations and Future Directions**

The findings discussed in the preceding chapters provide a snapshot of stakeholders’ perceptions as of 2004–2006. The situation may have evolved since then in terms of what language accommodation resources are available—with improvements, declines, or most likely both. After the current project is completed, I hope to share my findings with representatives of the immigrant, medical, and interpreter communities in the study area, and at that point I expect to learn more about ways in which conditions have or have not changed.

The study would have been stronger had I additionally collected data from actual medical appointments. While I believe there is a great deal of valuable information in the viewpoints expressed retrospectively by my participants, it is also quite true that people do not always do what they say they do (e.g., Quinn & Holland, 1987). Audio or video data from appointments would undoubtedly have yielded additional insights, as in Leanza’s (2005) and Rosenberg, Leanza, and Seller’s (2007) studies of interpreted doctor-patient communication. Gathering appointment data is among my goals for further study.
A second limitation relates to the issue of language. In this study, I analyzed utterances in English, that is, comments made by participants in English or interpretations from Russian to English made by the study interpreter, Nina Vyatkina, during the interviews. While I have great confidence in the accuracy of Nina’s interpretations, another rich source of data would be gained through analysis of the Russian utterances as well. That, too, is among my goals for further study.

In the future, I hope to carry out analyses of cross-cultural health care involving additional stakeholder groups: other linguistic-minority groups in rural, semi-rural, or urban areas; lesbian, gay, bisexual, or transgender patients; and elderly patients or nursing-care residents. In addition, I hope to learn more about health-communication programs and ways to ethically convey useful information to both provider and patient.

A Final Word

I am very grateful to all of the participants—immigrants, medical staff, and volunteer intermediaries—who allowed me to interview them. Their information has helped me to see how complicated and difficult the issue of health-care access can be, and how many barriers to improved access might exist. These barriers may be situated in patient, provider, interpreter, socioeconomic conditions, or the larger U.S. system of health-care and its financing (Rose & Garwick, 2003). But as has become clear to me in analyzing the data from the participants, there are also potential ways to bring about better health-care access for the Russian-speaking immigrants in my study context—and by implication for other linguistic-minority groups in the U.S., as well. While it might seem burdensome to medical facilities to take steps to increase their language accommodation and cultural competency, the risks to patients and providers seem too great to not take such steps. To tackle problems of health-care access will likely require much
hard work and activism on the part of immigrants, medical staff, and interpreters, both in my study context and elsewhere.
Literature Cited


GSA and APHA.


Appendix A

Question Pool for Pilot Project #2

Questions for Pilot Interview #1 (October 2004)

BACKGROUND
1. About how many Russian or Ukrainian immigrants live in this area?
2. Do you know many of those people? (Most of them?) (Few of them?)
3. About how many of the immigrants speak English?
4. What year did you move to America?
5. Could you tell me your birthdate?
6. Have you lived anywhere else in America, or always in ((Town Name))?
7. In Russia, did you live in a small town, or a medium-sized city, or a big city?
8. Please make a list of all the illnesses that you can think of.
9. Thinking about getting medical care … What things are better here than in Russia (Ukraine)? What things were better in Russia (Ukraine) than here?
10. Please think about a time when you, or someone in your family, or one of your friends got sick. Who helped with the situation?
11. Please think of a time, after came to America, when you helped someone who was sick. (Or had any medical problem). What was the person’s relationship to you? How did you help? Why?
12. If a sick person is not one of your family, will you usually help? (Who? How? Why?)
13. Is the situation different when children are involved?
14. Is the situation different when old people are involved?

GETTING ADVICE
1. When someone in your family is sick, who is the first person you tell about the problem?
2. When someone is sick, how many people do you ask for advice? (Could you tell me who they are? [Get a specific relationship title.])
3. When someone in your family gets sick, how do you decide what to do?
4. What kinds of health problems do you consider to be little problems?
5. What kinds of health problems do you consider to be big problems?
6. Could you tell me about a time when you or someone in your family had a little illness? (Where did you get advice, etc.?)
7. Could you tell me about a time when you or someone in your family had a big illness? (Where did you get advice, etc.?)
8. Do you and your friends help each other when someone is sick? What kinds of help?
9. ((Name a specific problem that they mentioned)): When someone has this health problem, who do you ask for advice? ((Get a specific relationship title like “husband, wife, father, aunt, friend, doctor, etc.”) ((Do this for a sampling of little, big, and in-between problems.))
10. Since you came to the United States, have you ever called people in Russia or Ukraine for advice? (Could you tell me about the situation?)

11. Do people ever go back to Russia or Ukraine to visit doctors or dentists? (Why?)

12. Do you ever go to a doctor first ... and then later get advice from one of the other people you mentioned?

13. How do Russian people here find out which doctors are good and which doctors are bad? (What makes a doctor good? What makes a doctor bad?)

14. Do you ask Americans which doctors are good and which doctors are bad?

GETTING MEDICINES

1. Do people in ((Town Name)) ever go to New York City to get Russian medicines?
2. Can they get Russian medicines from anywhere else in America?
3. When people visit Russia or Ukraine, do they ever bring medicine back to America with them? (What kinds of medicine? For what illnesses? Why?)

GETTING TRANSPORTATION

1. If someone does not have a car and gets sick, how will the sick person travel to the doctor?
2. Are there certain people that you can call if someone needs a ride to the doctor?
3. Does your church help people with transportation to the doctor?

GETTING LANGUAGE HELP

1. If someone is sick and cannot speak English very well, does anyone go with them to the doctor? Who?
2. Do any of the doctors here speak Russian? (Nurses, receptionists, other hospital workers, etc.) (I heard about a doctor in ((another town in region))--they said she speaks Russian. Have you heard this?)
3. Do people ever ask American friends to go to the doctor with them?
4. Have you ever used an interpreter during a medical visit?
5. Who was the interpreter?
6. Does the government provide any help like interpreters, or social workers, or...?

DOING PAPERWORK

1. Does your doctor (nurse, receptionist, etc.) have paperwork in Russian and English both, or just in English?
2. I think medical paperwork is sometimes difficult to understand. Have you ever asked anyone for help with medical paperwork? Who?

GETTING FINANCIAL HELP

1. If someone is sick for a long time and cannot work, does anyone help him or her to pay the rent?
2. If someone has many medical bills, do his or her friends help to pay?
3. Does your church collect money to help people who are sick? (To help church members? To help other people in ((Town Name)) who are not members of your church?)
4. Is the situation different depending on whether the sick person has health insurance? (Do most of the immigrants have health insurance? Many? Few?)
5. You’ve mentioned a number of places where people can get help with bills. Are there any others?

STAYING WITH A SICK PERSON
1. If someone is sick for a long time, who stays with that person?
2. Is there help from people who are not in the person’s family?
3. If someone is sick and cannot take care of the house, does anyone help him or her?

GENDER
1. When someone is sick, do men and women give the same kind of help, or different? (see Lyons et al., 1998, p. 594)
2. When someone is sick, do men and women ask for the same kind of help, or different?
3. What kinds of help do women give when someone is sick?
4. What kinds of help do men give when someone is sick?

WHO DECIDES?
1. Please think about a time when someone who you know was very sick and some other friends helped out. How did you hear about the situation?
2. Did you think of the problem as belonging to you all together? Or were you just helping the sick person with their own problem?
3. Who decided the best way to help? Was it coordinated or did each person decide on her own to help? [see Lyons et al., 1998, p. 584-585]
4. Who decides how big the response should be? (Ask for specific examples/narratives.) ➔ ((i.e., when can I as the sick person ask for help, and when does an offer have to come from some person or persons other than the person in need? How is the degree of response determined—i.e., what the needy person is “eligible” for? [see Lyons et al., 1998, p. 584, point #2 ] ))
5. How do people decide, “OK, we’ve helped that person enough”?

ANY CHANGE IN COPING?
1. Has anyone from this community ever left ((Town Name)) and moved to a place where there were not many Russians? Thinking about the things we have been talking about … how did moving away affect that person?
2. When you lived in Russia (Ukraine), did you depend on help from your family more or less than here in ((Town Name))?
3. When you lived in Russia (Ukraine), did you depend on help from your neighbors more or less than here in ((Town Name))?
4. When you lived in Russia (Ukraine), did you depend on help from your church more or less than here in ((Town Name))?
5. What if the sick person is very sick—in fact, is slowly dying? (Does the help change?)
6. Thinking about the things we have been talking about …as immigrants live here a long time, do they do things differently when getting medical help? (Does it have anything to do with ability to speak English?)
7. How about young people and older people? Do they ask for help in the same ways?
8. Did anyone ever have a problem that was “too big” for other people to help? (What problem?)
9. (Tie this in the list of illnesses) Do some illnesses require more people to help?

MISCELLANEOUS
1. Here in ((Town Name)), when women are having a baby, do they ever use a midwife? Was it the same in Russia? Do any of the women in the immigrant community know how to do this?
2. Are there any people here who are not doctors but who know how to treat illnesses? Was it the same in Russia?
3. We’ve been talking about how people help each other. Do most of the immigrants in ((Town Name)) do things the way you said?
4. ((Do you think the answers will change for any reasons that we didn’t talk about?))
5. What if the person needs dental care?
6. How about eye care?
7. In some churches, there are “healing services” for sick people. Does your church ever do that?
8. Do people from your church pray for sick people?

Questions for Pilot Interview #2 (November 2004)

Since last week, have you thought of anything else you wanted to tell me?

I plan to do more of these interviews with immigrants in the spring. Can you give me advice on what questions I should ask?

GO THROUGH THE LISTING ACTIVITIES (2).

Kinds of help for people who are sick

advice about dealing with the medical system
advice about treatment
babysitting
financial help
going with the person to the doctor/pharmacy
help choosing a doctor
help with paperwork
housecleaning
interpretation or language help
personal care (help dressing, bathing, etc.)
phone calls to talk with the sick person
prayer
shopping for the sick person
staying overnight with person
transportation
visits

Next to each item in the list above, please label whether it is generally handled by the sick person’s relatives, or friends, or outside help (such as nurses, social workers, etc.)

R=relatives
F=friends
O=outside help

Now please look at this list again. Please circle the 5 items you think are most commonly given to Russian immigrants in the ((Town Name)) area.

One of the articles I read had an interesting quote. Please tell me what you think about it: “For elderly Russians, it’s a national kind of sport to see doctors. It’s their occupation.” (Aroian, 2001, p. 267—said by the child of a Russian immigrant in Boston.)

Could you think about a situation where you interpreted for a sick person in the ((Town Name)) area. (It could be one time or more than once.) Try to tell me as much as you can remember about the situation (you don’t have to mention information that is confidential). [See Goodnow, p. 17.]

→ Who contacted you about helping the person?
→ Were you interpreting at a hospital, or doctor’s office, or someplace else?
→ How many visits did you make?
→ What went well?
What could have made things go better?
Were you paid (if you want to tell)?
Let’s imagine … What if doctors or nurses wanted to give health information to the whole community of immigrants, how could the doctors or nurses do it? (In other words, if they want to distribute information to reach most of the immigrants, who would they contact first?)

What is the most difficult thing about offering interpretation help? What is the easiest thing?

Do you ever have to tell patients—or doctors and nurses—“I’m sorry, but what you are asking me to do is too difficult?” (If yes, is there anyone you can refer them to?)

When you helping immigrants with language issues, do people ever feel too proud to ask for help? (Either patients, or doctors and nurses.) [See Meegan, p. 12]

When you are interpreting for someone who is not your relative … do you ever become like “one of the family”? [See Goodnow, p. 22] (How do you know?)

Do you try to educate the patient (or their family) so they can handle communication themselves in the future? How well does that work? [Goodnow, p. 23]

If people need help, how do they find out about your ability to interpret? (Who tells them?)

You mentioned last week that when you can’t directly help people with a problem, you try to refer them to other help. Could you talk a bit about where you refer them to?

I know there are some English classes for immigrants in ((Town Name)). Do many Russian immigrants take those classes? Do you know whether the classes work on medical communication?

Do most of the older immigrants have relatives in ((Name)) County?

For those older people who don’t have relatives here, does someone “watch out” for them—make sure they are eating well, going to the doctor, and so on?

(I may have asked you this last week, but…) Do any of the doctors in the area speak Russian? (I heard a rumor that a doctor in ((Town)) speaks Russian.)

In the doctor’s offices (or at the hospital), do they have bilingual paperwork or other things like that? (Like charts of illnesses, in English and Russian.)

I’ve heard that there’s a free clinic—((the Free Clinic)). Do many immigrants use it? About how many doctors and nurses work there?

THANK YOU
Appendix B

Question Pool for Immigrant and Interpreter Participants

(Current Project)

[REMINDER: THE QUESTIONS IN **BOLD** ARE KEY AND SHOULD BE ASKED IN ALL INTERVIEWS. THE OTHER QUESTIONS ARE LOWER-PRIORITY AND MAY BE OMITTED BASED ON APPLICABILITY TO IMMIGRANT PARTICIPANT’S LIFE CIRCUMSTANCES, AS WELL AS TIME AVAILABLE.]

SECTION: GENERAL QUESTIONS ABOUT MEDICAL ACCESS SITUATIONS AND ATTITUDES ABOUT MEDICAL CARE

1.1: When you first arrived in this area, how did you find out which doctors were good and which weren’t?

1.2: Do you know any medical personnel in this area who speak Russian? (This could be doctors, nurses, receptionists, therapists, hospital staff, etc.)

1.3: In the doctor's offices you have gone to (or at the hospital, or in the ambulances), is written information available in Russian? (If yes, what types of information--paperwork, charts of illnesses, etc.?)

1.4: Are there particular doctors or medical facilities where a lot of people from the Russian-speaking community go? (Why? Could you give me the names of the doctors or medical facilities?)

1.5: There's a clinic called ((the Free Clinic)) that helps people who have no insurance. Have you ever used it? (Why or why not?) Do many people from the immigrant/refugee community use it?

1.6: Let's imagine --What if doctors or other medical personnel wanted to give health information to the whole community of immigrant/refugees ... how could the medical personnel do it? In other words, if they want to distribute information to reach most of the immigrants, who would they contact first? (Does the Baptist church ever make announcements about medical issues--such as free immunization clinics or free health screenings?) (Do people put announcements about health screenings, etc., at the East European market on ((Name)) Street?)

SECTION: SPECIFIC ILLNESS NARRATIVE (CLOSE PERSON)

2.1: Please think of a recent time--since you have lived in this area--when you or someone in your family had an illness that required medical treatment. Can you tell me the story of what happened? Here's a timeline chart that might help you
organize your story:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. You became</td>
<td>2. At the doctor’s</td>
<td>3. At the</td>
<td>4. Other</td>
</tr>
<tr>
<td>aware of the</td>
<td>office or</td>
<td>pharmacy</td>
<td>follow-up</td>
</tr>
<tr>
<td>medical</td>
<td>hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>problem</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

((Ask prompt questions selected from the following list, if needed))

A. What happened once you became aware of the problem?
--What was the first thing you did after becoming aware for the illness?
--Let's try to think of all the steps that occurred from the time you realized you should seek help until the time when you arrived at the doctor’s office (or hospital). How many people did you talk with? What were their roles (e.g., friends who helped you schedule the appointment, receptionist, nurse, etc.)? How many of them spoke Russian?
--[IF NOT ALREADY ANSWERED]: Did you ask anyone for help at that time? (Who? What kind of help?)
--[IF NOT ALREADY ANSWERED]: In this situation, who was the first "medical helper" you had contact with? (For instance: 911 dispatcher; receptionist at doctor’s office; ambulance driver; nurse; doctor.) Who handled the communication with that medical helper (you or someone else)? How well did the communication go with that person?
--How did you get to the doctor’s office?

B. What happened at the doctor’s office or hospital?
--Can you tell me a step-by-step story about what happened during the actual visit at the doctor's office or hospital? (For instance, at the clinic or hospital or doctor's office, what staff members worked with you [IF NOT ALREADY ANSWERED]? How long were you in the waiting room, the examination room, etc.? How well did the communication go with each person, including the doctor?)

C. What happened at the pharmacy?
--How did communication go at the pharmacy?

D. What happened during the follow-up process (e.g., physical therapy)?

2.2: Please compare the communication during this medical situation to the communication during the very first time when you sought medical care in the United States.....

2.3: If the recent medical situation had occurred in Russia, would the situation have been any different (for instance, your access to medical care, medicine, etc)?
SECTION: SPECIFIC ILLNESS NARRATIVE (MORE DISTANT PERSON)

3.1: Please think of a recent time, after came to America, when you helped someone who had a medical problem--someone who doesn't live with you. Can you tell me the story of how you helped? (What was the person's relationship to you? In what ways did you help? How did you hear that the person needed help? Why did you help?)

HELPING BEHAVIORS

- advice about treatment
- advice about ways to deal with the medical system
- baby-sitting
- borrowing someone's prescription medicine
- financial help
- help choosing a doctor
- help setting up an appointment
- help with communication during the medical visit
- help with paperwork
- herbal medicines
- housecleaning
- interpretation or language help during a visit to a doctor/medical facility/pharmacy
- personal care (help dressing, bathing, etc.)
- phone calls to cheer up the ill person
- prayer
- shopping for the ill person
- staying overnight with the ill person
- transportation
- visits to cheer up the ill person
- other help that is not on this list
4.1: [INSTRUCTIONS to be read to the participant:]

A) FIRST, please look through the list. Thinking about times when you or someone close to you has been sick in America, please select the 5 types of help that you most commonly ask for. Label those items 1-5. If there are items that you never ask for, just cross them out.
((GIVE THEM TIME TO DO THE TASK.))

B) NEXT, please go back though the list and label your next most commonly sought types of help as 6-10. ((GIVE THEM TIME TO DO THAT.))

C) NEXT, please go back though the list and label your next most commonly sought types of help as 11-15. ((GIVE THEM TIME TO DO THAT.))

D) NOW, please go back through the list and label the remaining items as 16-20 in order of how commonly you have asked for them.

4.2: Based on your experience, are there any items that I should add to this list?

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4.3:
Now please look at the items on the list. For each one, please mark down who typically provides this help—the sick person's relatives, or friends, or outside help (such as nurses, social workers, etc.)

R=relatives
C=close friends [“blizkie druz’ya”]
J=more distant friends/“just friends” [“prosto druz’ya”]
O=outside help

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GROUP BACKGROUND

5.1: For this next question I'm going to ask you to think of the names of people you know. You will write them down for your own reference, but please don't show me the names—I don't need to know them.

First, write down the names—the first that come to your mind—of 20 people you know in the United States. (GIVE THEM TIME TO DO THAT.) [If they don't know 20, they can just write as many as they can list.]

Now, next to each name, write down whether the person is your relative, or a close friend, or a more distant friend, or an acquaintance. (GIVE THEM TIME TO DO THAT.)

Now, please tell me how many people were in each category ("relative," "close friend," "more distant friend," or "acquaintance").

And finally, how many of the people on your list speak Russian only? How many speak English only? How many speak both?

6.4: In the Russian-speaking community, are there certain people that everyone knows about who can provide communication or language help during medical visits? (Do you think they'd be willing to talk with me? Could you ask them to call me?) [I SHOULD WRITE DOWN MY NAME AND PHONE NUMBER IN RUSSIAN FOR THE PARTICIPANT SO THEY CAN PUT IT ON THEIR FRIDGE.]

SECTION: EXPERIENCE WITH INTERPRETERS

6.5: Have you ever used an interpreter during a medical visit? [ASK QUESTION IF NOT ANSWERED PREVIOUSLY IN INTERVIEW.]

6.6: Who was the interpreter?

6.7: Do the government or local medical offices provide any help such as interpreters, or social workers to help Russian-speaking people with health-care access?

6.8: Have you ever asked an American friend to go to the doctor with you?

6.9: Have you ever interpreted or provided other language help for a sick person in the ((Town Name)) area? (It could be one time or more than once.) If yes, please think of one particular time when you provided this help. Try to tell me as much as you can remember about the situation (you don't have to mention information that is confidential).

For example:
--Who contacted you about helping the person?
--Did you provide the language help on the phone or at a hospital, a doctor's office, or someplace else?
--How many visits did you make?
--What went well?
--What could have made things go better?
--Were you paid (if you want to tell)?

SECTION 8: CRUCIAL QUESTION TO ASK:
7.1: If you could tell medical personnel one thing so they could give better help to Russian immigrants/refugees, what would you tell them?

SECTION 9: WRAP-UP
8.1: Before we finish, is there anything else you'd like to tell us that might help improve health-care access for immigrants/refugees in ((Name)) County?

8.1a: Can you suggest any group of immigrants/refugees who might be interested in learning more about my project (a Sunday school class at your church, or an English class for older people, etc.)?

8.1b: How can I best run into Russian-speaking people who might be interested in talking with me about this project?

8.2: If you have friends or relatives you think might be willing to be interviewed by me, please ask them to call me--[GIVE PARTICIPANT MY NAME IN ENGLISH AND RUSSIAN WITH PHONE NUMBER AND E-MAIL CONTACT.]

8.3: Thank you very much for your help!
Appendix C

Question Pool for Medical-Staff Participants

(Current Project)

[Questions in **bold** are key questions. Others are lower-priority but should be asked if there is time.]

SECTION 1: PERSONAL BACKGROUND
1.1: Could you please tell me when you were born?

1.2: **Please describe your professional duties.**

1.3: How long have you done this sort of work in ((Name)) County?

1.4: Have you worked/practiced in other geographical areas?

SECTION 2: GENERAL CHARACTERISTICS OF PATIENTS
2.2: If you were going to list some characteristics of a “good patient,” what would they be?

2.1: **About how many patients/clients do you deal with in a day, on average?**

2.2: About what percentage of your patients/clients are people from the Russian-speaking immigrant/refugee community?

2.3: Are there particular needs that people from the Russian-speaking community have when accessing care at this facility/office?

SECTION 3: SPECIFIC NARRATIVE
3.1: Could you walk me through a recent time when you dealt with someone from the Russian-speaking immigrant/refugee community? (If you could tell me a story—what had occurred before you saw the person, what occurred while you were working with the person, and what happened afterward—that would be great.)

---Additional questions if needed to prompt recollections:
   --What were your first thoughts upon meeting the patient that day?
   --Had you worked with this person before?
   --Did the patient have other people with him/her? If yes, who were they? How did they contribute to (or detract from) the situation?
   --How would you rate the communication during the visit? (How confident were you that you and the patient understood each other?)
   --Did you have any follow-up meetings? If yes, was your impression from the first meeting—about the communication—confirmed or not?
3.2: When people from the Russian-speaking community come to see you, how often do they bring family members along? How does that affect the process? Do the patients bring anyone else along, for instance an interpreter from outside the family? Again, how does that affect the process?

SECTION 4: PERCEPTIONS OF SITUATION
4.3: Thinking about the whole system--immigrants, medical staff, state and federal agencies, etc.--what is the biggest challenge?

4.3: If you could tell people from the Russian-speaking community one thing that would help to improve health care for them, what would you tell them?

SECTION 5: INSTITUTIONAL RESOURCES [ASK IF INFO HAS NOT ALREADY BEEN MENTIONED PREVIOUSLY]
5.1: Does (this facility/this office) have any special resources that can help people from the Russian-speaking community deal with the medical system? For instance, does this institution have interpreters on staff, interpreters available with advance notice, bilingual paperwork [get samples], Language Line telephone services, education programs for members of this patient population, staff education programs about dealing with this patient population [or any patient population with Limited English Proficiency]...

Have you received training about how to work with interpreters (in person or on the phone) when dealing with patients?

I’ve heard that sometimes the hospital uses bilingual staff to interpret. Do you know whether there’s a training or certification program they go through?

5.2: Are there any additional resources you wish you had available for dealing with people from the Russian-speaking community?

5.3: (Follow-up question, if needed: Any suggestions for how that resource could be obtained?)

5.4: What are your thoughts on the government’s CLAS standards for Culturally and Linguistically Appropriate Services in Health Care? [This is a probe to find out what degree of familiarity--if any--the participant has concerning the CLAS standards. The interviewer will take a copy of the CLAS standards in case the participant wants to consult them during the discussion.]

SECTION 6: WRAP-UP QUESTIONS
6.1: Anything else you’d like to mention about improving health-care access for these immigrants?

6.2: Could you list for me the languages you know?

THANK YOU SO MUCH FOR YOUR TIME. THE INFORMATION YOU GAVE HAS BEEN EXTREMELY HELPFUL.

[GIVE THEM MY CARD WITH CONTACT INFORMATION]
Appendix D

Alphabetical List of All Codes Used in the Study

(Current Project)

1. ACCOMPANY TO DOCTOR—narratives about a patient being accompanied to the doctor by a third party
2. ADVOCATE—narratives about an intermediary who challenged authority structures or took protective measures on behalf of client
3. ANTIBIOTIC—mention of this form of medication
4. AT&T LANG LINE—mention of this telephone-based interpretation system
5. AWFUL—participants’ very negative evaluations of situations
6. BAPTIST—mention of this religious affiliation
7. BETTER EXPLAN—narratives or advice in which participants said better explanations from medical providers would make treatment better
8. BILINGU—catchall label for mention of bilingualism
9. BILINGU STAFF—mention of bilingual staff at medical facilities
10. BLOOD PRESSURE—mention of this medical condition
11. BUSINESS—mention of the business aspect of medical care
12. CANCER—mention of this medical condition
13. CHURCH—mention of Christian religious establishments
14. COMM ACCOMM—mention of communication accommodation (e.g., interpreter, bilingual paperwork, etc.) provided by a medical facility
15. COMM FAIL—narratives about failed communication attempts
16. COMM HELP FROM FRIEND—a friend served as a communication intermediary
17. COMM HELP FROM RELA—a relative served as a communication intermediary
18. COMM SUCCEED—narratives about successful communication attempts
19. CONFIDENTIALITY CONCERNS—participants’ mention of the need to protect confidentiality of patients
20. COST FACTORS—mention of the expense of various medical options
21. COURTESY—mention of polite behavior as a trait desired by interpreters, patients, or staff
22. CREATE CHANGE—interpreters acting to increase the sociolinguistic resources available to Russian-speaking immigrants in the area (Blommaert, Collins, & Slembrouck, 2005)
23. CULTURAL KNOWLEDGE—mention of insider knowledge available to people socialized in particular ways that might not be known to people from other communities
24. CULTURE BROKER—discussion of people who act to explain information that might not be known to all parties during cross-cultural medical visits (see Dyart-Gale, 2005, and many others)
25. CYNICISM—participants’ discussion of feelings of distrust toward (usually) medical providers or insurers
26. DEATH—mention of death as a medical outcome
27. DENTIST—mention of this kind of provider
28. DIABETES—mention of this medical condition
29. DIAGNOS—mention of diagnoses as a salient or contested feature
30. DISSEM—discussion of ways to disseminate information about health care (and the related ideas of access and improving communication) among the Russian-speaking population of the area
31. DISTRUST—patients’ discussion of lack of faith in medical system or providers
32. DOC NOT GOOD—participants’ negative evaluations of a medical provider
33. DOC REFUSAL—narratives about doctors who did not do what the patient asked
34. DOCS TRAINED—patients’ comments about the training received by medical providers in the U.S. or former Soviet Union
35. DOCTOR—an overly general category, eventually abandoned as too broad
36. EARLY HISTORY—information about the early days (late 1980s) of the Russian-speaking community in the study area
37. ELDERLY—narratives dealing with people described as old
38. EMPATHY—mention of this trait
39. EMT—mention of paramedics
40. ENVY—an interpreter’s attitude toward some of her clients
41. ER—narratives dealing with emergency-room treatment
42. ESL—mention of English as a Second Language needs or resources
43. ETHICAL GRAY ZONE—when the speaker (typically an interpreter) describes a practice that seem ethically questionable to the principle investigator
44. EVOLUTION—ways in which a situation has changed over time (e.g., the proficiency of an interpreter, or the ability of the Russian-speakers to handle their own health-care communication)
45. FIND DOCTOR—narratives about how patients located a medical provider to help them
46. FREE IN RUSSIA—discussion of forms of health-care that were free in the former Soviet Union
47. GENDER—moments when maleness/femaleness were described as salient by the participant
48. GEOGRAPHY—ways in which location affected health-care access, employment, etc.
49. GO TO RUS—narratives about immigrant patients who did/would return to the former Soviet Union to get treatment there
50. GRATEFUL—code created to address medical staff narratives in which grateful clients were described positively
51. GREEN CARD—mention of this document or the related immigration status (permanent resident)
52. HELP SOUGHT BUT NO—narratives about patients seeking language accommodation or other types of help that were not available
53. HERBS—mention of this variety of alternative medicine
54. HI COST—narratives about high prices for medical care
55. HUMAN & MACHINE—narratives in which speakers talked about their views on the appropriate balance of “human touch” vs. advanced technology during medical interactions
56. IMM MEDPERSON—an immigrant who received medical training in the former Soviet Union
57. IMM STATUS—discussion of the effects of varying immigration statuses such as “refugee,” “parole,” “green card,” etc.
58. IMMIGRANTS—used to refer to immigrants in general; overly broad code
59. INFORM PATIENT—expressions of a wish that doctors would tell patients more information
60. INJURY—mention of this variety of physical condition
61. INSUFFIC EXPLAN—narratives about medical providers who did not provide enough explanation, in the view of the patient
62. INSUR—discussions of health insurance or lack of insurance
63. INTERPS—mention of interpreters; category too broad to be useful
64. INTERPS’ VALUES—moments in which interpreters discussed their ethical values explicitly or implicitly (e.g., my evaluation of their statement)
65. JOB STATUS—mention of employment status as a factor in health-care access
66. KEY QUALITIES OF AN INTERP—discussion of what makes a good interpreter
67. KIDS—children mentioned
68. LAB—discussion of medical laboratories
69. LANG ATTRIT—discussion of people (generally children) in the Russian-speaking community losing their ability to speak Russian
70. LANG LEARN—discussion of people learning Russian or English
71. LANG PROFIC—discussion of language proficiency as a salient factor in health-care communication
72. LISTSERV—mention of the L-C CCP listserv (on-campus resource for people from the former Soviet Union)
73. MASSAGE—mention of this technique as a health-care practice
74. MEDICAL FACILITY #1 (this code has been masked to preserve participant confidentiality but referred to a specific, named facility)
75. MEDICAL FACILITY #2 (this code has been masked to preserve participant confidentiality but referred to a specific, named facility)
76. MEDICAL FACILITY #3 (this code has been masked to preserve participant confidentiality but referred to a specific, named facility)
77. MEDICAL FACILITY #4 (this code has been masked to preserve participant confidentiality but referred to a specific, named facility)
78. MEDICAL FACILITY #5 (this code has been masked to preserve participant confidentiality but referred to a specific, named facility)
79. MED NARRAT—participants’ stories about seeking or providing health care
80. MEDICARE—mention of this government social support program
81. MEDICINE FROM RUS—mention of bringing medications to the United States from the former Soviet Union
82. MEDPERSON CARED—patients’ evaluation of a medical provider as having cared about the patient
83. MEDPERSON THOROUGH—patients’ evaluation of a medical provider as having made a thorough attempt to help the patient
84. MINOR INTERP—mention of people under age 18 acting as medical interpreters
85. NAIVE INTERP—interpreters who lacked medical bilingualism or health-care knowledge; note: I do not include my three focal interpreters in this category, but rather in the “non-professional, non-naïve” category discussed below
86. NEED MED TERMS—discussion of the need for interpreters to have command of medical terminology and concepts in both English and Russian
87. NETWORK—discussion of patients’ social networks
88. NO BILINGU PAPERW—bilingual paperwork not available or not offered to patients
89. NO INTERP—no interpreter available at a medical site
90. NO RESOURCE—generally used for medical-site staff’s mention of resources their facility lacked (e.g., funding, bilingual paperwork, etc.)
91. NON-PROF, NON-NAIVE INTERP—code I used for the three focal interpreters in my study, intermediate between naïve and professional interpreters
92. NOT BAPT—an immigrant who reported being Orthodox Christian, non-religious, or other non-Baptist affiliation
93. NOT COMPLIANT—code created for medical staff descriptions of patients who did not follow prescribed medical procedures
94. NURSE—mention of this kind of health-care provider
95. ONE ADVICE—participants’ answers to my question about one piece of advice they would give the other stakeholders to improve health-care access for Russian-speaking immigrants
96. ORTHODOX—label for those who identified as Orthodox Christians
97. PAPERWORK—general mention of medical or legal paperwork; overlaps somewhat with code NO BILINGU PAPERW
98. PARAPROF—label for mention of Certified Nursing Assistants or other paraprofessionals
99. PATIENT AGREE—label for narratives in which the patient agreed with the medical providers’ course of treatment
100. PATIENT DISAGREE—label for narratives in which the patient did not agree with the medical providers’ course of treatment
101. PATIENT SOLU—descriptions of patients taking steps to address a medical or financial issue, in spite of or instead of advice from medical system (e.g., switching to a different medical provider, getting a second opinion, asking friends to bring medicine from Russia)
102. PHARMA—discussion of pharmaceuticals, pharmacies, or prescriptions
103. PHONE HELP—mention of providing or receiving help in calling for appointments or via telephone interpreting
104. PHYS ASST—mention of a physician assistant
105. PORTRAY MEDPERSON—patients’ evaluation of a medical provider
106. PORTRAY RUS SYSTEM—descriptions of logistics or values associated with the health-care system in the former Soviet Union
107. PORTRAY SITUAT—an overly broad code, of little use, since it covers almost every mention of any life condition
108. PORTRAY US SYSTEM—descriptions of logistics or values associated with the health-care system in the United States
109. PREVENTION—mention of preventive care
110. PROBLEM RECURS—a health problem is not resolved
111. POSTSECONDARY INSTITUTION (this code was masked to protect participant confidentiality but referred to a specific, named entity)
112. REFUGEE—mention of this immigration status
113. RUNAROUND—a participant’s experience of bureaucratic hurdles that are difficult to surmount (as with an insurance company)
114. RUS LOGISTICS—ways of approach used in the health-care system of the former Soviet Union (e.g., use of neighborhood polyclinics)
115. RUS SPEAK MEDPERSON—mention of a health-care provider who can speak Russian (either an actual, known person or a wished-for, hypothetical person)
SATISFIED—a participant’s evaluation of the health-care encounter as good
SCARY—evaluation of a health-care situation as frightening or embarrassing (usually by participants, but occasionally my own evaluation of a described situation)
SELF CARE—descriptions of ways in which patients take care of themselves medically (e.g., checking own blood pressure, using herbs)
SELF WEAK COMM—a patient’s self-description as having difficulty communicating with doctors in English
SHOCKING—one patient’s description of an unexpected (and negative) situation
SPONSOR—sponsorship of immigrants by people already in the United States
TAKE BP—references to having blood pressure measured or measuring it oneself
TECHNOLO—discussion of advanced medical technology
TESTS—descriptions of medical tests performed
THEY DON’T KNOW HOW—interpreters describing a situation in which immigrants do not know how to navigate the medical system, adequately serve as interpreters, etc.
“THIS IS NOTHING”—words reported by patients to have been spoken frequently by some medical providers in response to patients’ medical or dental complaints
TRAINED INTERPS—mention of people with training as medical interpreters
TRANSPOR—transportation as a salient factor in access to medical care
TYPES OF HELP—generally applied to the types of help given within the immigrant community (e.g., information, transportation to medical visits, language help, etc.)
TYPICAL ILLNESSES—mention of illnesses described as common in the Russian-speaking study community
UNPLEAS—patients’ evaluation of a health-care situation as negative
VOLUNTEER—a person serving without pay as an interpreter, medical provider, etc.
WAIT—mention of delays in seeking or receiving care
WEIRD—one participant’s evaluation of an inexplicable situation described in a narrative
WELFARE—mention of government-provided social support
WHY NOT MEDPERSON—explanations given by those immigrants with medical training as to why they were not practicing medicine professionally in the U.S. (or at least not at the same level as in the former Soviet Union)
YELLOW CARD—mention of a government-provided medical access card

The following six “super-categories” are combinations of various coding permutations that I used to filter my results.

ACCOMPANY TO DOCTOR + COMM HELP FROM RELA
COST FACTORS + HI COST
NOT ACCOMPANY TO DOCTOR & NOT COMM HELP FROM RELA &..
NOT MED NARRAT & NOT PORTRAY US SYSTEM & NOT PORTRA..
NOT PORTRAY US SYSTEM & PORTRAY RUS SYSTEM
MED NARRATIVE (NARROWED)
VITA
Charles Brua

EDUCATION
Ph.D. Applied Linguistics, Penn State University—2009
M.A. Teaching English as a Second Language, Penn State University—2002
B.A. English (writing option, with highest distinction), Penn State University—1986

AUTONOMOUS TEACHING & INSTRUCTIONAL CONSULTATION
• LING 100: Foundations of Linguistics
• APLNG 484: Functional Grammar
• ESL 118g: American English for International Teaching Assistants III
• ESL 116g: Composition for Academic Disciplines
• Graduate consultant, Schreyer Institute for Teaching Excellence

PUBLICATIONS
• “Role-blurring and ethical grey zones associated with lay interpreters: Three case studies” (2008), Communication & Medicine, 5(1), 73-80
• “Shouldering the burden: Two immigrants’ choices in the absence of institutional interpreting resources,” book chapter under review

PRESENTATIONS AND POSTERS
• “Tensions around medication: Russian-speaking patients and English-speaking doctors in a small town,” accepted by the Society for Medical Anthropology’s September 2009 meeting (poster)
• “Immigrants’ medical training as an ‘unofficial’ resource,” Society for Medical Anthropology; 2008
• “Culturally shaped healthcare beliefs: A key factor in intercultural medical communication,” American Association for Applied Linguistics (poster); 2008
• “Clinical medical interpreters: A new profession on the health care map,” co-presented with Robert Schrauf and Priscilla Ortiz, Health Services Research Colloquium, Penn State; 2008
• “Medical interpreters as a focal point of sociolinguistic change,” American Association for Applied Linguistics; 2007
• “‘Ideal’ visits and agency in 3-party medical communication” (co-authored with Nina Vyatkina), American Association for Applied Linguistics; 2006
• “Evaluating communication resources for Russian-speaking patients,” Penn State Graduate Exhibition (poster); 2006
• “Health-care access in a Russian immigrant community: The role of culture brokers,” American Anthropological Association; 2005
• “Discourse strategies in a newspaper debate about sexual orientation,” American Association for Applied Linguistics; 2004
• “Homophobic bullying as a convergence point,” Conference on Lavender Languages and Linguistics, American University; 2004
• “Searching for echoes and anomalous voices,” text-analysis session presented at the Conference on Lavender Languages and Linguistics, American University; 2003

GRANTS AND AWARDS
• Spector Award for Outstanding Graduate Student in Applied Linguistics, Department of Linguistics and Applied Language Studies, Penn State; 2006
• Dissertation grant, RGSO, College of the Liberal Arts, Penn State; 2005
• Gil Watz Fellowship, Center for Language Acquisition, Penn State; 2005