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Stephen T. Harvey, M.D., Editor

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Anesthesiology and the Non-English-speaking Patient

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“Hello, sir. How are you?” The patient stared blankly at me, and I immediately understood he did not speak any English. All I could muster was a simple, “Hola, cómo está?” The patient and I quickly realized that we would not be able to communicate effectively, so I asked the nurse to call for an interpreter.

This situation has become all too common in health care. More and more patients emigrate from other countries, and many understand little English. As a healthcare provider, I have a duty to provide patients with the best care possible despite any language barriers that may exist. Studies have shown that patients who do not speak the same language as their doctor or nurse receive inferior care.[1]

This Spanish-speaking patient was 37 years old and presented for a left fourth digit amputation and debridement for necrotizing fasciitis. This was his fourth surgery related to this infection. As I spoke to the patient through the interpreter, I wondered if everything I said was translated accurately. Did the patient understand me? How would I know? The patient rarely sought medical care but stated he did not have any medical problems and was only taking the pain medications prescribed by his surgeon. I was able to determine that he could safely undergo general anesthesia, except he did mention having chest pain and palpitations that day. After further discussion with the interpreter, we determined that his symptoms could be attributable to anxiety. I quickly dismissed other serious etiologies, such as arrhythmias, and explained to him the anesthetic plan.

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As I left the room, I wondered if I should have offered him a peripheral nerve blockade. While he was not an ideal candidate for a peripheral nerve catheter due to his continued infection and home intravenous antibiotic regimen, he could have benefited from a single-shot peripheral nerve block. The surgeon asked me earlier in the day to not perform this procedure, and I didn't question him at the time. He thought the patient was going to have pain but had access to oral pain medications at home. I rationalized the decision to defer peripheral nerve blockade, realizing it would be challenging to communicate with the patient if any problem occurred. Would he be able to communicate to us if he felt lightheaded or dizzy or had perioral numbness? If he developed a phrenic nerve palsy, would he understand that his breathing may feel different? Could he comprehend that this would be self-limited?

I couldn't put my finger on it. Did I not offer the nerve blockade because of the previous stated reasons, or were there other factors subconsciously involved in my decision? We all know that an anesthesiologist in a busy ambulatory center never has enough time; speaking to a patient *via* a translator would only hinder my ability to perform other tasks. Did I not perform this procedure because I subconsciously felt that it would take more time? Is this the kind of doctor I have become? Am I more interested in getting to the next task than taking a minute to consider how I can best take care of my current patient? If the patient had spoken English, I honestly do not know if I would have acted differently. This scenario has occurred previously during my career, and sometimes I did not advocate for a nerve blockade, while other times I did.

The patient underwent an uneventful general anesthetic. However, in the postanesthesia care unit, he complained of increasing pain around his surgical site, stating his bandage felt too tight. In addition, his blood pressure was elevated significantly from his preoperative baseline value. With the assistance of the interpreter, I determined that he had no chest pain, shortness of breath, headache, or other alarming symptoms. His other vital signs and rhythm strip were normal. His intraoperative course was unremarkable. He was given oral acetaminophen and gabapentin in addition to intravenous hydromorphone. His pain significantly improved, and soon he was discharged home.

Later that night, I thought again about the situation. Often, especially with orthopedic surgeries, I premedicate the patient with oral acetaminophen and gabapentin. However, in this situation I did not. Had I forgotten to order these medications because I was too busy, or because I did not want to take the time to discuss them with the patient? The fact that I cannot deny this possibility speaks to the subconscious biases in management preferences that I and other medical providers may have toward non-English-speaking patients. Despite my continued reflection, I wonder how I will react the next time I see another patient who does not speak English. I can only hope it is with the best interests of the patient in mind.

References

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