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ROLE EVOLUTION OF LANGUAGE TRANSLATORS IN A MAJOR MEDICAL CENTER

by

CHARLOTTE A. WEAVER

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

MEDICAL ANTHROPOLOGY

in the

GRADUATE DIVISION

of the

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DISSERTATION ABSTRACT

Role Evolution of Language Translators in a Major Medical Center

by

Charlotte A. Weaver

The central focus of this dissertation is the role that developed for 33 medical language translators at San Francisco General Hospital, and the evolution of that role over a three year period. What translators came to do in their work is documented and why they came to assumed these functions is explained. The impact that this personnel had on the delivery of health care to non-English speaking patients is examined in detail, and specific recommendations are made to help providers work more effectively with medical translators. Recommendations are also directed toward hospital administrators, private/group practitioners and health policy planners regarding selection criteria for translator personnel, training curriculum for medical translators, and types of program structures for the institutional management of translator personnel.

Conceptually, three analytic approaches are used in this dissertation -- structural analysis, historical-political framework, and social interaction analysis. The structural analysis relates the social system of the institutional setting and the larger social system of the City and County government of San Francisco to economic and political forces that shaped the language translator role at San Francisco General Hospital. The historical review of San Francisco explains the evolution of the inter-ethnic political relations of San Francisco's ethnic groups, and provides the framework to understand the current social structure and the social forces that caused language translation services to be instituted at this county medical center. The range of functions performed by translators is described through a social interaction approach. Extensive variation in the functions enacted within the role of translator was found.both between translators and situationally with the same translator. Thus, the observed variance in functions is related to the following factors: socio-demographic characteristics; specific structural demands of differing clinical settings; and, the dynamics of translator-patient and translator-health provider bonding that occurs (or does not occur) during the patient-translator-provider interaction.

Joan Ablon

~~Dissertation~~ Chairman

November 28, 1981

date

DEDICATION

I dedicate this work to Mrs. Elouise Westbrook and to individuals like her who spend their lives working for the social welfare of others, and who are seldom acknowledged for their work or for their expertise.

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There are many people whose sponsorship, advice, cooperation and caring made it possible for me to do this dissertation. I did not do this dissertation alone. Ms. Ana Teresa Fischer actively sponsored my research request in the face of much opposition, as did Mr. Charles Winsor. I owe a special thank you to my faculty advisor, Dr. Joan Ablon who counselled me wisely through the difficult times that occurred in my fieldwork, as well as to Mr. James Gray and Dr. Reynaldo Maduro who both gave me invaluable guidance and tutoring in the realities of ethnic research. To the personnel of San Francisco General Hospital and the Multi-Cultural Program whose work and lives make up the substance of this dissertation, I extend my most humble and heartfelt thankfulness.

A number of research participants critiqued my dissertation for accuracy of facts and interpretations. These readers spent long hours on this effort and while each of them knows who they are, I would like to thank publically those who gave their consent for acknowledgement.

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Dr. Dick Fine, M.D., Chief and Director, General Medical Clinics, San Francisco General Hospital

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CHAPTER 1

INTRODUCTION

Research Question:

In April 1978, a new type of health personnel was introduced into the City and County hospital of San Francisco General Medical Center (referred to hereafter as "San Francisco General Hospital"). The official title given these personnel was "Interpreter Patient Assistants", and their mandate was to serve as language translators for non-English speaking patients. This dissertation focuses on the role that was to develop for the language translators over a 22-month period and to analyze the forces that were to shape the definition and evolution of that role.

My interest in the role of medical language translators developed during participation in the initial six-week training program for the first group of translators recruited into the Multicultural Program ("MCP") in April 1978. I viewed these translators as interjected third parties to the normally dyadic healer-patient relationship. They also would represent a potential cultural translator for both the Western provider and the foreign-born patient. Given the increasing non-English speaking population in the United States (U.S. Department of Justice 1978), and the dilemmas that linguistic and cultural pluralism present to the patient-provider relationship, I

viewed the phenomenon of bilingual translator personnel as signifying an important trend in health care policy making as well as in the future practice of medicine in our increasingly diverse population.

My research documents the role evolution of the language translators at San Francisco General Hospital ("SFGH"), describes the structural factors that determined the role functions of translators, and assesses the impact of the personnel on the delivery of health care to the non-English speaking patients. The research population consists of the new personnel in the Multicultural Program and a stratified sample of the hospital personnel composed of administrators and primary care providers.

Research Setting:

The medical complex of San Francisco General Hospital covers two square city blocks of a sloping hill in the southeast section of San Francisco that overlooks the Mission valley and the hills of Diamond Heights and Twin Peaks that rise to the west. The grounds of San Francisco General Hospital house an assortment of new and old buildings. The old red brick buildings of an ornate Italian architectural style of the 1920s stand in contrast to the stark concrete gray buildings of the 1970s. The red brick buildings of the former hospital are now used as offices. The new, seven-

story concrete gray medical center is snuggled behind the old buildings and extends back to the freeway. The carefully landscaped grounds, the front entrance fountain, and the large, ultra-modern sculptures attempt to project an image of affluence. The building's size and newness suggest broad-ranging, medical modernity and scientific expertise. To the newcomer the San Francisco General Hospital medical complex is an intimidating and awesome sight.

In terms of functional size, San Francisco General Hospital is licensed for 653 hospital beds and lists 411 beds as available for use (WBAHA Study Report 1980). In the fiscal year 1979 there were 127,000 out-patient admissions, 79,000 Emergency Room visits, and 193,000 out-patient visits. The annual budget runs approximately $60 million and employs approximately 2,300 people with a nursing staff of about 500 registered and licensed vocational nurses (WBAHA Study Report 1980; Department of Public Health Affirmative Action Report 1981).

Medical personnel and all physician services are contracted from the University of California, San Francisco School of Medicine. All attending physicians are University-appointed faculty and the City pays each University department for a given contracted number of physician hours for clinical services at San Francisco General Hospital. In the fiscal year 1978-79 this amounted to $2.7 million for

approximately 2000 hours per week, i.e. 50 Full Time Equivalents (FTE's) from the University of California, San Francisco (WBAHA Study Report 1980:23). Additional physician personnel hours are realized from research fellows and resident staff in training, both of which are funded from outside sources. A more extensive description of San Francisco General Hospital is offered in Chapter III. The range of clinical services and special service programs provided in the medical center are outlined in Appendix I.

The Fieldwork Process:

A. Gaining entre

Fieldwork officially began in October 1978, following a protracted five-month period of negotiation that occurred partly as a result of the reshuffling of the Multicultural Program's top administrative personnel, but also due in part to the political sensitivity of my research request. This request to document the role that was to evolve for the language translators evoked sharp debate among the program personnel. An important issue involved in the debate was my Anglo ethnicity. As friends in this program were to tell me later:

> "You are unmistakenly Anglo. You can't pass for anything but what you are, White! And that's the wrong thing to be around here."

The performance of previous white social scientists,

who were reported as coming in and collecting the information they wanted and then disappearing never to be heard from again, added to the MCP personnel's resistance to allowing another white social scientist to study them. Furthermore, my request was cited by these research-wise individuals as part of an educational pattern in which the poor and minority groups are used as "training fodder" for the career advancement of "white folk". There is no defense against this historical fact of the social and medical sciences; thus I found that gaining entry to this research setting required time for the prospective participants to get to know me and to negotiate reciprocity terms for their participation in my study. Most often this involved my willingness to help them with problems associated with work, to be a social companion, or to listen to their personal problems. Permission depended not only on the merit of my research proposal and my educational qualifications, but on whether or not they _personally_ liked me. Their acceptance of me depended on my political views on issues such as racism in social science, civil rights, affirmative action programs, as well as my ability to relate to others in a socially appropriate and friendly manner. I was quizzed incessantly about both my political-social views and all aspects of my personal life. This quizzing continued throughout the fieldwork period.

This evaluation of me as a private person began with my role as teacher. I participated in the six-week training

period at the start of the Multicultural Program, and this preceded my research interests. The course covered material including: cross-cultural comparisons of medical belief systems; dilemmas presented in instances of cultural differences between provider and patient; the values and cultural premises of Western medicine; and, cultural values of American society and its significance for delivery of health care to the poor.

This evaluation of me as a private and social person also served as the basis for the Hospital administrator's evaluation of my research request. The formal permission-seeking interview lasted about 60 minutes and took the form of a casual discussion, albeit under the total direction of the administrator. Instead of questioning me on my research design, methods, risks and benefits, this Executive Director simply talked about his philosophy of health care and the problems of administration in the public sector. I fell into the role of a questioning listener. At the end of the interview hour, the administrator indicated his approval by stating:

> "While you may not have the right ethnic background, you seem to have the sensitivity to do this work."

It became obvious to me in retrospect that the administrator had been closely evaluating me during this interview through my responses to the issues that he raised and that held importance for him.

In negotiating permission with the Multicultural Program administration, it was the fact that I had entered into this setting as a contributor through my volunteer teaching that allowed my research request to be considered at all. This view was emphatically stated during the early negotiation process by the Program Director:

> "I bet I've had 30 requests from State colleges and universities to come study us (MCP program). Now, I know it's important for all these students to get their theses done, but right now (8/1978) they can't contribute to us. They can't help us or facilitate our efforts to get organized and get things stable. Now, we've got problems and who knows how things are going to work out. So I've turned all research requests down 'cept yours. Cause you have been involved since the beginning of this thing and you have helped in the training."

The agreement for entry that I negotiated with the Multicultural Program administration was based on a number of conditions. Firstly, I was to refrain from any type of intervention in their management policies. I was given the following directive: "We don't want someone snooping in our business saying, 'Well, things should be done this way and that way, or you shouldn't have done it this way'." Secondly, any work that I produced from this research would be shared with them as my contribution back to those who gave me so much. And thirdly, each individual had to consent to allow me to work with him or her and this consent could be revoked at any point in the research process. Actual program consent was obtained in a general staff meeting after an open - and heated - discussion. At issue was the ability of a white social scientist

to accurately and objectively study non-white peoples. The majority of the program staff voted to allow me to do my research, and thus the final hurdle was crossed. Implicitly understood but not acknowledged between myself and the program administration, specifically the Director, was that administrative support could be withdrawn at any time should my presence become troublesome in their perception and I would then have to terminate my research relationship with the Multicultural Program personnel.

In an effort to assure that my conclusions reflect an emic view, i.e. that of the insiders, as well as the etic view of the outsider, I have taken the added measure of having all my work reviewed by various parties involved in this social system, which include translators, program administrators, hospital administrators, and direct providers (nurses and physicians). This also includes their review of this dissertation.

B. Personal Methodological Notes:

Upon beginning fieldwork in October 1978, I was required to participate as an instructor in eight weeks of training for the second group of trainees, which included both language translator and patient representative personnel. While the training activity consumed two months of my time, it justified my daily presence. My right to be ever present

was never challenged thereafter, despite an early stipulation that I only do six hours per week of fieldwork. This initial two-month period served as a critical "getting to know you" time. It gave me time to build up trust and rapport with program staff while they decided whether they wanted to participate in my research and on what reciprocal terms. By the time that I actually approached individual translators for consent, they had had two to four months in which to evaluate me. No one refused my direct requests for research participation. In retrospect, I would advocate this delay between field entry and data collection as an important methodological technique for establishing the rapport and trust needed to support a researcher/study participant relationship.

During the first eight months of fieldwork, I maintained a 40-hour-a-week presence, and as a result of this full-time staff like role in the training processes, I came to be included in most program activities, e.g., general interdepartmental, and supervisorial staff meetings, as well as social functions. In my efforts to ensure the continued consent of the MCP administration, I socialized with them individually and as a group, on and off the job. I socialized in a similar manner with approximately eight staff members who came to be my key research participants.

Labor/management conflicts which existed as a constant in the social organization of the Multicultural Program

escalated to a frank and protracted confrontation 14 months into the fieldwork. To minimize the risk of losing entry permission I assumed a non-aligned, neutral position throughout the confrontation. Neither side trusted this position, however, and as the labor/management conflict escalated, so too did each side's unease over my research presence. Also still inextricably tied to the participants' discomfort over my research presence was the issue of my ethnicity. Even my closest study participant let me know that in this kind of setting I would always be suspect and that even she could not trust me completely. Seeing my own distress over this reality, she tried to comfort me by explaining that it wasn't personal, stating:

> "It's because you are white, and the history of the white man -- how he has treated all non-whites ever. You just never trust a white person."

My anglo ethnicity also operated in other ways to complicate my data collection efforts. I found that while I may have established rapport, friendship and trust with an individual at one point, if I stayed away, or worked in another hospital area or shift, so that contact with that individual was temporarily lost, so too would be the relationship. The experience of chronic rejection, and uncertainty of the responses that I would receive, provided what I believe to be first-hand experience of what it is like to be a minority in this country. I must add that the experience of having to operate as a culturally isolated person in a non-accepting social milieu, of having to work hard to win personal accept-

ance, and then exert constant efforts to maintain that acceptance and cooperation evoked fear, dread, avoidance conflicts, and anger. Many times I took accusations and rebuffs personally rather than as directed towards the social person that I represent and the history tied to that legacy.

My field notes abound with wishes to withdraw from fieldwork as well as wanting it to be over. At times I detested fieldwork and all the people associated with the setting. Another condition that operated to increase the stress of this fieldwork was my private social and cultural isolation. The task of fieldwork totally consumed me so that my social network could not tolerate the topic, meaning that I had no one in my social world with whom to talk about my work. As I neared the end and was doing marathon hours of fieldwork in order to interview participants before they left SFGH and the area, my erratic and unpredictable hours kept me unavailable for any social interaction with friends. Without a doubt, this loneliness and isolation throughout my fieldwork had to affect my perceptions and recording of data. Fieldwork as the key data-gathering method in anthropology, and its requirement for continual presence in many levels of the research participants' social lives, taxes the emotional, psychological and rational fiber of the social scientist. I conclude from this experience that one does not have to leave home for far-away places to experience the deprivation, alienation and culture shock of fieldwork that serve as the time-honored "rite of passage" ritual in anthropology. Fieldwork in any setting is an in-

tensely emotional experience, and the human being as research instrument is fallible. Innumerable vulnerabilities make objectivity something to be sought after, but never fully realized.

I finished my fieldwork at San Francisco General Hospital in February 1980, just 22 months after walking into the classroom of the first group of translator trainees. I remained in periodic contact with the Multicultural Program personnel, as well as with those no longer involved with the Multicultural Program, over the year and a half between the conclusion of my fieldwork and completion of this dissertation. My return visits were always warmly received.

This reaction indicates to me that once the researcher is no longer in a dependent-taking position but still opts to maintain contact with former study participants, genuine acceptance occurs. The researcher's motives are less suspect, and the fact that the researcher communicates caring and acceptance to the research participants. I also suspect that the researcher's return symbolizes a rising above of the politics of race relations and power conflicts between whites and non-whites, that indeed one has "not taken it personally". A new dimension of relief, appreciation, and trust is formed between the researcher and former study participants.

I also continued to be invited to teach the course, "Cultural Aspects of Health Care" to the new trainees, so

that from April 1978 to February 1981 I taught eight groups of translator trainees.

I was able to maintain a good working relationship with the individual who came to be the Assistant Director as well as with the new administrative personnel hired after I had officially concluded fieldwork. Thus, I was able to keep abreast of new developments and received much assistance from these new administrators in their critique of my work, the provision of statistics and other background information essential to documenting the history of the Multicultural Program and the impact of its personnel on the delivery of health care to the non-English speaking patient.

Emotionally, this fieldwork caused me great pain, sorrow, despair, anger, and frustration; but it also brought me joy, satisfaction, tenderness, companionship and love. On the one hand I would be depressed and angry for months at a time over my helplessness to intervene in even the simplest communication misunderstandings (due to my promise not to intervene) and my physical health during these periods would reflect my mental state; on the other hand much of the nurturing, love and caring that I received during this period of my existence came from the individuals who made up my research population.

Study Population:

The study population is defined as the Multicultural Program (MCP) administration, and the first and second group of trainees - 46 individuals in all.

Throughout the first 18 months of the Multicultural Program operations, program personnel consisted of 26 translators, three supervisors, four administrators, and one secretary. The second group of trainees, starting in October 1978, included four translators from the first group who were being retrained to work as patient representatives (see Chapter IV), and new staff of four Hispanics, two Chinese and four Blacks. Attrition within the first group reduced their ranks from 33 supervisors and translator staff to 28 by October 1978, and to 26 by December. Thus, the addition of six new bilingual staff from the second group merely kept constant the number of translator personnel.

Data were collected on 29 of the 46 MCP program personnel for a participation rate of 63 percent. The 17 non-participants were excluded from the study for the following reasons: 11 left the program early in their MCP employment and before I could establish a research relationship with them; two were deliberately not recruited for participation; two chose not to participate. I chose not to interview or actively work with two individuals because I felt one to be marginal to the program and the other to be psychologically too fragile. The two individuals who chose not to participate

were an elderly male and female and of different ethnicity. One explained her reason for refusal to a friend, saying that she felt that she had not worked as a translator and therefore did not have anything to say. The second person voiced strong objections to allowing anyone to study or write about him and his remarkable career, saying; "because then they (researchers) get all the credit for all I've done." Due to time constraints I was unable to interview two consenting participants before their CETA (Comprehensive Employment Training Act) employment expired.

Table 1 summarizes the sociodemographic characteristics of the Multicultural Program personnel eligible for study participation by age decade, sex, language group, ethnicity, and marital status. Language group for the MCP personnel showed the following distribution: 54 percent (n=25) Spanish; 22 percent (n=10 Chinese; 11 percent (n=5) English-speaking Blacks; and 13 percent (n=6) Single Languages (Korean, Tagalog, Samoan, Cambodian, Arabic and Sign). The term, "single language" means those language groups for which there was only one translator position awarded to the MCP program. There were 26 females and 20 males (57 versus 43 percent) in the MCP personnel, and approximately two-thirds of the personnel were less than 39 years of age.

TABLE 1. Eligible Multicultural Program Personnel by age decade, sex, language group and marital status.

	20-29		30-39		40-49		50-59		60-69		Total			
	M	F	M	F	M	F	M	F	M	F	M	F		
Spanish													n	%
married	-	2	4	1	-	3	-	-	-	-	4	6		
divorced	-	-	1	2	-	2	-	-	-	-	1	4		
never married	2	5	-	1	1	1	-	-	-	-	3	7		
											8	17	25	54
Chinese														
married	1	1	3	-	1	1	-	-	3	-	8	2		
divorced	-	-	-	-	-	-	-	-	-	-	0	0		
never married	-	-	-	-	-	-	-	-	-	-	0	0		
											8	2	10	22
Single Languages														
married	1	2	1	-	-	-	-	-	-	-	2	2		
divorced	-	-	-	1	-	-	-	-	-	-	-	1		
never married	1	-	-	-	-	-	-	-	-	-	1	-		
											3	3	6	13
English (Blacks)														
married	-	-	-	-	-	1	-	1	-	1	0	3		
divorced	-	-	-	1	1	-	-	-	-	-	1	1		
never married	-	-	-	-	-	-	-	-	-	-	0	0		
											1	4	5	11
Total	5	11	9	6	3	8	0	1	3	1	20	26	46	100%
n=	16	(35%)	15	(35%)	11	(24%)	1	(2 %)	4	(9%)	(43%)	(57%)		

Comparisons of age and sex characteristics of each ethnic group show marked dissimilarities between the groups. Within the Spanish and Black groups, approximately 70 percent were female, in contrast to the Chinese group in which 80 percent were male. Also, among the Spanish, 26 percent had never been married, and 38 percent (n=9) were less than 30 years of age. The Chinese in contrast were all married and tended to be older; only two individuals were under 30 years of age, but three individuals were 60 years or older. The Blacks also tended to be older; their ages ranged from 34 to 64 years, and all had been married and had teenage and/or adult children. Single language translators ranged from 25 years to 35 years of age, and all but one were married. As will be shown in later chapters age, sex, marital status and life cycle are important to the manner in which translators performed their translator role.

Table 2 describes the socio-demographic characteristics of the non-participants (those who were eligible but not included in the study) for language grouping, age decade, marital status and sex. Language groupings for participants and non-participants shows the following distribution: Spanish 52 and 58 percent; Chinese 24 and 18 percent; Single Language 14 and 12 percent; English (Blacks) 10 and 12 percent, respectively. These same proportions in the general MCP population are 54 percent, 22 percent, 13 percent, and 11 percent, respectively. Comparisons on sex show that there are an equal number of male

TABLE 2: Nonparticipants in the Multicultural Program Personnel by age decade, sex, language group and marital status

Language Group	20-29		30-39		40-49		50-59		60-69		Total			
	M	F	M	F	M	F	M	F	M	F	M	F	n	%
Spanish														
married	-	1	1	-	-	-	-	-	-	-	1	1		
divorced	-	-	1	1	-	1	-	-	-	-	1	2		
never married	1	3	-	-	1	-	-	-	-	-	2	3		
											4	6	10	58
Chinese														
married	-	-	2	-	-	-	-	-	1	-	3	0		
divorced	-	-	-	-	-	-	-	-	-	-	0	0		
never married	-	-	-	-	-	-	-	-	-	-	0	0		
											3	0	3	18
Single Languages														
married	-	1	1	-	-	-	-	-	-	-	1	1		
divorced	-	-	-	-	-	-	-	-	-	-	0	0		
never married	-	-	-	-	-	-	-	-	-	-	0	0		
											1	1	2	12
English (Black)														
married	-	-	-	-	-	-	-	-	-	1	0	1		
divorced	-	-	-	-	1	-	-	-	-	-	1	0		
never married	-	-	-	-	-	-	-	-	-	-	0	0		
											1	1	2	12
Total	1	5	5	1	2	1	0	0	1	1	9	8	17	100%
	(35%)		(35%)		(18%)				(12%)		(53%)	(47%)		

and female non-participants, but a greater proportion of female to male participants. In the general MCP personnel, females outnumbered males 57 (n=26) percent to 43 percent (n=20).

The age decade distribution for the total study population is shown in Table 1 to be as follows: 20-29 years -- 35 percent; 30-39 years -- 33 percent; 40-49 years -- 24 percent; 50-59 years -- 2 percent; and 60-69 years -- 8 percent. In comparison, the age decade distribution for participants and non-participants demonstrates the following proportions: 20-29 years -- 31 and 35 percent; 30-39 years -- 31 and 35 percent; 40-49 years -- 28 and 18

percent; 50-59 years -- 3 and 0 percent; and 60-69 years 7 and 12 percent, respectively. While the actual numbers are small, these percentage comparisons are presented to demonstrate the sociodemographic similarities between the study participants and non-participants. The study participants represent a healthy cross-section of the total population eligible for study.

Field Methods:

Data were collected in the classic anthropological fashion of adopting a "continuous presence" so as to experience the life of those studied as much as possible. At the same time the researcher observes and questions the study participants so as to build a cumulative body of information. I used this traditional "participant-observation" method in conjunction with informal and formal interviewing, which meant that I was constantly seeking information from and the views and attitudes of the participants. I also attended all levels of personnel meetings and accompanied translators as they went about their daily work. In this way I was able to cover each of the clinical areas where a translator was assigned, for a total of eight translators. I would accompany translators who made up the float pool or the evening shift as they went from one site to another.

The bulk of the participant-observational data were collected through observation of 15 key study participants: eight held translator positions, four were assigned to patient rep-

resentative positions, and three were supervisory/administrative personnel. In order to protect the key study participants' identities, sociodemographic descriptions are not presented in table form but by single variables as follows: language groups -- 7 Spanish, 3 Chinese, 2 Single Language, and 3 English (Blacks); sex -- 6 males and 9 females; marital status -- 9 married, 2 divorced and 4 never married; age decade -- 20-29 years -5, 30-39 years - 3, 40-49 years - 5, 50-59 years - 1 and, 60-69 years - 1. For the key study participants other than the English language group, the length of stay in the United States for native-born and foreign born ranged from six months to 42 years, with a medium of 25 years and a mean of 16.5 years. Of the 11 key participants who were married and divorced, seven had children in their teens and/or early adulthood, and four had infants and/or young children. Within this group all but one had chosen their spouse or partner from within their own ethnic group. Nine of the key participants lived in ethnically segregated neighborhoods, two lived in areas boardering ethnic enclaves, and four lived in suburban and/or anglo residential areas in the San Francisco Bay Area.

The clinical areas represented by eight translators of the 15 key participants are the following: gynecology-obstetrics out-patient clinic, labor and delivery, surgical, orthopedics, and eye-ear-nose-throat out-patient clinics, emergency room and the adult medical out-patient clinic. I depended heavily on the floating translator personnel (n=3) for case data in the clinical areas of pediatrics, psychiatry,

family practice and in the medical-surgical in-patient wards, since these units tended not to have permanently stationed translators during this phase of fieldwork. Key participants represent those individuals with whom I was able to establish the level of rapport sufficient to support the imposition of intensive and prolonged observation.

Maintaining a 40 hour work week for the first eight months of my fieldwork allowed me to carry out ongoing, informal interviews with about 90 percent of the MCP personnel, as well as with numerous hospital staff. These observational and interview data then structured the focus of the final phase of data collection in the formal interviews. The 15 key research participants were interviewed formally twice, and the remaining 29 were interviewed once. Most of the formal interviews were taped. I completed all aspects of data collection with the Multicultural Program personnel in December 1979.

Interviews with nurses and physicians occurred as described above throughout the fieldwork period, but the formal interviews were concentrated in the period of December 1979 through February 1980. A total of 27 physicians, 11 nurses, and five SFGH administrators were formally interviewed. After the completion of fieldwork, I typed, coded and analyzed fieldnotes for the following five months. I had begun the analysis process during the

period of data collection by writing a summary analysis of my observations, outlining the conditions characterizing specific interactions, events, changes, and my explanation for the reasons for those changes. This technique ensured that I was not missing general patterns and/or the trend of those patterns over time. It also served to focus my thinking and to create new directions and questions to address in my fieldwork.

After completing the typing and coding of my fieldnotes, I did five months of historical library research and additional interviews with government agency personnel and ethnic community leaders to provide a historical and political context of San Francisco General Hospital. From beginning to completion, this task has taken three years and five months.

<u>Theoretical Framework</u>:

The creation of the "Interpreter Patient Assistant" role within the institutional context of the Multicultural Program and San Francisco General Hospital offered an unusual opportunity for an anthropologist to document the historical conditions that demanded the role be created, the social forces that influenced the shaping of that role over time, and the effect of these personnels' activity on the social system of San Francisco General Hospital. This focus represents a classic social anthropological approach, and so I relied

heavily on the concepts of social structure (Radcliffe-Brown 1940, 1965), social organization (Firth 1954, 1961, 1965), and role analysis (Nadel 1951; 1957). To understand the actions of individuals and the motivations behind their actions, however, I depended upon the concepts of the individual as a self-interested actor (Barth 1966), conflict and social change (Gluckman 1940; Leach 1954), social networks (Barnes 1954, 1966; Boissevain 1968; Bott 1957) and social networks and the controlling affect of gossip (Epstein 1969).

For analytic techniques I used Victor Turner's "social drama" method in which crisis situations are presented to illustrate the basic features and workings of a group's social structure. (See Chapter IV). My applied interests led me to focus on the work actually performed by the personnel within the institution of San Francisco General Hospital. I wanted to answer not only what translators did, but why they did what they did (see Chapter V); and to have validity I thought that these observations should be placed in a historical context as well as span over a period of time (see Chapters II, IV). Thus, I choose an evolving, diachronic approach rather than a synchronic, point-in-time description. Also, my keen interest in the problems inherent in patient-provider relationships in the United States health care system led me to do a microanalysis of the patient-provider interaction of which Goffman's work (1963) serves as an example (see Chapters VI, VII).

Organizational Framework:

In order to explain the determinants of the language translator role at San Francisco General Hospital, I will first analyze the social system of the institutional setting, as well as its relationship to the larger social system of the City and County government of San Francisco. And again, little of the present can be understood or explained without examining the historical events, attitudes and inter-group relationships of the past that laid the groundwork for the present. Thus, Part I of this dissertation contains an account of the history of San Francisco and traces the economic, political and cultural factors responsible for the current culture and social structure of San Francisco. Part II will relate the significance of this structure to the role that language translators came to have at San Francisco General Hospital (SFGH). Part III presents the summary analysis of the triadic patient-translator-provider interaction, the evolutionary outcome of the Multicultural Program and its translator personnel, discussion of the findings, statement of the art, and recommendations for health care administrators and providers.

Chapter I introduces the dissertation. Chapter II contains a historical overview of San Francisco from 1850 to the present and focuses on the ethnic groups that have immigrated to San Francisco and their economic and political relationships to one another over that time. The current geographic layout of

the city is presented and gives the ethnic compositions and socio-economic indices by districts. The history of San Francisco General Hospital is presented in Chapter III and delineates its governance form and the consequences of this structure for the way work is performed, specifically, the delivery of patient care. This discussion of SFGH's social structure includes its relationship to the University of California San Francisco, to city government, and to the ethnic communities represented by its patient population.

The history of the Multicultural Program is covered in Chapter IV starting with the conditions that led to the introduction of language services at San Francisco General Hospital, and concluding with the political and economic constraints that affected its social form over the three year study period.

Chapter V in Part II begins the analysis of the language translator role, specifying its content and status within the structure of SFGH, and examines three levels of influencing factors: 1) the correlation of the sociodemographics of the individual translators with variation in the range of functions performed within the role; 2) variations in role expectations of translators by health care providers and the strategies adopted by translators for managing the uncertainty of expectations; and 3) the macrosocial constraints and conditions that affected the development and evolution of the translator

role. Chapter VI examines the triadic patient-translator-provider interaction and provides the data upon which the trust bond model presented in Chapter VII is based.

The summary and conclusion of this research are found in Part III. Chapter VIII summarizes the characteristics, conditions and outcome of the triadic patient-translator-provider interaction. Recommendations for health care delivery and program planning in culturally diverse settings, given the political reality of state and federal civil rights legislation and minority militance of the 1980s are outlined in Chapter VIII. The last section of Chapter VIII is my statement on the contributions that social science can make to medicine. This statement is directed as a challenge to social scientists and as an explanation to health care providers who remain uncertain of the benefits of social science in the world of applied medicine.

CHAPTER II

THE WHITE/NON-WHITE DICHOTOMY IN SAN FRANCISCO'S RACIAL AND CULTURAL HISTORY

Color, Language and Power:

The social phenomenon of non-white lobbying groups, such as Latinos for Emergency Bilingual Health Services (LEBHS) and Chinese for Affirmative Action (CAA) putting pressure on the city of San Francisco to provide bilingual services is inextricably bound to San Francisco's ethnic history. It is a peculiar history due to an almost instantaneous urbanization resulting from the Gold Rush of 1849 (Lotchin 1974), and also because the social structure that evolved was created from an ethnically diverse population of newcomers (US born migrants and immigrants) -- but as a class structure that was tied to a white/non-white dichotomy from the city's inception.

The social groups designated as non-whites i.e., Chinese, American Indians, Blacks, and later Japanese and Mexicans, were systematically denied access to resources that were allowed the white ethnic groups and that were necessary for social and economic mobility (Camarillo 1979; Daniels 1980; Dicker 1979; Hendrick 1977). These non-white groups were barred from owning land, or if they had land, the land was taken from them (Bean 1974 Camarillo 1979; Montesano 1967; Nee and Nee 1972). They were excluded from all but the most menial and lowest pay-

ing jobs by the Irish-dominated labor unions and public opinion (Daniels 1980; Dicker 1979; France 1962; Nee and Nee 1972), and they were not allowed to vote and/or were barred from political power as a vehicle for social mobility (Hendrick 1977; Katznelson 1973; Lortie 1970; Montesano 1967). This subordinate posture of whites towards non-whites was supported by social Darwinist beliefs of the absolute superiority of whites over non-whites, as well as the "manifest destiny" world view that characterized the U.S. frontier society. Exclusion of the non-white ethnic groups from economic and political participation was effected through legislation, court decisions, the apparatus of local community power and by white public opinion (Record 1963; Wirt 1974). Despite the recent elimination of legislative structures, the non-white groups have continued to occupy the lowest socio-economic positions in San Francisco's social structure throughout San Francisco's 130-year history.

World War II caused profound changes in the United States' social climate. The supremacy beliefs of white America were severely strained by the near success of Japan's military challenge; also, the war gave the non-white minorities a chance to participate in the war effort both at home and abroad and to demonstrate their equality with, and sometimes even superiority over whites. The sixties witnessed a nation-wide challenge to the multilevel subjugation of non-whites in the form of the Civil Rights Movement, the 1964 Civil Rights Act, the rise in ethnic militance, and the War on Poverty programs.

The latter placed federal monies in ghetto communities, carrying the stipulation of "grass-roots" participation in program planning and administration. This requirement provided a vehicle for ethnic communities to enter the local political system and placed individual ethnic community leaders into political appointments and elected offices. During the sixties and seventies, the War on Poverty involved San Francisco's non-white ethnic communities in local political life in a participatory manner that had previously been denied them, training them in political strategies, and finally allowing for their representation. Basically, this means that the Black, Hispanic and Chinese communities entered the political arena only 20 years ago, and consequently their power to command political responsiveness to their respective communities' needs is still being strenuously resisted by the white-dominated power elite (Lapp 1979; Nee and Nee 1972; Wirt 1974; Wong 1977).

The leadership within both LEBHS and CAA emerged from the aftermath of the ethnic consciousness that followed the Black-led "Third World" student strikes at San Francisco State University and the University of California, Berkeley in 1968. As educated professionals and community activists, the leaders use and continue to use the fighting strategies learned through their student confrontation experiences to achieve gains in economic and political power. It was clearly understood by the Latino and Chinese activists in their tactics for fighting with the city and with the SFGH administration over their de-

mand for language services that the American ideal of equal opportunity for all applies as long as a given social group possesses enough political power to take what it wants (personal interviews Feb. - June 1981).

The pattern of the present power distribution in the city was formed in the first decades of San Francisco's history. Thus, in order to explain the role that ethnicity plays in the behavior patterns observed at San Francisco General Hospital, and in the larger social structure that envelops SFGH I will briefly outline the ethnic history of San Francisco starting with its Gold Rush beginnings in 1850.

The White Ethnic Groups:

The major white ethnic groups which divided up political and economic power in early San Francisco were the native Yankees (Anglo-Saxons), German Jews, Italians from northern and central Italy, and the Irish (Wirt 1974). Each group dominated specific and mutually exclusive arenas in San Francisco's economic structure.

The Yankees and German Jews mostly made their early fortunes as merchants and bankers serving the miners in the northern California gold mines (Lotchin 1974; Wirt 1974). The Italians monopolized the fishing, agriculture and food industries, as well as the marketing connected with these

industries (Gumina 1978; Radin 1935). The Irish entered San Francisco largely as unskilled laborers, but brought with them from their long subjugation under English rule a tendancy toward militance, good organizing skills and a strong political orientation (Katznelson 1973; O'Grady 1973; Wakin 1976; Walsh 1978; Wirt 1974). The Irish used these skills to organize the large labor population (including Germans, English, Polish, Slav immigrants) in San Francisco into a political force that dominated the city well into the 20th century, and to control the assignment of jobs even into the 1960s. In addition to their control of the labor unions, the Irish monopolized the Catholic Church and the civil service system -- most importantly the fire and police departments (Hansen and Quinn 1981; Wirt 1974).

The Yankees and German Jews emerged in the 1850s as the wielders of economic and political power and went on to form the upper stratum of San Francisco's society where they remain to the present day (SF League of Women Voters, interview 1981; Wirt 1974). Whereas the Italians achieved economic wealth decades later in the 1880s they steadfastly avoided political participation due to their traditional mistrust of government (Gumina 1978). In contrast, the Irish seized political power through their organization of the labor movement, and by 1880 they had successfully challenged the big business Yankee/Jewish political power monopoly. The Irish maintained this power base until their

gradual and steady economic mobility thrust them out of the working class into the middle and upper middle-classes by the 1960s, and for the Irish that achieved upper middle-class they went on in quest of upper class "respectability" (Walsh 1979; Wirt 1974).

That subgroup of Irish which achieved upper middle-class status adopted the same social behavior patterns of the Yankee/Jewish Republican elite, i.e., they dropped their Democratic party working-class political ties, withdrew from political offices, and moved into the suburbs or the more exclusive areas in the city (SF League of Women Voters 1981 Wirt 1974).

The working-class third and fourth generation Italians began to migrate to the suburbs as their acculturation and social mobility nullified their needs for the insularity afforded them by North Beach and other enclaves throughout the city (Gumina 1978). However, with the decreased political participation of the Irish during the 1960s the Italians began to seek political office, as did the Jews and members from the non-white ethnic groups (Wirt 1974). As the Italians and Irish left their homes in the Sunset, Richmond, Mission, and Ocean/Merced/Ingleside districts for the suburbs in the early 1960s, middle-class Blacks and Chinese moved out of their respective ghettos into housing that previously had been denied them by restrictive real estate

covenants (France 1962; Lapp 1979; Nee and Nee 1972). The Mission district also experienced a dramatic change in the composition of its population during the 1960s. Housing vacated by the Irish and Italian exodus was filled just as rapidly by an influx of Central and South American immigrants, predominantly Nicaraguans, Guatemalans, and Salvadoreans (SF Examiner 6/19/72).

Table 3. Foreign Born Population of California's Major Immigrant Groups from 1850 to 1940.

Immigrant Group	Census Year									
	1850	1860	1870	1880	1890	1900	1910	1920	1930	1940
Chinese	660	34,935	48,790	74,548	71,066	40,262	27,778	19,456	20,041	16,676
Japanese	-	-	32	133	1,224	10,264	38,184	51,138	48,477	33,569
Mexican	6,454	9,150	8,978	8,648	7,164	8,086	33,444	86,610	368,013	*
Irish	2,452	33,147	54,421	62,962	63,138	44,476	52,475	45,308	45,385	34,799
Italian	228	2,805	4,660	7,537	15,495	22,777	63,601	88,502	107,249	100,911
English	3,050	12,227	19,202	24,657	35,457	35,746	48,667	58,572	85,025	73,345
French	1,546	8,462	8,063	9,550	11,855	12,256	17,390	20,387	21,329	17,696
German	2,926	21,646	29,699	42,532	61,472	72,449	76,305	67,180	81,840	71,727
Portugese	109	1,459	2,459	4,705	9,859	12,068	22,427	24,517	22,711	18,944
Total Population	92,597	379,994	560,247	864,694	1213,398	1485,053	2377,549	3426,861	5677,251	6907,387

* Separate classification for Mexicans was discontinued with the 1940 Census. (table compiled from census data from 1850 through 1940 -- see U.S. Department of Commerce: and from Statistical Yearbook of Immigration and Naturalization, 1978 -- see U.S. Department of Justice).

The Non-White Ethnic Groups:

In early San Francisco, there were basically three non-white ethnic groups: a small settlement of the native Mexican "Californios" and other Spanish-speaking immigrants who lived in the old Mission de Delores (inner Mission District today), a large working-class Chinese population who were restricted to the confines of Chinatown; and a small black population who were scattered throughout the city. Table 3 and Table 4 trace the ethnic composition of San Francisco from 1850 to 1980. While San Francisco has had a large Chinese population from its beginnings, the increase in the size of the Black and Hispanic communities occurred after 1940 and 1960 respectively.

Table 4. Population of San Francisco by Ethnic Groups from 1930-1980

Ethnic Group	1930	1940	1950	1960	1970	1980
White	594969	602701	693888	604403	409285	395082
Hispanic	7922				101901	83373
Black	3803	4846	43502	74383	96078	86414
Chinese	16303	17782	24813	36445	58696	
Filipino		3483		12327	24694	147426
Japanese	6250	5280	5579	9464	11705	
American Indian	151	228	331	1068	2900	3548
Other (non-white)	4996	216	7244	2226	10415	46504
Total Population	634394	634536	775357	740316	715674	678974

(U.S. Department of Commerce 1932, 1943, 1952, 1973; San Francisco Department of City Planning 1981)

Hispanics:

Mexican "Californios" originally owned the majority of land surrounding San Francisco and much of Southern California, but gradually the United States government invalidated the Mexican land grants and awarded these lands to "white" settlers (Camarillo 1979; Coro Foundation 1979; Bean 1973). Almost overnight Hispano-Americans were transformed from a position of equality (even dominance in some parts of California), to one of subjugation and intimidation (Lotchin 1974). Consequently, when the large Mexican immigration began in the 1920s, the Mexicans entered California and San Francisco without a resourceful host group and without resources themselves (in contrast to the Italian immigration occurring at the same time). Their large numbers, lower socio-economic status, and their use by industry and agriculture as a cheap labor source, caused their previous "white" color status, designated in the 1849 California constitution, to slide over into a "non-white" status in schools and in residential segregation legislation by 1935 and to be excluded from labor-controlled jobs in the city (Hendrick 1977). The U.S. Census categorized Mexicans separately until 1930 when, in response to a formal protest by the Mexican government, they were included in the "white" category (Hendrick 1977). But as Camarillo (1979) observes, Mexican-Americans, while accorded a legal status of white have been socially categorized as non-white within California since

their first contact with U.S. settlers.

Mexican immigrants into San Francisco during the first half of the century assumed their place at the bottom of the social hierarchy as did most new immigrants. Critical to Mexicans' inability to realize social mobility in California, and specifically in San Francisco, however, was their lack of economic resources, urban skills, and political orientation (Bean 1973; Wirt 1974). The Central Americans who began arriving in San Francisco's Mission District in the mid-1960s merely inherited the social and color status assigned to the Mexicans by the dominant white majority in the 1930s. The Spanish surnamed population of the inner Mission increased from 5,531 in 1950 to 11,625 in 1960 and to 23,183 in 1970 (Coro Foundation 1979; see Appendix 1 for ethnic composition by district). For the Mission District as a whole, Spanish surnamed residents represented half the population by 1972 (Coro Foundation 1979; S.F. Examiner 6/19/72:6); and approximately 75 percent by 1980 (U.S. Census Tract by County 1980). The predominant countries of origin for the Mission's Hispanic population are listed in rank order as follows: Mexico, Nicaragua, El Salvador, Guatemala, Puerto Rico, and Peru (U.S. Bureau of the Census 1970; U.S. Immigration Bulletin 1968; 1972, 1976).

The 1980 U.S. Census counted San Francisco's Hispanic population at 83,373, a decrease of about 20,000 from the

1970 census (101,901). This decrease in San Francisco's Hispanic population is puzzling in light of the heavy influx in the late 1970s of civil war refugees from Nicaragua and El Salvador, and a 61 percent increase in the state's Hispanic population. Community leaders claim that the Census did not account for approximately 40,000 recent immigrants here as aliens on temporary visas, or lacking valid visas. Regardless of the "reality" projected from the 1980 census statistics for San Francisco, the health care providers at San Francisco General Hospital state emphatically that their patient clientele over the last four years has become predominantly Hispanic.

Chinese:

The Chinese were severely blocked until after World War II from using the same mechanisms for gaining social mobility in San Francisco that were afforded the "white" immigrant groups. The most far-reaching measures used to curtail Chinese competition were legislation that classified the Chinese as aliens "ineligible" for citizenship (not revoked until 1943) and land laws that prohibited ownership by aliens (Nee and Nee 1972). In addition, the Irish built their labor movement on anti-Chinese prejudice, a fear of the "Yellow Peril", which demanded that this competitive, cheap labor source be removed from the country. This demand resulted in the Chinese immigration laws passed

from 1882 to 1924 (Dicker 1979; Nee and Nee 1972). The Chinese survived in a hostile society by insulating themselves in Chinatown, maintaining their cultural separateness, and adopting an accomodating, silent posture towards the dominant white majority (Dicker 1979; Johnson and Reinhardt 1979; Nee and Nee 1972). The discrimination against and persecution of the Chinese has been thoroughly documented in numerous historical accounts; and is summarized by Johnson and Reinhardt (1979) for its ramification on San Francisco's current ethnic politics:

> "The exploitation and exclusion of the Chinese in the nineteenth century is (sic) the ugliest chapter in San Francisco's history, and it is not over. Although there are now 80,000 to 100,000 Chinese in the city, and old Chinatown has burst its historic boundaries, the Asian community remains isolated from much of the city's economic, political and cultural life" (1979:108)

The social mobility realized by many Chinese today started with the native-born Chinese who spoke English as their first language. This population entered institutions of higher education in the 1940s, building a small professional class within the Chinese community. A small merchant class also developed by the 1950s, but underneath these small strata of upper and middle-class lay a large working class that remained culturally, linguistically, and occupationally tied to Chinatown (see Nee and Nee 1972 for description of Chinatown's menial labor institutions). As a direct consequence of being denied employment and educational opportunities for over 100 years in San Francisco the Chinese

community finds itself in a position of needing to demand affirmative action measures from the city government, such as language translation services for health care, through activists groups such as the Chinese for Affirmative Action (CAA).

<u>Blacks</u>:

With the advent of World War II, the demand for labor in the military and shipping industries became so critical that industry was forced under Executive Orders and Supreme Court rulings to recruit workers among the non-white minorities (France 1962). Thus, the federal government forced industry to bypass Labor's exclusion of Blacks from union membership and union controlled jobs. In response to industry's recruitment, San Francisco's Black population grew from 4,474 in 1940 to 43,503 by 1950 (see Table 5). The Blacks migrating to San Francisco came from rural Texas and Louisiana, lacking in resources, and dependent upon the city for housing (France 1962). The San Francisco Housing Authority constructed public housing according to the federally designated "neighborhood pattern", creating two segregated areas in the city for Blacks to live, Hunters Point and the Western Addition/Fillmore District. Blacks initially were able to move into the Western Addition/Fillmore District due to housing vacated by interned Japanese. By 1960, San Francisco's Black population increased to 74,383, intensifying the popula-

tion density in the segregated Black residential areas and making them true ghettos (France 1962).

Table 5. Growth of San Francisco's Black Population from 1850 to 1980.

	San Francisco			California		
Year	Black		Total	Black		Total
	(n)	(%)		(n)	(%)	
1850	464	.01	30102	962	.006	155900
1860	1176	.02	56802	4086	.017	379994
1870	1330	.008	149473	4272	.007	560247
1880	1628	.007	233959	6018	.007	864694
1890	1847	.006	298997	11322	.009	1213398
1900	1654	.005	342782	11045	.007	1485053
1910	1642	.004	416912	21645	.009	2377549
1920	2414	.005	506672	38763	.011	3426861
1930	3803	.006	634394	81048	.014	5677251
1940	4846	.008	634536	124306	.018	6907387
1950	43502	.05	775357	462000	.044	10586000
1960	74383	.10	740316	884000	.056	15717434
1970	96078	.134	715674	1400000	.070	19971069
1980	86414	.127	678974	1819282	.077	23668562

Figures compiled from the U.S. Department of Commerce 1932, 1493, 1952, 1973, 1975; U.S. Department of the Interior 1883).

While World War II allowed Blacks to realize new levels in civil rights and economic gains, the decrease in jobs following the war resulted in Blacks being the last hired and first fired (France 1962). Unemployment and underemployment again plagued the Black population in the form of labor unions' continued reluctance to hire Blacks in numbers proportionate to the general population. Proportionate hiring was not realized until after the 1964 Civil Rights Act with its subsequent affirmative action programs (Bean 1973; Lapp 1979). Against the backdrop of increasing residential segregation and decreasing educational and occupational opportunities, the Black community in the 60s exploded with the philosophically opposed Civil Rights Protest Movement and the youth-led "Black Revolution", which was centered in the San Francisco Bay Area. The Civil Rights Movement mobilized Black San Franciscans to challenge the hiring practices of private corporate industry as well as those of the city. The Committee of Racial Equality (CORE) introduced the strategy of mass picketing with full media coverage as a power tactic to successfully reduce job discrimination against Blacks in San Francisco. This strategy was later widely adopted by other non-white community leaders as their principal fighting tactic during the 60s and early 70s.

San Francisco's Current Ethnic Political Structure:

The end of the federal poverty programs in the mid-1970s

produced a devastating effect on the Black, Latino and Chinese communities. The most active political leaders inevitably were absorbed by political appointments, advancement to professional schools, or jobs that resulted from their political positions, which then distanced them economically and socially from their communities (Wirt 1974; personal interviews 1981). Gradually the structures of the community's political organization and leadership were dismantled (personal interviews 1981). Most unfortunate of all is the fact that the poverty programs were structured with failure built in, so that no real structural changes in education, jobs, or housing were realized (personal interviews with community leaders and agency personnel 1981). Consequently, the residents in the Mission, Hunters Point, Western Addition/Fillmore, and Chinatown still rank the lowest of all of the city's socioeconomic indices (see Appendix 1 for district statistics).

In mid-1981, the political cohesiveness and leadership of the non-white minority communities in San Francisco are not only suffering from a moderate-radical factionalization, but also from schisms between the native-born and foreign-born, and/or nationality divisions within the Latino and Chinese communities. Possibly the hardest hit is the Mission District's political organization. With the departure of Model Cities programs in 1972, much of the indigenous community organization in the form of the Mission Coalition Organization (MCO) was simply dismantled. The MCO had become inextricably

intertwined with the Model Cities programs in the community and at the city levels via mayoral appointments to commissions and political office (Wirt 1974; personal interviews 1981). As one past Mission community leader described the current state of the Mission political organization:

> "It is a disaster! No one group can represent any of the other groups. It's the Puertoriquenos against the Salvadorenos, against the Nicaraguenses, and all of these against the Mexicans. Then on top of that it's pochos (native born) against the immigrants who come here after they have grown up in their own country. And the cholos -- you see what's happening to our young. They are born here, but they can't be white! The whites won't accept them. They can't be Latino. What's it mean to be Latino? They were born here. They speak English. So, they make up their own culture to survive." (Speaker's emphasis. Personal interview June 1981).

The social reality reflected in this description stands in ironic contrast to the U.S. Bureau of the Census' classification of Hispanics as "white". Socially Hispanics have been categorized as "non-white" since the Gold Rush period. As is clearly evidenced by this Latino father's anguish, in addition to the political and economic struggle of the non-white minorities in San Francisco for equal education and occupational opportunities, a psychological dimension has been added to the struggles of the young. This struggle is poignantly expressed in the words of the native Chinese-American San Franciscan playwright, Frank Chin:

> "I would say that white racism has had no greater success than with Chinese-Americans because, with mass popularization of the stereotype through education, in the mass

media, on all levels of writing from the level of Joseph Conrad and Jack London down to Pearl Buck, over six generations, it has managed to produce a Chinese-American character that is without an ego, that has no self-respect, that has internalized almost fatal suicide doses of self-contempt. A race that has remained silent, has remained completely out of the stream of culture. "(...) The Blacks complain about being emasculated. The genius of white racism in regard to the Chinese is that they never granted them balls in the first place." (as quoted in Nee and Nee 1972:386).

Conclusions and Summary:

The ethnic politics of San Francisco in 1981 remain divided along a white/non-white dichotomy, with militance and rebellion lying dormant in the segregated and lower income non-white ethnic communities in the city. The systematic dismantling of affirmative action and civil rights programs effected by the Reagan administration and the Burger Supreme Court expresses the conservative pendulum swing prevalent today in the United States. This dismantling will serve to perpetuate the structural conditions that first created and now maintain a large lower class. The white supremacy folk prejudices plus the economic and political power that operated from San Francisco's beginnings dictate that this large, lower class will be predominantly non-white.

The intolerance, hostility, and embitterment expressed to me during the course of this fieldwork by white San Franciscans regarding the demands of the ethnic communities for

tax-supported social service programs (such as the bilingual services at SFGH, special job training, free health care, welfare programs, and most importantly affirmative action programs in education and the job market) are due in part to the white population's ignorance of the historical experiences of the non-white ethnics in San Francisco and on the state and national levels as well, In response to the demands of the 1968-1969 "Third World" student strikes in the San Francisco Bay area, ethnic studies programs were instituted throughout the state that have taught ethnic history to non-white students. It is not the unevenness of historical knowledge that makes this situation dangerous, but a condition of "double unawareness" that it supports. The non-whites assume that whites know what has been done to the non-whites in the past, and feel that whites are merely perpetuating that history in their denial of the deliberate historical structuring of the present social inequities. The consequence of this double unawareness between the whites and non-whites is the misreading of each other's motivations in demand-confrontation situations. LEBHS' and CAA's contract negotiations with SFGH serve to demonstrate the dynamics of the double unawareness in which each party perceives the other as lacking "good faith". This atmosphere on a society-wide level creates a bleak future for compromise and political solutions to social problems.

In conclusion, it is my observation that when a class

hierarchy is constructed on a white/non-white dichotomy all segments of the society suffer. Anger and reproach responded to by fear and guilt characterize the non-white/white social interactions in San Francisco, and specifically the provider-patient relationship at San Francisco General Hospital. In the words of Benjamin Davis, editor of the Atlanta Independent in 1914, outlining the costs to the white South for their continued subjugation of the Blacks:

> "...but the whites will not be able to escape the consequences. They will have to bear the economic losses that a large and inefficient mass is certain to inflict, they will be victimized by the diseases that spread death and disaster among poorly housed and miserably environed human beings and they will not escape the deadly blight of the immorality and vice that thrive among the ignorant, the desperate and the neglected poor." (Pollard 1978:27)

The maintenance of a white/non-white dichotomy in our social hierarchy is a luxury that San Francisco (and the larger U.S. society as well) will pay an increasingly dear price to keep. The enlightened militance of two generations in the non-white ethnic groups makes it likely that future political strategies used by community leaders will be far removed from the previous game rules of "working within the system", as exemplified by LEBHS' and CAA's civil rights grievance against SFGH.

Access to quality health care is the specific issue presented in this dissertation, but it is embedded in other "fundamental rights", such as educational and occupational opportunities, which Chinese, Blacks and Hispanics have historically been denied by virtue of their "non-white" status. As political

conservatism dismantles the structural mechanisms for instituting and enforcing affirmative action and civil rights, conflict engendered by the white/non-white dichotomy would appear to have few options for resolution other than social violence. Our health care system is directly tied to the social structure of U.S. society, by virtue of <u>who</u> delivers it, <u>who</u> receives it, and the manner in which it is delivered to different strata of society; and consequently, health care will continue to be political and conflict-laden.

CHAPTER III

HISTORY OF SAN FRANCISCO GENERAL HOSPITAL: CITY GOVERNMENT, UNIVERSITY OF CALIFORNIA MEDICAL CENTER, PERSONNEL AND PATIENT CLIENTEL

Historical Background:

The 130-year history of the city and county hospital of San Francisco is closely intertwined with the ethnic and political history of the City of San Francisco. The city began its role as a health care provider in 1850 by contracting Dr. Alfredo Milhado M.D., to care for the medically indigent. After many reports of his negligence and abuse the city council revoked Dr. Milhado's contract and awarded it to another physician, Dr. Peter Smith. In 1851 the city incurred financial difficulties and refused to honor the script that it had issued Smith for his services. Smith sued and the city was ordered to auction city-owned lands to pay Smith. The result was that valuable property (estimated at that time to be worth over 2 million dollars) was auctioned off for $60,000 cash. (Irvine 1974). This ended the individual physician contract phase of the city's health care system, and began the city's long-term association with medical schools.

In 1854 the North Beach School, near Francisco and Stockton streets, was converted to serve as the city's first hospital. By this time San Francisco's population had increased to about 40,000, and the small 135-bed North Beach hospital could not

keep up with the city's growth. Consequently, numerous wooden shacks were added to handle the communicable diseases, and in 1867 an almshouse was built on the present location of Laguna Honda Hospital to handle the elderly indigent as well as the mentally ill.

Medical schools have been affiliated with the city's hospital from its earliest days. Elias Cooper founded the city's first medical school in a red brick building at Second Avenue and Mission which housed a twelve-member faculty. Based on an apprenticeship system of six months to one year of training, Cooper started teaching anatomy and physiology as the foundation of the training curriculum. By 1860 Cooper's apprentices were serving as the city hospital's physician house staff assuming responsibility for the emergency room, the infectious disease service, and surgery (Curry 1981). In 1864 another aspiring physician, Dr. Hugh Toland, built his medical school across the street from the county hospital, and with Cooper's death that same year the two groups consolidated. However, the overcrowded conditions of the North Beach hospital soon started drawing public criticism and demands that the pestilence housed in the middle of the city be moved. The Board of Supervisors appropriated $250,000 in 1868 for a general hospital of sufficient size to relieve the overcrowding, but only reluctantly agreed to change locations (Irvine 1974).

Toland resisted plans to change the hospital's location

because of its proximity to his medical school; however, factions within the old Cooper faculty pushed for a change to the undeveloped southeast area of the city which would allow for expansion with minimum cost. The ensuing dispute caused the Cooper faculty to split from Toland, but the city followed the Cooper group's recommendation and the new city hospital was erected on the present site at Potrero and 22/23 Avenues (Irvine 1974). The infighting over the hospital's location delayed its construction until 1872, and even then only a temporary building was erected. With the Cooper group's departure, Toland was left with buildings but no faculty. Subsequently, Toland offered his buildings in exchange for faculty through affiliation with the University of California, Berkeley; creating the University of California, San Francisco medical school in 1882 (Curry 1978). The Cooper group eventually affiliated with Leland Stanford to become the Stanford University medical school in 1906 (Irvine 1974). As the two groups formalized into medical schools, they split physician coverage of the hospital until 1958 when the Stanford group moved south to join the Stanford University campus.

The city and county hospital of San Francisco opened in 1872 as a two-story building with "prodigiously" long corridor-like wards having a patient capacity of 400 (Irvine 1974). Even so the city's demand quickly exceeded the hospital's bed capacity, and so new structures were added over the 36 years of its existence until by the time of its destruction in 1908

the hospital consisted of 16 structures. The original hospital structure had been built to serve as a temporary, emergency measure until more monies could be raised and a more permanent facility built. However, as Irvine (1974) so aptly notes:

> Political intrigue, neglect, and many years of graft all combined to keep these temporary buildings going for the next 36 years, and even then, it was only a scandal that brought them down. (Irvine 1974:3)

The scandal that Irvine refers to was the documentation of the spread of communicable diseases (tuberculosis and plague) with the city hospital as the source of contamination. Communicable diseases were rampant during this period of San Francisco's history, e.g., smallpox, cholera, typhoid, tuberculosis and plague, and the city hospital served as the primary care center for patients with these diseases (Irvine 1974). However, due to the conditions of overcrowding, lack of proper facilities for isolation, and insufficient numbers of health personnel to care for the patients (all conditions that reflect a lack of funding), the city hospital acted as a reservoir for infectious diseases and a contagion source (see Report of the Board of Health 1896).

The city's Health Officer was forced to report in 1890 that patients admitted for diagnoses other than tuberculosis were contracting the disease during their hospital stay. In the late 1890s numerous health officials and medical faculty filed reports of the hazardous, unethical conditions at the

city hospital with recommendations that it be destroyed and rebuilt. John M. Williamson, a member of the Board of Health wrote the following passage in the 1896 annual report to the city:

> They (hospital structures) have been allowed to remain in their present situation until they are rapidly falling to pieces from decay. For a quarter of a century they have served as refuge for every known form of disease. They are saturated with filth and impregnated with germs. They are a menace to the health of the community in which they are located. (...) The further continuance is a crime against humanity; and in the interest of common good, they should be demolished. (...) and the erection in its stead of a new structure, modern in its design, intelligent in its conception, scientific in its appliance and to which the city and state may point with pride and not with shame. (As quoted in Irvine).

Mr. Williamson's findings and recommendations went unheeded, as did his colleagues, and other reports of other medical personnel and requests for changes to the mayor and board of supervisors (not unlike the city officials response to the four studies commissioned by them during the 1970s to diagnose the structural ills of SFGH with recommendations for changes that they have ignored (Coordinating Council 1973, Touche Ross 1970; Thompson 1977; West Bay Health Systems Agency 1980).

The medical community vehemently protested to the city when it became clear that their own health was in jeopardy. In 1899, four medical faculty warned city officials:

> The Hospital is becoming a place to contract diseases rather than one to recover from them and not alone the patient but physicians and nurses are being infected. (...) Were it a private institution it would have been condemned and closed several years ago, if for no other reason than that physician and patient would have had nothing to do with it. (as quoted in Irvine 1974:4).

Again, no dialogue for proposed changes at the city hospital was forthcoming from the city officials in response to the warnings of the medical faculty; instead the board of supervisors maintained their "niggardly appropriation of $.50 per day per patient" (Irvine 1974:4).

The presence of plague in the city finally broke the city politicians' resistance to allocating the needed funding to build a proper hospital, but again, it did not happen without considerable conflict and loss of life. The first plague epidemic struck in 1900, but due to feared loss of tourist trade and business a coalition of politicians, newspapers, businessmen and the medical leaders banded together to deny its existence. The medical community was at war with itself. The Public Health Officer was arrested for reporting the presence of plague to the U.S. Public Health Service, and all of the Board of Health officials were fired by the mayor for declaring an epidemic. During this first "non" epidemic there were 113 deaths in the North Beach and Chinatown areas (Curry 1981). A second epidemic followed the 1906 earthquake and fire, involving 166 cases and 77 deaths, but this time there were no cases in Chinatown or North Beach (Curry 1981).

During the second plague outbreak, the city hospital was found to be a resevois source of plague due to its rat population. In a scene reminiscent of Europe's Black Plague of the 16th century, Irvine (1974) describes the conditions underlying the rat infestation:

> The contagious disease pavilion then was a collection of ramshackle buildings, situated apart on the grounds of the Hospital. For it no house staff was supplied, no staff of trained nurses or attendants.... To give care to plague patients in a way that would protect the community was utterly impossible." (Irvine 1974:5)

A night inspection found scores of rats feeding on the cooled remains of a bonfire used to burn the pus-filled dressings from the plague patients. A sample of 100 rats revealed 66 of them to be plague infected (Curry 1981). Further investigation found plague-infested rats in the walls and floors of the operating room. Medical students had long complained that observation floors were so thick with fleas that they had to sit on the backs of the chairs while observing surgery. During the 1906 plague epidemic a nurse, a physician, a patient and an orderly contracted plague at the city hospital (Curry 1981).

Once the findings from the rat inspection were reported, city officials acted quickly to close the hospital. It should be mentioned also that during this period the notorious Ruef political machine (mayor and members of the board of supervisors) was being prosecuted for graft in a reform movement that ended its corrupt control of the city. The new city

officials were more responsive to the conditions at the city hospital than were the former Ruef-Smith administration. Patients were evacuated and SFGH was put under a 40-day quarantine. The Public Health Officer at the time paid a late night visit to the SFGH grounds to ensure personally that the city politicians would build a new hospital. He dropped his lit cigar onto some boards well soaked with gasoline and concluded a chapter in the city hospital's less than noble history (Curry 1981).

The Ingleside race tracks were used for acute care services from 1906 until 1915 when the new San Francisco County Hospital was opened. The new facilities were reasonably well supplied and efficiently designed, allowing the medical staff for the first time to practice a technical quality of medicine comparable to that on the East coast (Irvine 1974). Problems of overcrowding again caught up with the new facility so that bond issues had to be passed in the 1920s for additions that expanded the bed capacity to 1,000. The budget level maintained over the next 40 years, however, did not allow for technological or staffing growth. As Sweet notes in his historical overview of the period:

> The tremendous advances in scientific medicine since 1945 left the Hospital in the backwash in terms of methods, equipment and personnel necessary for practice of the best methods. (Sweet 1974:5).

Formulization of the Relationship between San Francisco General Hospital and University of California, San Francisco:

San Francisco General Hospital had again fallen behind the standards of medicine practiced in the rest of the country. The impetus for change came from the University of California, San Francisco, intern class of 1956. The disenchanted interns systematically documented the conditions within the Hospital which they felt reduced the quality of their medical training to "cheap labor for the City". The interns submitted their report to the executive committee at San Francisco Hospital in December, 1956. Implicit in the power negotiations between the students and the faculty was the threat to go public with their report if no actions were taken by the medical school. (Intern Class Report 1956).

The Intern Class Report (1956) chronicles the staffing shortages in nursing, radiology and laboratory, and the consequences of these shortages on their ability to deliver safe and accurate medical care, as well as for the quality of their training. Standard diagnostic equipment and laboratory supplies were found deficient, absent or non-functional. Under medical education the report criticises the lack of attending contact, resident supervision, and interestingly, the lack of patient contact for anything but routine work-ups. In the cover letter to the medical faculty the intern class warns that of the 48 class members "ten had already written back to their respective medical schools (...) advising against coming

to this hospital for internship", and that others were planning on doing the same (Intern Class Report 1956).

The medical school's correspondence files ~~for~~ this period begin to express fears for UCSF's continued accreditation, as well as for the loss of reputation in medical education circles. In part these fears were realized in the form of a letter from Dr. Gordon Meiklejohn, the Head of the Department of Medicine at the University of Colorado. Dr. Meiklejohn outlined the complaints of his graduates who took their internship at SFGH as being "overly burdened with laboratory work", "exploited as cheap labor by administration", "placed in an inferior position in relation to the nursing staff", and "that administration's interest in supporting a good training program is virtually nil." In conclusion Dr. Meiklejohn informs the U.C. medical staff that:

> "...there has been a gradual loss of prestige of the San Francisco Hospital internship among our graduates and, at the present time, there is a strong feeling that none of them would be wise to consider applying seriously for a position there. I agree with them whole-heartedly and if consulted will attempt to dissuade any of our graduates from applying..."(Meiklejohn 1957)

The University of California, San Francisco medical school was in trouble. The city hospital's deteriorating condition was compromising the quality of medical training to the extent that the future of San Francisco's only medical school was threatened. In the face of this threat the entire medical

community coalesced as a united front and was aided in the ensuing negotiations with the city by the support of powerful philanthrophic figures, church groups and by editorial support from the city's newspapers (UCSF, Dean's Correspondence Files 1957-1959).

The Dean's correspondence files from 1957 to 1959 reveal the careful planning and subtle politicking used to influence the Chief Administrative Officer, the three members of the finance committee from the board of supervisors, and the mayor. The basic strategy consisted of exerting pressure on these key city officials through their friendship ties to the highest socially ranked individuals in the coalition. This informal network strategy succeeded in obtaining from the city a contract for all physician services to be supplied by the University of California, San Francisco, as well as funding to increase staffing and to modernize equipment and facilities.

By 1965 the hospital facilities were 50 years old and their structural inefficiencies were again threatening the hospital with a loss of its licensure and the medical school with a loss of its accreditation (Coulson 1976). The same coalition used to obtain the 1957 contract agreement was again mobilized in 1965 to convince voters to pass a bond issue for the construction of a new modern hospital. The bond issue passed with a 77 percent voter approval and the new seven story concrete SFGH structure was opened for business in July 1976, 11

years after the bond issue was passed. It was not just the architectural layout of the buildings, however, that caused San Francisco General Hospital to run inefficiently as a system.

Governance Form of the City and County of San Francisco San Francisco General Hospital's Social Organization:

San Francisco General Hospital is administered under the control of the Chief Administrative Officer (CAO) and his deputy, the Director of Public Health. Financially, the Board of Supervisors and its Finance Committee, as well as the mayor, control the budget of SFGH. This organizational structure is specified in the city charter of 1937, and can be only minimally affected by the legislative powers of the board of supervisors.

The organizational inefficiency of the current administrative structure of SFGH has been clearly documented in four separate management studies conducted during the 1970s (Coordinating Council 1973; Touch Ross 1970; Thompson 1977; West Bay Health Systems Agency 1980), and is reflective of the type of city government that San Francisco has. It is one which diffuses power among a strong, autonomous city manager (the Chief Administrative Officer is appointed by the mayor for a ten year term), a large 11-member city council (each member of the board of supervisors may be elected by as few as 2,000

voters), and a weak mayorality position that lacks legislative and administrative power (San Francisco League of Women Voters 1967). This diffuse power means that the day-to-day administrative and financial decisions for SFGH as for other city departments are made by the Chief Administrative Officer and the Controller, and that most of the city governance is spent on budget preparation. As a SFGH administrator declared: "Someone should go to jail for the fact that I spend 80 percent of my time on the budget. That is a crime" (personal interview; see Appendix 2 for an illustration of SFGH's budgeting process).

Recommendations for structural changes to relieve the economic and personnel waste caused by the lack of direct management power, bureaucratic complexities of the city government, and basic business inefficiency at SFGH have gone unheeded for reasons outlined by my study participants: jealousy over territory by U.C. physicians and the Chief Administrator Officer, all of whom fear that they will lose power with changes; the hesitation of the board of supervisors to act decisively on an issue that most of them do not understand and are not encouraged by their constituency to resolve; and lastly, the rigidity forced upon city government by an inflexible city charter. This charter is widely acknowledged as unworkable and archaic, but to change it is such a complicated task for voters that charter revisions continually lose at the polls (interview with San Francisco League of Women Voters, February 1981).

The internal scrutiny of U.C.'s structural relationship to SFGH that resulted from the Intern Class Report of 1956 and the subsequent contract negotiations with the city, led to a basic reorganization resulting in greater faculty involvement in terms of time and numbers, as well as to greater organizational autonomy and faculty independence from U.C. Medical Center. These structural changes allowed for the development of a first-rate residency program and vast expansion of medical and specialty services provided by the university medical staff at SFGH. In addition to the usual acute care services provided at major medical centers, SFGH has also developed an extensive out-patient department. Utilizing the 1960s influx of poverty monies earmarked for community based health clinics, SFGH created the Division of Outpatient and Community Services. The SFGH out-patient department operates the adult, children's, family and women's health centers and more than 25 specialty clinics (see Appendix 3 for listing). Three satellite clinics operate as community health centers in the ethnically segregated neighborhoods of the Southeast-Hunter's Point, Potrero Hill and South of Market districts (the Department of Public Health directly administers five district health centers throughout the city).

Description of SFGH's Personnel:

Table 6 delineates SFGH's personnel by sex, ethnicity and a select number of occupational categories. Unevenness is

noted in the predominance of white females (particularly Irish), and Filipino females in the registered nursing categories, the predominance of Black females among licensed vocational nurses and clerical staff, Black males among the orderlies, and the predominance of white males in the skilled craft categories and as physician house staff.

Table 6. San Francisco General Hospital Employees by Occupational Category Ethnicity, and Sex as of June 1980*

	White	Black	Hispanic	Asian	Filipino	Am.Ind.	Malé	Female	Total
1 Resident I	41 (84)	-	3 (6)	5 (10)	-	-	32 (65)	17 (35)	49 (100.0)
Intern	46 (85)	-	3 (5.6)	5 (9.3)	-	-	37 (69)	17 (31)	54 (100.0)
Registered* Nurse	233 (56	32 (7.7)	102 (3.6)	2 (7.7)	28 (24.6)	388 (.4)	416 (6.7)	(93.3)	(100.0)
Licensed* Vocational Nurse	9 (11.3)	53 166.2	3 (3.8)	1 (1.2)	14 (17.5)	-	3 (3.8)	77 (96.2)	80 (100.0)
Orderly*	72 (5.3)	211 (65.3)	15 (4.6)	5 (1.5)	64 (19.8)	1 (.3)	79 (24.5)	244 (75.5)	323 (100.0)
Office and Clerical	64 (20.4)	101 (32.3)	29 (9.2)	42 (13.4)	76 (24.3)	1 (.3)	82 (26.2)	231 (73.8)	313 (100.0)
Skilled Craft Workers	31 (91.2)	-	1 (2.9)	1 (2.9)	1 (2.9)	-	34 (100.0)	-	34 (100.0)
All SFGH Department Totals	M 395 (18.9) F 497 (23.7) 892 (42.6)	M 237 (11.3) F 381 (18.2) 618 (29.6)	M 55 (2.6 F 57 2.7) 112 (5.3)	M 83 (4.0) F 102 (4.9) 185 (8.8)	M 75 (3.6) F 207 (9.9) 282 (13.5)	M 3 (0.1) F 3 (0.1) 6 (.2)	848 (40.5)	1247 (59.5)	2095

*Numbers derived from statistics provided in the DPH, Affirmative Action Plan, 1981 and from statistics provided by the San Francisco Human Ri-hts Commission, June 30, 1980.

The University of California has delineated its faculty and staff at SFGH according to numbers and bilingual capacity. As of March 1980, U.S. listed 150 academic personnel (37 percent with bilingual proficiency, and estimated* as 90 percent male); 216 house staff (40 percent with bilingual proficiency and approximately* 68 percent male); and 250 staff personnel (40 percent with bilingual proficiency and about* 70 percent female) Nelson 1980; * my estimates).

Utilization of Services by Ethnic Population:

The ethnic composition of the patient population which uses the inpatient services and the outpatient clinics has undergone drastic changes from 1975 to the present due to the Southeast Asian refugee influx, the heavy Central American immigration resulting from the civil wars in Nicaragua and El Salvador, and the large numbers of Filipino and Korean immigrants (the first and second largest immigration groups, respectively, since 1972) (U.S. Bureau of the Census, 1980). Most of the Asian immigration to the U.S. is absorbed by the Pacific rim of California, specifically by Los Angeles and San Francisco (U.S. Department of Justice 1970-1980). As an SFGH administrator noted in 1979:

> You know the Statue of Liberty should be moved out of New York to San Francisco, because we are not the home of the poor, the destitute and the political and religious refugees. Nobody is going to New York anymore, they are coming to San Francisco. And we take care of them at San Francisco General Hospital. (personal interview 1979).

A survey conducted in 1977 reported the following ethnic composition for SFGH's patient population:

	In Patient	Out Patient	Total San Francisco Population 1977*
white	46.4%	31%	53.1%
black	23.6%	27%	14.3%
Asian	5.1%	5%	11.7%
Latin	10.6%	20%	13.7%
Filipino	2.9%	11%	4.8%
Am. Indian	0.3%	--	0.5%
Samoan	0.4%	--	0.7%
Other/unknown	10.7%	5%	1.2% (other non-whites)

(West Bay Health Systems Agency 1980)

*Department of Public Health 1980

The differences in the ethnic composition of the in-patient and out-patient statistics reflect the emergency trauma services of the hospital and the city policy that all emergencies are sent to SFGH. Out-patient services are totally voluntary, and as such reflect the populations that depend upon the medical center as their primary source of health care. Asians and whites underutilize the medical center's outpatient services in proportion to their numbers in the total population, whereas Blacks and Latinos are over represented. Thus, Blacks and Latinos are proportionately the heaviest users of SFGH medical center.

Analysis of the 1977 patient survey for the need for translation services revealed that of the 221,080 outpatient visits during 1977, eight percent or 17,686, required translation

assistance. The eight percent of the total population means that 32 percent of all Latino, 31 percent of all Chinese and eight percent of all Filipino patients needed translation services (West Bay Health System Agency 1980). However, in a 14-day survey conducted by the State's Office of Civil Rights in May 1978, a higher proportion of monolingual patients was reported. Of the 60,050 patients processed during this two week period, a full 4,804 or 12.5 percent were determined to be monolingual Spanish. A later survey in the same year determined Chinese monolingual patients to represent three percent of the total patient population. This finding represented a doubling in the proportion of the patient population requiring translation services between 1977 and 1978. As late as March 1981 informal estimates by the physician faculty indicate that this proportion continued to increase. The physician staff of the out-patient Pediatric and Adult Medical Clinics estimate that about 50 percent of their patients are Latino, 40 percent of whom are monolingual Spanish.

As can be seen from the city map in Appendix 1, the areas nearest to San Francisco General Hospital includes the highest concentrations of the non-white ethnic populations in the city's districts with the exception of Chinatown and the Fillmore/ Western Addition. Table 7 illustrates the ethnic composition of the following areas surrounding SFGH: Potrero Hill, Bayview-Hunders Point, South of Market, Mission and Inner Mission.

Table 7. Ethnic Composition of the Residential Areas Surrounding SFGH (1978) by percentage

Ethnic Category	Potrero Hill	Bayview Hunter's Point	South of Market	Mission	Inner Mission
White	45(%)	20(%)	39(%)	49(%)	26(%)
Black	31	66	10	2	7
Latin	19	8	33	37	55
Chinese	1	1	4	2	2
Japanese	-	-	-	1	-
Filipino	2	3	10	6	6
American Indian	-	-	1	1	1
Other	2	2	3	2	3
Foreign Stock*	32	16	51	55	60
Spanish Speaking	17	6	28	32	50

Given SFGH's history as the major source of health care for the city's lower socio-economic groups and the newest immigrants and native-born migrants, and its geographic proximity to the ethnically segregated neighborhoods described above, these ethnic groups have come to view SFGH as "their" hospital. Blacks preceded the Latino and Filipino immigration and therefore first laid claim to SFGH as both users and staff. Until the 1970s the Chinese avoided SFGH as a geographic and culturally distant place with potentially dangerous government connections. As the Latinos and Filipinos began to arrive during the 60s and 70s they encountered Black staff in contact positions who often carried the attitude that SFGH was "their turf" (personal interviews with translator personnel 1978-1980). As Filipinos entered the system in large numbers as nursing personnel, they outranked the Black staff at the clerical, orderly and LVN levels and could begin to protect the interests of their people. Hispanics have yet to enter the system at anything but

the lowest job levels and in small levels and in small numbers (Department of Public Health 1981) and therefore attitudinal changes toward Hispanic patients have been externally (i.e. LEBHS) rather than internally generated. However, as each ethnic group has managed to penetrate the various levels of job categories within the SFGH hierarchy, the system, due to the actions of its ethnic individual members, has become more sensitive, knowledgeable, and tolerant in its inter-ethnic contact between provider and patient. That is not to say that the latest newcomer does not receive the full brunt of racial prejudice and intolerance from the more established groups. But with repeated exposure, reciprocal acculturation, and incorporation of the latest arrivals into the personnel of SFGH, racial intolerance is dissipated. This systemic pattern of intolerance gradually changing to tolerance and "belonging" is also one of the cyclical aspects of San Francisco General Hospital's 130-year history.

Conclusions and Summary:

What this historical account plainly shows is that nowhere in the numerous moves to upgrade the standards of medicine practiced at SFGH has the issue of the "quality of patient care" served as a force for change. Organized consumer demands for accountability for the standards of health care delivered in the public sector developed concurrently with the Civil Rights Movement of the 1960s. To analyze the conflict

between the city and the Latino and Chinese communities over the city's obligation to provide equal quality health care to non-English speaking clients, one must understand that the people who control San Francisco General Hospital, as a social system, has been in conflict with its recipient communities from its inception. The data upon which I base this conclusion come from historical accounts spanning over 100 years and from recipients' statements.

In describing the benevolent association formed by the early ethnic groups, Lotchin (1974) refers to the urgent medical needs of the population and the inadequacy of the services provided by the city hospital.

> The complaint that foreigners were not allowed into the city hospital was not true; but they, along with everybody else, got pretty mediocre care. Sometimes the language barrier further compounded their discomfort, and these deficiencies encouraged the founding of new establishments. (Lotchin 1974:119, emphasis added).

A prominent Irish physician recounted his experiences as a patient at San Francisco General Hospital in his street urchin days as a poverty-stricken youth in the 1930s. Having overheard his diagnosis in the night nursing report as being "meningitis with a poor prognosis", he lay awake all night waiting for the physician to see him in the morning. In the morning a prestigious University of California professor entered, followed by a flock of medical students. After speaking over the youth as if he had no ears, the physician acknow-

ledged his existence by informing him of how fortunate he was to be in the care of one so famous as himself, but failed to reassure the patient regarding his chances for survival. The sick but proud Irish youth ridiculed the physician in front of his house staff and then ran for his life since this interaction had convinced him that his life counted for little in this system (personal interview February 1981).

And lastly, the hospital's community liaison officer, in an interview, explained that the confrontation with the Latino community simply represented a repetitive event that marks an ethnic group's political development stage, stating:

> Community confrontation is an ongoing problem that the hospital has had with numerous ethnic groups over time. It's an onslaught that happens repeatedly with one group after another and who historically have always made demands for the upgrading of their care. (Interview October 1978).

The conflict may take on different expressions and the groups involved may vary over time, but the presence of conflict within the social system is a constant. At the heart of the conflict lies the discordance between the American democratic ideals and the value system demanded by a frontier, capitalistic society. The value of life and the right to health care regardless of ability to pay is the professed ideal; the reality is that of a fee-for-service health care system and the cultural expectations of self-reliance, independence, hard work and economic success. The public health care system is financed by, and for the most part provided by, those who meet

these cultural expectations and who explicitly state that those who cannot pay for their health care should not be able to receive the same services as those who can pay.

The unwillingness of the San Francisco taxpayers to fund SFGH at a level equal to its counterpart in the private health care sector is reflected in the city politicians' financially conservative posture toward the hospital throughout its history. Each expansion or improvement has only come after deplorable conditions have been exposed by accrediting and/or licensing bodies, or the medical students and house staff training at the hospital (medical white paper of 1956; intern and resident strike (SFIRA) in 1980) or when the conditions threatened the public health of the city (e.g., plague epidemic from the rats infesting SFGH grounds). Significantly, change has never been initiated by the medical schools using the institution, nor by the city politicians, and rarely by the city public health officials.

There are two basic strategies used historically by the ethnic groups in the patient populations of SFGH to cope with the discrepancy between health services needed and those actually provided. As Lotchin (1974) points out, the early ethnic groups (French, German and Italians), aided by cultural insularity, formed self-help groups who built and staffed their own hospitals (French and Mount Zion Hospitals are the only ones remaining today). The early immigrants expected the system to allow them the means (i.e., jobs) by which to provide

themselves with health care, and herein lies their distress over the current demands of the non-white ethnic groups that government provide the actual services for them. The following excerpts exemplify comments made to me during this fieldwork by native white San Franciscans regarding the non-white ethnics' demands for social services:

> We did it ourselves. When we came here we didn't have anybody helping us. We raised money to build our own churches, to bury our dead, schools to teach us English, and we built our own hospitals. We didn't speak English when we came here either, but we sure learned." (Interviewee -- a 55 year old, second generation Slav, and San Francisco historian.)

And again, from this fourth-generation Italian in the city's Public Health Department:

> "The harassment that these community groups give out constantly and the demands of the Latinos are hard to take. They want it all without working for it and they want it now... And the Blacks are not too sympathetic towards them. They have laid the groundwork for the Latinos, and now the Latinos want everything that the Blacks have worked for over the generations. But they want it given to them. I'm sure that you have picked up on this attitude in the hospital. My grandparents came here not speaking a word of English, but they learned. And the next generation learned to speak it a little better. They worked for what they got, nothing was given to them." (Interview March 1979).

What is not understood by the acculturated and socially mobile white ethnics, is that since the time of their forefather's immigration, significant changes in the area of social welfare have taken place. With Franklin Roosevelt's

social welfare and work programs of the 1930s depression era, government adopted the role of social service provider and assumed responsibility for those self-help functions formerly deemed the responsibility of each ethnic group to provide for itself through its benevolent associations.

The social change resulted in, among other things, the State Welfare and Institutions Code, which assigns to local governments the legal duty to provide medical care for the indigent and medically indigent. Section 17000 of this code states:

> Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully residents therein, when such persons are not supported and relieved by relatives or friends, by their own means or by state hospitals or other state or private institutions.

Consequently, San Francisco General Hospital has historically served as the primary source of health care for low socio-economic groups in the city (non-white ethnics, see Chapter II) and the latest arrivals, both the immigrant and the migrant. And now due to state and federal civil rights legislation, SFGH will have to add to its staff bilingual members of the arriving immigrant groups. Title VI of the 1964 Civil Rights Act states:

> No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. (Civil Rights Act of 1964 §601).

In May 1972, "national origin" was extended to cover non-English speaking persons. Subsequently, the federal government directed that "in communities with large numbers of national origin minority persons, such as Spanish-surnamed Americans, Orientals or American Indians, special measures to deal with language problems must be undertaken" so that there are no differences in treatment or the manner in which services are delivered to non-English speaking persons (DHEW Publication No. (OCR) 75-1).

California legislated its own civil rights act in 1980, keeping language differences as a part of the national origin definition, but substituting the phrase "color and ethnic group identification" who cannot "read, speak or write" English (Title 22, Division 8 (AB803) July 1980) in place of the term "national origin". Thus, even if the federal requirements for language in the definition of national origin should be deleted, California's state laws will continue to require language services in all government agencies or businesses receiving state funds. Therefore it is safe to conclude that the need to provide bilingual services in health care settings like San Francisco General Hospital is not transitory, but will continue for some time to come.

CHAPTER IV

MULTI-CULTURAL PROGRAM HISTORY

The Beginnings of the Multi Cultural Program:

The case of a Latina who delivered stillbirth at home began the history of the Multicultural language translator program (MCP) at San Francisco General Hospital. The expectant mother presented for obstetrical care at SFGH and was sent home due to the inablility of the English-speaking medical staff to understand the medical history being given by the Spanish-speaking women. Members of SFGH's house staff, frustrated over their own inability to provide care without bilingual personnel, reported the incident to the editor of the Spanish newspaper, El Tecolote. The response of the community to this event resulted in the formation of Latinos for Emergency Bilingual Health Services (LEBHS). LEBHS began negotiating with the SFGH Administration for bilingual services in May 1977.

Due to the governing structure of SFGH (see Chapter III), the hospital administrators were structurally blocked by their lack of budgetary and administrative power from responding to the Latino community's request for language services. Similarly, the Director of Public Health also found that he was unable to effect any structural response for the same reasons to the Latino community's request. In November 1977, just two months

after promising in negotiations with LEBHS to obtain Comprehensive Employment Training Act (CETA) and permanent civil service positions for translator personnel in the 1978-1979 Public Health Department budget, the Director had to report back to LEBHS that his request had not been approved. Consequently, on January 20, 1978, eight months after beginning their negotiations with the respective city authorities and departments responsible for running SFGH, LEBHS filed an administrative complaint with the Office of Civil Rights in the State Department of Health, Education and Welfare, charging SFGH to be in violation of the Title VI of the 1964 Civil Rights Act.

On February 8, 1978, two weeks after the Civil Rights Office (CRO) notified SFGH of LEBHS' administrative complaint (the Chinese for Affirmative Action's (CAA) filed a separate complaint in April 1978), and the CRO's impending investigation of SFGH, the board of supervisors approved a board-initiated request for 33 CETA-funded positions for language translator personnel at SFGH to be released immediately. A number of pressures undoubtedly served to motivate the board's prompt action on the issue. LEBHS had succeeded in gaining the media's attention covering their civil rights complaint and charge of poor health services delivery to Latinos and Chinese at SFGH. Politically it was bad publicity for the city. In conjunction with the media coverage, LEBHS and CAA had been able to enlist the aggressive support of minority Supervisors Gordon Lau and Robert Gonzales. Lau's position as Chairman of the Health

and Environment Committee was directly responsible for the proposed legislative intervention being presented to the board of supervisors. The language translator personnel also represented a quick and cheap way (due to use of CETA funding) to correct for language deficiencies before the CRO investigations, and to avoid the complications and the expense to the city that could follow a noncompliance finding. Despite these measures, when the state CRO staff conducted their two week study of the hospital in March 1978 (and again in May in response to the CAA's complaint) they found SFGH to be in noncompliance in six areas of service (see Appendix 4 for statistics). In their June 23, 1978, letter of findings to the late Mayor George Moscone regarding LEBHS allegations of "national origin discrimination on the basis of linguistically inaccessible services at San Francisco General Hospital," the CRO investigators conclude:

> San Francisco General Hospital provides medical services to its monolingual Spanish-speaking clients that are not of the same levell of care as is provided to its English-speaking clients. According to Health, Education and Welfare guidelines, this constitutes discrimination on the basis of national origin.

The legal consequences of noncompliance with the Civil Rights Act, Title VI regulations carries the potential threat of state and federal intervention in the form of the withholding federal and state funds to all city health service programs. To avoid incurring such sanctioning once found to be in noncompliance, city agencies are obligated to institute

corrective actions to meet compliance requirements.

Caught between the community groups and the city government officials, the hospital administrators were forced into an alliance with city government against the ethnic community organizations, even though they initially shared the philosophical views of the latter regarding rights to health care. The three hospital administrators interviewed agreed that without the community's political pressure the language service program would not have been instituted. This was a bitter admission for the administrative team as expressed in the following statement of an administrative assistant:

> We got all the anger of the community groups directed at us. And in the fairness to ______ SFGH Exec. Director) he had to take a lot. They (LEBHS) didn't give him any credit for his attempt to get these kinds of programs long before they came along. But his requests were turned down (who not specified), he really didn't get anywhere."

The hospital administrators thus found themselves in the position of having a mandate for a service imposed upon them by city officials responding to community demands which they would have already instituted had they been allowed to exercise the normal administrative powers that accompany their offices in the private sector (San Francisco Chronicle October 4, 1978).

The concept of a language translator pool existed as early as the 1960s at SFGH as a means of handling translation

service needs. The Multicultural Language Translator Program also was not the first actual effort to introduce translators into SFGH, as many of the health personnel pointed out in initial fieldwork contact. Previous efforts were cited as failing due to loss of funding, lack of training for the non-medical personnel recruited for the positions, and/or conflicts concerning the acceptance of the translators by the staff.

An administrative assistant involved in the early planning of the Multicultural Program (MCP) explained that the proposal to form a translator pool was viewed with skepticism within the SFGH hospital administration, which believed such a program represented a potential "bureaucratic nightmare". The concern was not that it would be "organizationally so difficult, but that it would be politically impossible to manage all the relationships of the different ethnic groups" to one another and the resulting power struggles. As this administrative insider analyzed the situation some nine months after the program was started, this prediction "has proven to be true -- that it is what happened, and is continuing to happen".

When the SFGH administrators were first approached by LEBHS in May 1977, they had few response options available to them to meet the community's demand for bilingual personnel and translator services due to the severe administrative restrictions on budgetary decision-making under which they

were forced to operate. The principal strategy used was to identify and utilize talent from within SFGH; thus, three Spanish/English bilingual employees were recruited from different hospital departments and moved into administrative positions. These three were assigned the following tasks: to recruit Spanish bilingual nurses; to identify the bilingual capabilities of all hospital personnel; and to compile an accurate list of employees available for translation services. In January 1978, these three were directed to write a program proposal for CETA-funded translator positions at SFGH, and then came to be identified as the administrative team responsible for the implementation of the translator service program.

Recruitment of the Multi-Cultural Program Personnel:

Following the allocation of 33 CETA-funded positions, the Multicultural Program was created as a separate program directly under the SFGH Executive Director. The three Latino administrators were assigned to formal administrative positions within the MCP as Director, Assistant Director and Training Officer. These three MCP administrators then conducted an extensive community-wide search to recruit 26 translators, four staff supervisors, a program coordinator and a public relations officer. The MCP administrators recruited personnel by using community hiring agencies, groups and organizations, radio and television advertising

and talk shows, and job opportunity releases through the city's civil service network. One hundred and twenty applicants were screened by an interviewing team consisting of the three MCP administrators, a community member, a CETA representative, SFGH's patient advocate officer, and a nursing representative. The criteria for eligibility included the following: a minimum of a high school education; fluency in English and the native language; and one to two years of public contact experience with a priority for health care positions. Candidates were given written, verbal and manipulative skills tests, and interviews were conducted in both languages to judge language proficiency. Candidates were also screened closely during the interviewing process for personal traits such as credibility, empathy, good judgment and maturity which were held by the MCP administrators as basic to the nature of the translator role.

As one of the MCP administrators explained, they were looking for "not just language but cultural translators", i.e., people who could represent the culture of the language which they spoke. She states:

> It is a very beautiful thing in which a person who is new to this country, who is hurting and sick, who comes into a hospital like San Francisco General where everyone is speaking a foreign language and to be greeted by someone who speaks your mother tongue. This person can act kind of as your liaison person and protector, and I think that we got that in our IPA's (Interpreter Patient Assistants). They are a good bunch of people, dedicated to the patient populations which they are going to serve.

Furthermore, those individuals with higher degrees were not excluded in the MCP screening, so that this first group of translators differed substantially from later groups who were recruited strictly according to CETA's standard economically disadvantaged and chronic unemployment criteria.

Training and Clinical Placement:

The next phase of the MCP program implementation was the six week training period. The training curriculum consisted of interviewing and communication skills, intense medical terminology, proper role conduct for translation situations, and finally, an introduction to the structure of hospital organization and the culture of Western medicine taught by myself. Instruction in translation methods and job responsibilities of the IPA role were taught through role playing as well as by lectures from various medical faculty who held conflicting and sometimes opposing views. The three MCP administrators agreed that formal training was crucial if translators were to be accepted by the health professionals. The pressure exerted by the impending state Civil Rights Office's investigation of SFGH's bilingual services caused the hospital administrators to urge immediate installation of the MCP translator personnel upon their being hired in April 1978. The MCP administrators, however, solidly resisted a no-training plan and by their persuasive arguments they won support of the six-week grace period for

training, although they lost the battle for supportive continuing education once on the job. Consequently, the translators were just being placed in the clinical areas at the time of the CRO's investigation in May 1978.

The two MCP administrators who had extensive work experience at San Francisco General also realized that the introduction of the language translators would be a racially sensitive issue with the hospital's black and white personnel. As a result they decided on careful groundwork and specific clinical site placement for the translators. Their requests for placement in the clinical and emergency units were met with reluctance and expressed "resentment over instituting special language services for people in America", and frank statements that "all these people should learn English". While labeling this behavior as blatantly racist, these two Latino MCP administrators did not argue for acceptance with the SFGH personnel from a moralistic stance, explaining that they felt that the right to bilingual services is a type of argument that is impossible to refute. Rather, they took what they termed a "personalistic approach" which consisted of the following type of strategy: "You know me, we have been friends, and I'm working very hard on this project, won't you please help <u>me</u>." Both of these program administrators were well known and liked throughout the hospital and across its many ethnic and occupational strata. And the above-described attitude was prevalent throughout all strata

of the hospital, from unit secretary to administrative personnel, as verified in fieldwork.

In this manner the fledgling "Interpreter Patient Assistants" gained clinical placement throughout the out-patient clinics, the emergency room, admitting, pediatrics, and the labor and delivery rooms at SFGH. A ceremonial graduation from the training was held May 16, 1978 with the Director of Public Health, the SFGH Executive Director, the three MCP program administrators, and representatives from CETA and the mayor's office in attendance. Speeches were given by all. It was a media event complete with flashbulbs as the Director of Public Helath awarded the diplomas and honors. The mayor's office representative proudly acknowledged their role in funding and securing the personnel positions. The SFGH Executive Director referred to the Multicultural Program as "my program" but warned of the possibility of failure due to general resistance to the language service concept by the SFGH personnel. LEBHS members instrumental to this program's institution were present in the audience as invited guests, but their role was not mentioned in any of the speeches. This omission was not unintentional.

The three program administrators worked hard to keep politics out of the program since they saw this as representing a "central danger to the program as a result of the nature of it (MCP program) and the importance of it to the community".

The MCP administrator most familiar with the politics of the Mission District explained that due to the program's importance to the community, administrating this program could potentially offer political advantages to anyone with political ambitions. For this reason, recruitment of the MCPs program staff was completed in such a way as to keep community activists out of any administrative or staff positions. Not understood by the MCP administrators was that the Multicurltural Program was political by the nature of the forces that caused its creation, and that by "keeping politics out of the program" the MCP administrators were acting as agents of the city in their strategy to maintain decision-making control over SFGH.

Administration of the Multicultural Program:

Jealousy over the control of the MCP began to surface among the three founding MCP administrators at the start of the hiring period and steadily grew, fractionalizing and polarizing them. The SFGH Executive Director's demands for a hierarchial structure in the program's administration changed their prior peer relationship with its "esprit de corps" egalitarianism to one of boss and assistants. The managing style of the one chosen by the SFGH Executive Director for MCP Program Director was severely autocratic and evoked bitter objections from the assistants. This dissention gradually filtered down to program personnel. Subse-

quently, charges came that the Program Director was using the MCP program as a personal career advancement platform at the expense of the other Latinos instrumental in the program's design and implementation. And then the most damning charge of all - in this setting of ethnic identity and its accompanying politics -- that the Program Director was not bicultural and therefore unacceptable to administer the program. Jealousies over the opportunities and prestige afforded by the program administrative positions, as well as conflicts between the hospital and the community interest groups over the program's philosophy and policies have plagued the MCP program from its inception to the time of this writing (May 1981, for discussion see pg.105 of this Chapter).

As the conflicts between the three founding MCP administrators escalated, one administrator who was popular with the Latino community as well as with the MCP staff resigned. The Program Director then honored a request to transfer the remaining Latino administrator to another department. Personnel initially recruited for the Co-ordinator or Supervisor positions were then moved into the job functions of the former program administrators.

The struggle for administrative control of the MCP program came to represent, to those actors involved, an attempt of the dominant political groups in San Francisco

to continue to control the subordinate groups' access to resources and social mobility opportunities; i.e., power. In the words of one MCP Latino staff member:

> The people in city hall, they won't listen to us unless we have a white face to represent us, and talk for us. Because we talk funny and have brown faces that means to them that we are dumb. And in this program we have the same thing. This is supposed to be a multicultural program, not one of continued colonialism. They (Program Director and SFGH administration) play their social games, do business over lunch or on the tennis courts. Places where we are excluded from so that decisions get made that we have no voice in. And that is the way that they effectively manage to exclude us and control us."

The conflict came to be defined by MCP staff as Anglos and middle-class representative of city government against the lower economic Latinos, Chinese and other non-white minorities. The outcome of this conflict resulted in the transfer of the Program Director to another department that was functionally removed from the Multicultural Program. More importantly, it developed the politicization of the program staff so that they became watchful and critical of the MCP program administration with frustrated expectations of democratic participation in decision-making and administration. Being spectators to the struggle for administrative control of the MCP program had been the translators' introduction to and socialization into the organization of the hospital's social system.

By August 1978 the Executive Director of SFGH faced the sensitive task of assigning a new Program Director to this

fledgling program, knowing that the program still faced serious challenges of non-acceptance within SFGH, as well as funding cuts in the city budget due to voter approved property tax reductions in the spring of 1978. Latinos within the MCP program and in the community (LEBHS) were demanding a Latino director with a record of community involvement. The SFGH Executive Director appointed an older black woman who had a strong record of community involvement and considerable experience in city politics.

The SFGH Executive Director's options in filling the MCP Director position were so limited by the Civil service system and funding that recruitment had to come from within SFGH. The new Director appointee had direct access to city officials from the mayor down, as well as a recognized personal friendship with the manager of the San Francisco CETA office. Thus, in terms of surviving program cuts, and maintaining the number of CETA positions already awarded, the new appointee represented a strong, politically experienced Director for the MCP Program. Also, due to the new appointee's advanced age and impending retirement, it was clear to the MCP staff that the new Director would not use the program for her own career advancement. However, a new twist in the exploitation concern was introduced -- that of the advancement of one minority group (blacks) at the expense of another (Latinos). The requirement that the Director be bilingual and bicultural was viewed as preceding all

other qualifications by the Latinos within the MCP program and LEBHS. Therefore, the new appointee was vulnerable to the same criticism as the first Program Director, by not having the correct ethnic identity to direct a service program for minority groups who have English as a second language, or who are non-English speaking.

The new Program Director recruited for her Assistant Director the MCP administrator who had been transferred out of the program by the former MCP Program Director, and succeeded in building a symbiotic working relationship with this credible and respected Latino. The Assistant Director greatly assisted the new Director's relationship with the MCP staff by serving as an intermediary and communication channel. The new Program Director administered the MCP program without crisis from August 1978 until January 1979.

<u>Merger of Language Translator and Patient Representative</u>:

When the new Program Director was initially approached by the Hospital Administrator to accept the position of MCP Program Director, she was in the process of instituting a CETA funded Patient Representative program. Given the limitation of administrative personnel and supportive staff, space, and services, logically she merged the two programs. The name Multicultural Program was changed to Patient Advocate Multicultural Program (PAMP), and a joint training pro-

gram was conducted for the second group of CETA trainees who started in September 1979. This second group included those hired as Interpreter Patient Assistants (IPA's) and Patient Representatives (Patient Reps). The new Program Director attempted to merge conceptually the two types of personnel explaining that both were "patient advocates" in that all patients served required a representative or intermediary to secure needed health services. Thus, six Blacks came to be included in the previously multilingual staff -- Black English not being recognized as a second language by the original MCP staff.

The new Director's attempt to merge the concept of patient representative and personnel with that of the Interpreter Patient Assistant and its language service program was objected to by the translator staff. The merger was cited as evidence of the Director's ethnicity conflicting with the best interests of a bilingual service program. Translator staff viewed the merger attempt as an expression of the new Director's concern for Blacks' welfare over and at the expense of Latinos. While this situation took months to evolve and solidify, a second event occurred in January 1979 that frankly initiated the translator staff's loss of confidence in the program administration. This second event was the administration's decision to cut back

translator coverage from the 24-hour service to weekdays from 8am to 9pm. These policy decisions came to be regarded by translator staff as demonstrating a lack of concern for the delivery of patient care to the non-English or limited English speaking patients. Program administration now consisted of the Program Director, the Assistant Director and a newly appointed Program Co-ordinator but due to the Program Director's domination of the leadership role, she was directly charged with being non-supportive of the language service concept. Both the program merger and coverage reduction decisions, when considered from an administrative perspective, however, were soundly based given the severe resource shortages of manpower, monies, office space, supplies, and secretarial support under which the MCP was forced to operate.

The following analysis outlines the motives of the various actors engaged in this social drama, the obstacles operating in the SFGH system that obstructed communication and mutual understanding, as well as the consequences of the conflict for the participants and its effect on the social structure and organization of the MCP program.

To understand the MCP staff's response to the new Director's merger attempts it is important to realize that the translators were well aware of the role that the Latino and Chinese communities had played in the creation of the MCP program, and many had come to possess a strong identity with

their community and concern over the problems of "their people". With the placement of the Patient Representative personnel in the Multicultural program it appeared to the Latino and Chinese MCP staff that the Blacks were going to be able to take advantage of their groundwork to secure positions as well as services for Blacks through "their" program. The informal message, passed through the hospital grapevine and back to the new Director, was that she was hiring her family members and using job positions that could have been awarded to Latinos. This antagonism was aggravated by the dismal failure of the patient representative position.

While the position of patient representative was originally conceptualized by the MCP Director as performing patient advocacy functions (i.e., to do whatever was necessary to secure services needed by patients), this personnel lacked entry to the provider-patient interaction that the translation function afforded the translator. Translators were an intimate part of the health care delivery process, whereas the patient representatives visited the hospitalized patients as outsiders and as potential critics of the health care providers. Their lowly para-professional status meant that they could not directly approach the higher status health care professionals as could translators due to their direct and informal contact with providers. The hospital and medical administration had stipulated the constraints under which

the patient representative would manage problem situations to the MCP Program Director. Patient representatives were merely to record a patient's concern (complaint was to be avoided as a negative word), file the report with their immediate supervisor who then would evaluate it and refer it to the "proper channels" -- to the MCP Assistant Director, then to the MCP Director who might refer it to the Executive Director, SFGH, and/or to the Associate Dean, or the Nursing Director. These higher authorities would investigate the incident and report back to the MCP Program Director their final decision.

Of the few cases that I knew to have reached the higher authority levels, the actions of the health care providers or institutional personnel were upheld. Most of the reports filed died on the supervisors' desks due to their lack of training as well as time, and in some instances to prejudices against the type of patient represented in the report -- Blacks, drug addicts, street people and others. Gradually the patient representatives stopped filing reports altogether to save themselves the frustration and the embarrasment of having to face the patient and admit that they were unable to help them. Some stopped or severely curtailed their patient visiting to avoid receiving patient complaints, others continued their visiting but would dismiss patients' requests for intervention by "referring" their problem to a social worker or advising them against being difficult, demanding patients.

The ineffectiveness of the patient representative personnel was neatly effected by the formality requirement of "going through proper channels", and because they lacked the translators' insider status and direct access to health care providers, this requirement prevented the patient representative from performing any advocacy functions. Instead, the patient representative came to function as an institutional advocate by blaming provider-patient conflicts on the patient, by alerting the hospital administration to potential legal action incidents, and by providing confidential information from patients regarding these disputes.

Insufficient supervisory personnel also contributed to the failure of the patient representative concept. Basically, the same supervisory personnel and administrative staff responsible for the MCP program were given the added management responsibility for the patient representatives. The management staff were not trained for this speciality area, and therefore knew less about the job functions and responsibilities than did the staff that they were supposed to supervise. There was simply too much for too untrained few to do, and this condition was a direct consequence of insufficient funding for effective program planning and implementation. Consequently, the patient representative position was reduced gradually to a do-nothing, busy-work job that was perceived and acknowledged as such by both the patient representatives themselves and the translators.

The idleness imposed on the patient representatives irritated the translators further. For not only had the translator staff not approved of the merger of the patient representative program with that of language services, they had come to resent these personnel for filling positions that they felt could have been used for more translators. This perception by the translator staff created distance and hostility between the Latinos and Chinese staff and the Black staff members. This phenomenon was observed to occur with varying expressions in competitive situations depending on the ethnicity of the competitors.

The world view of the minority groups, as represented in the staff of the Multicultural Program, most of whom reside in the Chinese, Latino, and Black ghettos of San Francisco, is one of closed doors and pervasive discrimination against them and their kind. Economic options and opportunities are limited and the competition for those opportunities that do exist is brutal. Thus, the promotion of a colleague is another's loss and evokes envy, resentment and ostracism of the successful one. The allocation of CETA jobs to Black individuals, in this setting, however, was responded to by MCP Latinos as meaning the gain of Blacks as a group over Latinos as a group. Given the condition of restricted access to economic opportunities and resources, when the competitors share the same ethnicity, the gain and loss dynamics are maintained on an individual level with the

loser(s) responding in a sanctioning manner towards the winner. When the competitors are ethnically different, however, a distancing, adversary posture is adopted by the loser group as a whole towards the winner group as a whole.

MCP Administration and Staff Conflict:

The event that triggered a frank confrontation posture of the staff towards the MCP administration occurred over the administrative decision to cut back translator coverage from a continuous 24-hour schedule to weekdays from 8am to 9pm. Administratively, the staffing pattern of three shifts over a 7-day period had proven to be an inefficient use of personnel resulting in serious understaffing for the heaviest demand periods during the out-patient clinic hours of 10am to 4pm on weekdays. The greatest amount of coverage could be accomplished by consolidating to two overlapping shifts of 8am to 4:30pm and 12 noon to 9pm. Administratively, this was a sound decision, seemingly beyond reproach. The furor that the decision created among the staff was unanticipated and caught the program administration off guard.

The rationale for the change in coverage was not explained to the staff prior to initiating the schedule change; it was simply announced. There was no channel for information exchange between staff and management, and therefore mutual

understanding of each group's concerns and perceived responsibilities was blocked. A number of staff involved in day classes and family responsibilities could only work evenings, nights and weekends, and these hour changes were forcing them to chose between resigning and school or family commitments.

A general staff meeting was called January 17, 1979, to announce these changes and explain the administration's rationale as well as to confront the growing objections of the staff. The subject was introduced by the Program Director by mentioning that supervisors were being forced to leave their offices and take translation requests during the weekdays due to the shortage of translator staff. Then the Director explained that one of the supervisors who had worked nights for months had found a low frequency of translator requests for the late evenings and night shift. This report was supported by the Assistant Director, who had recently worked an evening and night shift and received only three calls between 9pm and 8am. Based on these data the administration had decided to cancel late evening and night shift coverage.

If the program staff had been given the same data and responsibility for providing maximum coverage possible with the given staff limitations, they might well have recommended the same strategy. But due to being completely by-passed in the decision-making processes and planning, while not having their concerns recognized, dissension grew. Underlying the

more obvious problems of management style, and basic to this conflict, however, is the larger political strategy of maintaining the status quo by building failure into the structure of community service programs. The most commonly used failure mechanism, and the one used in the instance of the Multicultural Program, is to allocate just enough funding to implement a temporary program, but not enough funding to integrate the program as a permanent change into the functioning of the larger social structure. Thus, a social groups supposedly being helped are blamed for the program's failure and real change in the social structure is avoided. A Black community activist described this tactic as being like "throwing scraps to a starving pack, giving just enough to keep them fighting among themselves so they won't attack the real source of their starvation". This divide and conquer tactic is used consciously at all levels of our political system to maintain the economic and social status quo, and in the setting of the Multicultural Program it represented the major cause of the conflict between the program administrators and the program staff.

The larger structural determinants of political control and limited access to resources indeed was compounded by the MCP administrators' lack of training and management skills. However, this again reflects the severe economic constraints under which the MCP program was forced to operate. It was a situation of "catch as catch can" and "making do with what

you've got". This meant that the top MCP administrators lacked any prior administrative experience or continuing education support to obtain managerial training once on the job. Similarly, the supervisory positions were also CETA funded, meaning that they had to meet the criteria of unemployment, low job skills and minimal education. As one administrative aid summarized the achievements of the Multicultural Program in October, 1979: "I feel that a lot has been accomplished with very little, with a tremendous amount of hindrances and drawbacks". And in looking back on the sources of the administration's problems this same MCP administrator clearly viewed the stumbling blocks not to be the particular individuals involved in management tasks, but in the economic and structural constraints imposed by the program's total dependence upon CETA funding. He states:

> I have very serious doubts that under the present circumstances, given the CETA employment of interpreters, that it's ever going to work at anything close to optimum. You're always going to have the problem of cutting people off after 18 months, not providing them with a living wage, not providing them with pleasant surroundings when they come back to their ... whatever the central part of their program happens to be. That's going to continue and I don't care who they decide to put in charge of the program, they're going to be faced with the same headaches that they're facing now. (emphasis speaker's)

The new Director's leadership style reflected a mixture

of stern maternalism and confrontment used in her long career as a community activist. Thus, regarding the issue of the reduced hours, after explaining the need to maximize coverage by condensing staff into double-overlapping shift, the Director concluded;

> "While you may not respect me, you have to respect my position as Director of this program. I'm doing the best job I can, and if you don't like it -- you can quit! We've got lots to replace you, a lot of poor people without jobs. Now listen to me good, young people! I don't want you to do that. I want to keep each and every one of you, but we can't have all chiefs and no Indians here."

At this point in the staff meeting, the SFGH Assistant Administrator who had been assigned administrative responsibility over the MCP program joined the meeting. The Director then acknowledged that the staff's objections to the reduction of coverage were being expressed in threats to resign as well as to take their grievances to the Latinos (LEBHS) and Chinese (CAA) community groups. This direct acknowledgement of the gravity of the staff's objections occurred only after the SFGH Administrator had joined the meeting. The SFGH Assistant Administrator was introduced by the MCP Assistant Director, as coming over to talk about "staff dissention over the schedule change".

As a social person, the SFGH Assistant Administrator stands in marked contrast to the MCP Director. The former was a middle-class, east coast Black, who spoke painfully

proper English and affected a no-nonsense, business like administrator, presentation of self. In a rapid-fire, clipped manner of speech, the Assistant Administrator expressed amazement over the translators' objections to removing the undesirable hours from the work schedules (evenings, nights, and weekends) saying:

> We expected that people would want to work the straight day shift, so your complaints over the hour change is really puzzling. It's strictly an administrative-management decision. Threats of, 'I'm going to quit', or, 'I'm going to call in the CAA', -- now ...that doesn't do the program any good. Ultimatums are losing propositions because it leaves you no place to go and me no place to go. I don't understand how we got from A to Z so fast. There are alternatives, but we have to talk about them, and again, this can be done through channels.

While the SFGH Assistant Administrator had academic training in hospital administration, and therefore, a conception and expectation of the hierarchial nature of a hospital's social structure and the meaning of this for the way information is exchanged downward as well as upward, and for decision making to reflect this information exchange, the other members in this social system did not hold the same expectations. Throughout the Assistant Administrator's address the staff had continued to maintain a stoic, hostile silence, so he continued in his growing puzzlement to defend what he thought to be salient points:

> "We are working to keep your positions and your salaries. If you quit -- who are you hurting? Yourself! The people that follow

> you and the patients. We will all still be here (naming the MCP administrators seated around him)."

Still no response from the staff. A long pause followed as he looked at the tense faces in the room, until the Assistant Administrator frankly asked for the staff's perspective, saying; "I don't understand. What is the point of this? (pause) I'd like someone to explain to me...". And with this request, the Assistant Administrator was interrupted with an explosion of statements explaining the staff's grievances against the MCP administrators, specifically the Program Director. One articulate young woman who was fluent in English explained that the standard response to staff dissatisfaction was, "If you don't like it -- quit!" with the unstated message from administration to the staff being that, "You don't care what we think or feel, so I think that we feel that we might as well take what little control we have and quit."

A second objection explained by another spokesperson, was the failure to observe of standard civil service procedures in promotions, so that many felt that those who received promotions were the administration's favorites. Performance evaluations, merit, or other objectives criteria and open competition were bypassed. A third speaker explained that both of these concerns were different sides of the same problem that was upsetting the MCP staff: that the staff perceived the reduction of coverage and the promotion and

support of supervisory personnel who refused to do translation work as indicating a lack of commitment to the delivery of language services to the non-English populations of San Francisco by the MCP administration. This third speaker expressed the translators' sense of commitment and accountability to their communities as follows:

> "We originally told the people in the community that we would provide 24-hour service. Now it's down to weekdays and only from 8am til 9pm. We have promoted people who refuse to do the Interpreter Patient Assistant job. I don't know what they will say if we cut it less."

To the interpreter's sense of community accountability, the Assistant Administrator countered that accountability is only appropriate between the SFGH Executive Director and the respective community groups and informed them that it was inappropriate for them to feel personally accountable to the community. What the SFGH Assistant Administrator, as well as the MCP Administrators, did not understand was that "the community" to the translators were concrete individuals -- friends, neighbors, fellow church members and family, and that the translators were viewed within that social mileu as _the_ San Francisco General Hospital representative to the community (from interview and observational data). In an attempt to reduce the translators' sense of responsibility, the Assistant Administrator added that there had been interpreter services at SFGH prior to the Multicultural Program, and that structure was still operating in the form of bilin-

gual employees. This evoked a flurry of debate over the true availability of the bilingual employees listed on the volunteer translator list. (The CRO staff had found only 88 of 220 personnel listed as bilingual Spanish to be capable of translating in Spanish). The MCP Assistant Director acknowledged the flaws of this system, but outlined plans to bring the bilingual employee list up to date so that it could truly serve as a backup system to the MCP translator service. The MCP Assistant Director explained further that the translation demands were already exceeding the capacity of the program with the number of requests increasing every month.

The third MCP staff spokesman continued in an effort to communicate to the arbitrator, the SFGH Assistant Administrator, the dilemma that the reduction of hours was posing for the translators, stating:

> When I can't get an interpreter for a patient in the Emergency Room, I feel guilty about that. Or when I get a call for (an) interpreter five minutes to 9 -- what am I to do? Leave? I've done my shift. Leave knowing that that patient isn't going to get any service. I go home feeling guilty!

The guilt evoked within the translators when they were unable to respond to a translation request was clearly being directed as anger towards the MCP program administrators. For the translators their unavailability meant that non-English speaking patients would not get the health care that they needed, and this dilemma had made the translators rebellious and mistrusting.

The MCP Director's immediate response to the speaker's explanation was to state that this sort of incident rarely happened as based on their data showing a low frequency of translator requests for evenings and nights. The MCP Assistant Director took a somewhat more empathetic tack and a politically acute one by counseling the translators to keep in mind that the long-term goal was for the hiring of permanent bilingual employees, and as long as the MCP "patched up the holes" as a "bandaid" on the real need, they (DPH and SFGH) won't hire, and that's the real solution".

In succession, the administrators advised the translators not to view themselves as the "Saviors of San Francisco General", or as "indispensible" to patient care. The Assistant Administrator summarized the administration's view:

> Let's not get too hamstrung over what we can't do. Remember that if you don't stay around, they will still get good care. If you do stay, they will get better care. But regardless the patient will get good care.

This statement was unacceptable to the translators, and over the coming months was to be repeated to me many times as indicative of the administration's insensitivity to the quality of care delivered in the absence of language communication. It solidified the translators' resolve to fight for a service they viewed as essential for their people to receive appropriate and safe health care; a view that the translators came to feel the program administrators as well as the hospital administrators did not share.

Structural Constraints and the Prewritten Script:

At the start of the MCP program, the administrative staff had high expectations for creating the model paraprofessional, community program. Job training with the promise of permanent positions, career advancement opportunities, and tuition-free college training in degree-granting programs specially designed for the Multicultural Program were promised to the MCP staff. It was a time of optimism. Many of the first and second group of trainees entered the MCP at that time with the hopes of long-term employment, career advancement, hope that now their lives would be better, and the satisfaction of helping their own people.

The gulf that developed between the MCP program administration and staff was a direct consequence of the strategies used by the city officials to maintain their power and control over SFGH. The most important of these strategies was the funding source choosen to finance the MCP program, the reluctance to award permanent job positions to the translator personnel, and lack of administrative support for the translator concept.

CETA:

The structural conditions that determined the funding

source for the Multicultural Program and the translator personnel is one of the major forces influencing the role evolution of the Interpreter Patient Assistant at San Francisco General Hospital. Thus, it is important to discuss the role that CETA funding and its regulations played in determining the form and day-to-day operations of the Multicultural Program and the consequences of this for the way the MCP personnel went about doing their jobs.

The legislative purpose of the Comprehensive Employment Training Act (CETA) was to establish programs on the local level that would train the unskilled in a specific job setting so that the trainee could then be hired into that institution's work force. As represented in the example of San Francisco General Hospital, the legislated CETA mandate for training came to be reconstructed as a funding supplement to the city budget (personal interview, February, 1981). CETA benefited the city and the population segment but it did not always benefit the interest of the individual CETA trainee who was trying to secure marketable job skills and permanent employment. During the period of fieldwork from October, 1978 to February, 1980, I encountered many personnel who had been employed with CETA funds from two to five years but with no prospect of securing a civil service position as a result of their "on the job training", nor did they see that they would have job skills recognized in the general job market.

With the introduction of CETA to San Francisco in 1972, the Department of Public Health created 1000 CETA funded positions for badly needed service programs. San Francisco General Hospital, as a part of that department, received CETA funded positions for the staffing of a large proportion of their lowest strata occupational categories and special service programs.

In an attempt to regain the legislated intent of the CETA program, the CETA office announced in October, 1978, that an 18 month limitation on training would be enforced. For the first group of translators recruited in April, 1978, the announcement meant that they had only 11 months remaining in their positions. The second Program Director inherited this unforeseen complication. She inherited also a need to win immediate allocation of permanent civil service positions as well as to secure other funding sources that would allow the program to operate as a service program whose primary responsibility was the delivery of patient care, rather than the training program it was under CETA restrictions. The Multicultural Program had been given the mandate to provide continuous language services, yet its funding source required it to function as a training program. The MCP administrators then were faced with the task of continuous recruitment and training. Just as trainees became functional in the work setting, they would leave for a new job or for another educational opportunity.

In addition to the 18-month limitation, CETA required each trainee to be allowed 2 hours per day for optional skills training at the CETA skills center. Time was to be allowed for job hunting and interviewing. As CETA became more sensitive to protecting the interests of the CETA trainee, the ability of the program to provide services and staffing coverage was further eroded.

Once the 18-month limitation was announced in October, 1978, the MCP program administrators were forced to withdraw any claims of job security within the MCP and to encourage the staff to start active job hunting. There began a steady attrition among those most marketable and the less community oriented. The MCP continued to exist due to the unrelenting pressure of community groups and health care providers. The sanctioning power of the state and federal Civil Rights enforcement agencies supported these groups' demands for language services. These dynamics forced the MCP administrators to become involved in the tasks of securing alternative funding from more solid sources than CETA, as well as securing the allocation of permanent civil service positions from the city. The three beleaguered MCP administrators (director, assistant director, and co-ordinator) did not have the time, the expertise, the support of their administrative superiors or the political clout in city government to secure the economic resources needed. Yet they were perceived by the translator staff as having this power.

Administrative Ambivalence:

The major factor causing delay in the conversion of the MCP CETA positions to permanent civil service (unknown to the translator staff) was both the ambivalence of Public Health officials and the SFGH administration about the concept of the language translator and their resistance to being dictated to by the community activists groups. Both of these themes are evident in the correspondence between SFGH and the state and federal CRO negotiators, between LEGHS (and CAA) and the CRO negotiators, in the minutes of the CRO contract negotiation meetings of September, 1978 to July, 1979, and in interview data conducted by CRO staff (data obtained from State Department of Health, Office of Civil Rights, SFGH files reviewed June, 1981). The lack of administrative support for the translator personnel concept is evident in this early CRO staff interview with the Director of the Department of Public Health in March, 1978:

> I still do not feel that these translators are the answer. I don't even think they are the short-term answer. I don't want people around the hospital who are basically translators that have some knowledge of how to take a patient from radiology to the emergency room. It gets back to what I said before, that I want people at all levels, you know, to be bilingual, bicultural.

This same perception of the translators as an emergency "bandaid" solution was related to me by the SFGH Administrators in interviews conducted at the beginning of fieldwork (1978 and early 1979). Ironically, the temporary trans-

lator positions were not acceptable to LEBHS either; it demanded as a condition of the CRO contract agreement that permanent bilingual positions be created as the long-term solution. (For an explanation of the interactional dynamics that blocked the allocation of the permanent bilingual positions see Chapter VIII).

Thus, the translator concept lacked fundamental administrative support from its very beginning. The program was created as a temporary, stopgap measure with time-restricted funding. The translator position carried the stigma of CETA, meaning "hardcore unemployables", lacked the usual employment benefits such as health insurance, paid a minimum wage, offered no career advancement opportunities, and no job security. These conditions communicated the message of "marginal", "superfluous", and "soon to go". The translator staff were unaware of the external structuring of their positions and the lack of higher administrative support. They perceived the consequences of these conditions as being due to the actions of Multicultural Program administration, and specifically the Program Director.

Consequently, the MCP administration's inability to gain outside funding and offer any job permanence began to evoke charges of incompetence and insincerity by June 1979. The staff's rebellion openly challenged the MCP administrators' right to remain in control of the program by demanding their

resignations in a letter of complaint to the SFGH Administrator. Again, the MCP staff's challenge was directed primarily at the Program Director as being ethnically inappropriate for the director position. The central demand was that the patient representatives and language translators be separated as distinct programs, with the current Director being removed from all aspects of the bilingual component. This conflict involved nearly the entire MCP staff, SFGH administration, LEBHS, CAA, Interns and Residents Association (SFIRA), and the Rebel Workers of the Socialist Party. It extended over a five-month period and greatly affected the manner in which the translators performed their work (See Chapter VIII).

The time, effort and political clout required to extract the allocation of permanent civil service positions from the Department of Public Health and the CRO, and then to effect actual hiring of personnel for these positions, proved to be the Achilles' heel of the MCP administration. In December, 1979, the first stage of the CRO-negotiated agreement regarding the transfer of MCP staff into permanent positions was realized with the allocation of nine permanent civil service positions. This concession followed 14 months of negotiations between SFGH, LEBHS, CAA and the federal CRO negotiators. But it must be remembered that for the first group of translators, their 18 month tenure was up in September 1979. Thus, to many of the translators, these nine permanent positions were "too little and too late".

At the time of this writing (May, 1981) four of the 33 original MCP translators are now employed in permanent civil service Health Worker positions. None remains in the Multicultural Program. All the administrative personnel involved have voluntarily resigned even when it meant losing their civil service tenure and job security. A Latino acceptable to the Latino community now directs the MCP in a much reduced version of the former program and is preparing for further shrinkage as all CETA positions are to be terminated in July, 1981.

This historical account omits the emotional and psychological toll that involvement in the Multicultural Program exacted from all its participants. The Multicultural Program's three year history included disappointed dreams, bitterness, pain, loss of physical health, depression, despair and human wreckage. The emotions and the cost ran high because the participants believed so strongly in the importance of the language service concept and came to invest much of their personal selves in the effort. But they were doomed before they had even started in a script written by structural constraints such as the funding source, by the ambivalence and lack of commitment to the translator or bilingual personnel concept of the SFGH and Public Health Department administrators and by a lack of access to resources.

Therein lies the human tragedy of our age -- an unre-

sponsive economic and political system that wears the appearance of responsiveness so that their victims are perceived by others, as well as by themselves, as being to blame for their failure. Such is the history of the Multicultural Program at San Francisco General Hospital.

CHAPTER V

CASE STUDIES

Role Variation: Culture, Social Structure and Social Interaction. The Analytic Framework

This chapter describes the range of functions performed by the language translators at San Francisco General Hospital and relates the observed variance in functions to the following: the socio-demographic characteristics of the translator group studied; the specific structural demands of differing clinical settings; and the dynamics of translator-patient and translator-health provider bonds during the patient-translator-provider interaction. These relationships are illustrated by the case examples of three translators who represent examples of different sociodemographic profiles as well as contrasting types of clinical placements. Sociodemographic profiles are based on the translator's degree of acculturation, age and life cycle, ethnicity, sex, and marital status.

Range of Role Functions Observed:

The functions that I observed translators performing showed considerable range and situational variation. In addition to the universal task of linguistic translation, I observed translators adopting a large number of other roles; specifically, they functioned as patient advocates, cultural representatives, advocates of Western medicine to patients,

health educators, acculturation conselors, family and marital counselors, labor coaches at childbirth, legal advisors on immigration problems, medical advisors on the management of long-term chronic illness, emergency loan resources, and lastly, as friends.

If the range of these functions is considered as a continuum of broad to narrow, all of these functions together represent the broadest role. The narrowest role would be a restriction of functions to literal translation and patient escort service. The majority of the 26 translators studied functioned as patient advocates, cultural representatives, Western medicine advocates and health educators, and thus these constellation of functions make up the medium range of the continuum. The majority of translators who performed on the broader end of the continuum were female, 40-55 years of age, and married with teenage or young adult children. In contrast, those performing in the narrowest manner were young, 20-26 years old, single or married males with dependent wives and infant children. Older males tended toward the mid-point of the continuum, as did younger females. Thus, the most significant variables associated with translators' actual role performance in order of importance were age, sex, life stage and marital status. Ethnicity, on the other hand, did not account for the observed variation, since it was distributed across the continuum.

Regarding the translators' self-perception of their role,

all 26 translators interviewed described their primary responsibility not as linguistic translation, but more generally as soing whatever was necessary to secure health services for their patients. Most often this involved referring patients to the appropriate clinical services or to special social programs for the patient's particular problem. At times this also required translators to intercede on behalf of the patient to secure services form recalcitrant personnel such as physicians, nurses, eligibility workers, and registration clerks. In addition most translators would physically guide their patients through the complexity of this county medical center. In performing these services, the translators acted as buffers between the patient and the health care system, personalizing and softening the patient's contact with a culturally foreign and impersonal institution.

The translators' role as intermediary often meant that they were left to their own resources as to how to tell a mother that her child had died in surgery, or that genetic deficiencies had been found in the fetus of on older mother and the physicians were advising an abortion, or to communicate the necessary information for a patient to give informed consent for cancer therapy or for a dangerous diagnostic test or surgical procedure. The nature of their work brought translators face-to-face with the brutalities of human existence, such as child rape and mutilation, the blood and trauma of the emergency room, marital violence, and the agony of the mother

who delivers a baby dead at birth. Their training, however, lacked the socialization process that characterizes health professional training, i.e. a clearly defined helper role and defense mechanisms to deal with this responsibility.

Instead of avoiding these demands, the translators struggled on and off their jobs to learn the essential anatomy and physiology, medical procedures, and counseling skills for all the major problem areas of living and dying, as demonstrated by the examples of the three translators presented below. They bought their own textbooks and medical dictionaries, and incessantly questioned the health providers around them. Some even took outside classes at their own expense and on their own time. In their behavior as well as their self-perceptions, the translators portrayed themselves as professionals and as an important part of the health care team, but these aspects of their role went largely unrecognized by the program administration, and often unacknowledged by the other health care providers beside whom they worked.

Three Examples of Translators:

(All names are pseudonyms)

Translator #1

Mrs. Guzman is a 46-year-old married mother of a 14-year-old son and a 13-year-old daughter who has lived in the inner

Mission with her husband and members of her husband's family for the past 10 years. The Guzmans make long and frequent visits to their native Central American home where they enjoy a middle class status. Their children are sent to private Catholic schools in Central America. Mr. Guzman is a skilled laborer and speaks only Spanish. Prior to working at SFGH, Mrs. Guzman worked as a medical aide in a medical oncology clinic in her native home town. Mrs. Guzman is a high school graduate. At the time that I worked with Mrs. Guzman, she was placed in the women's out-patient clinic (an Obstetrics and Gynecology speciality clinic). Mrs. Guzman organizes her work by keeping a daily log of patients seen, noting what has been done and future appointment dates. She would greet each Spanish-speaking patient and visit with them even when she was not needed as a translator, explaining to me: "I always ask them how they are doing, if they have any problems, and in this way I keep up on what's happening with all my patients". Mrs. Guzman also ensures that all the non-English speaking patients do not get missed by checking to make sure that they are being processed and that an interpreter request has been placed with the MCP dispatch.

Case Example 1:

In the time that I spent with Mrs. Guzman, I often noticed that women would come directly to her, bypassing the registration/appointment process. Mrs. Guzman would talk with them for a while and then would either personally schedule an

appointment for them, take them to talk to a nurse in the clinic, or send them on their way with her own instructions and reassurances. The following represents such an interaction.

> As Mrs. Guzman and I were preparing to leave the clinic for lunch, a young Latina with a three-month-old baby in her arms greeted Mrs. Guzman with urgency and relief at having found her. The woman rapidly told Mrs. Guzman about the problems that she was having with daily headaches since the birth of her baby. Mrs. Guzman took her into the clinic and quickly decided who was the appropriate provider to see the woman. She decided upon the nurse counselor and presented the patient and her concerns to the nurse. The nurse took a short medical history and then went out to see if she could get one of the clinic physicians to write a prescription for the woman's headache complaint. The clinic was officially closed at this time, and these consultations were being done informally, bypassing the normal processing procedures. The nurse consulted with the physician in the hallway, but when the physician looked back and saw the patient, she immediately refused to write a prescription, stating that this woman had not kept her postpartum follow-up visit. The nurse called back down the hallway to Mrs. Guzman to make the patient an appointment with a shrug of her shoulders, as if saying, "That's all we can do". Mrs. Guzman was left on her own to explain the treatment plan and rationale, and to secure the patient's cooperation to come back for a physical exam. After spending 15 minutes explaining these issues to the patient, Mrs. Guzman walked her over to the family planning clinic so that she could also get help with contraception. We continued to see this woman as we went back and forth to lunch, and later as we left the clinic to visit the maternity floor that afternoon. Each time, Mrs. Guzman would mention that she would be expecting the patient on the day of the appointment, "Don't forget now, it's very important."

<u>Case Example 2:</u>

The following case exemplifies the trust and rapport that develop when translator and patient have established a close

personal relationship, when provider and translator are known to each other and have evolved a good working rapport, as well as when patient-translator-provider have had previous interactions. In addition, Mrs. Guzman's style of relating to the patient can be seen to be one of strong emotional identification and assistance with health care problems even outside her own clinical area.

> The patient is a 35-year-old Mexican mother of eight. She is approximately 35 pounds overweight with pronounced varicosities in both legs, and a marked mask of pregnancy still on her face (a darkening in the facial pigmant across the cheeks, nose and forehead). Her hair is straight and pulled back by bobby pins, and her clothes old and shapeless but neat and clean. In her two-week postpartum visit last week, she was found to have an acute uterine infection, so this visit was to ensure that the infection was gone and to discuss plans for contraception. The nurse-midwife, translator and patient had worked together over the course of this woman's pregnancy and delivery, and had established a good working rapport.
>
> As Mrs. Guzman prepared the patient for the pelvic exam, the women objected, saying that she thought this was something that was supposed to end after the baby. The nurse-midwife explained continuously, with Mrs. Guzman translating simultaneously, why the exam was necessary and encouraged her not to feel embarrassed, adding that we were all women in the room anyway. Then the conversation turned to contraception.
>
> Nurse-Midwife: "Do you want more children?"
>
> Patient: Shakes her head "No" with a slow smile.
>
> Nurse-Midwife: "Are you going to have your tubes tied?"
>
> Patient: "No. My husband doesn't want that."
>
> Nurse-Midwife: "Are you using any contraception to prevent getting pregnant?"
>
> Patient: "He sometimes uses a condom, but not always."
>
> Nurse-Midwife: "Will your husband have a vasectomy?"

Patient: "No tiene huevos" (translated by Mrs. Guzman as "He is chicken")

The nurse-midwife then asked if the husband would come to the contraception classes in the evening. The woman just shook her head "No", and then Mrs. Guzman added that her husband refuses to come near the hospital.

Nurse-Midwife: "But you can have a tubal ligation even without your husband's permission."

The patient looked gravely at the nurse-midwife as Mrs. Guzman translated the above sentence to her. She responded slowly, starting and then stopping as if choosing her words carefully. Mrs. Guzman did not translate the patient's answer immediately, but just looked at us and then said quietly: "She says that her husband will leave her if she does that". No one in the room spoke until finally the patient looked up at the nurse-midwife, and tearily asked, "Que puedo hacer?" (What can I do?) The nurse-midwife reached out and patted her shoulder and said "Not much!". The patient began rapidly talking to Mrs. Guzman and to cry frankly. Mrs. Guzman translated to the nurse-midwife that the baby had been found to have a heart murmur and that they were planning on doing a series of tests on the baby tomorrow. After they explored the baby's condition, the nurse-midwife reassured the mother that the baby's condition was not immediately life-threatening, and Mrs. Guzman volunteered to accompany the mother and baby for the next day's pediatric visit. The nurse-midwife sent the mother home with instructions and supplies for the foam/condom method of contraception and wished her good luck. The following day I saw the mother come into the clinic and just stand by the door and wait. When Mrs. Guzman looked up and saw her, she immediately dropped what she was doing in the clinic (telling the nurses they would have to call dispatch if they needed a translator) and left with her.

Case Example 3:

This case demonstrates the tendency of the health professional to place translators in a direct provider role that requires medical expertise, and involves legal responsibilities. In addition, translators often found themselves in a position of "telling the doctors what they thought was wrong with the

patient" in response to physicians' requests for such input. In one instance, Mrs. Guzman found herself being chastised by the chief resident for not advising an older expectant mother of her right to an amniocentesis, despite the fact that a pregnancy history had been taken by a registered nurse and a physical exam performed by a resident. The following case illustrates this type of demand and Mrs. Guzman's strategies for limiting and coping with these demands.

> The patient was a 42-year-old woman from Guatemala who was pregnant for the first time. Due to her age the patient was enrolled as a high-risk obstetrical patient and she was being seen for her initial pre-natal visit and amniocentesis counseling. This woman was unaccompanied and shy. She smiled often but said little. As the resident, the translator and I prepared to enter the exam room where the patient was waiting, the resident told Mrs. Guzman that he wanted to do an amniocentesis on the patient today and directed her to explain this procedure and get the consent form signed. We all three entered the room as Mrs. Guzman countered the resident's directive by saying that she would take the patient to talk with the nurse counselor "who can explain it much better and can talk about the risks much better than I can."
>
> During the actual exam, the resident spoke only to Mrs. Guzman with instructions to impart to the patient about the physical exam he was conducting. When finished he stated: "Tell her if she doesn't want an idiot baby, she must take the test". Mrs. Guzman waved him off saying, "I will take care of it". Mrs. Guzman immediately located the nurse counselor and arranged for a conference by introducing the patient to the nurse, and explaining to her the reasons for the conference.
>
> The nurse expressed to Mrs. Guzman her distress over the resident's intention to do the procedure today at SFGH and not at UCSF where all previous patients had been referred. The nurse proceeded to read the prepared explanation of an amniocentesis and Mrs. Guzman translated the technical description, genetic risk, and probability of complications in a reciprocal sentence-by-sentence translation, but without the benefit of a prepared statement. Throughout the explanation the patient's glance darted back and forth between the nurse and the translator.

By the end of the explanation, the patient had stopped looking at them, and sat with her head hung down staring at the table.

In the initial visiting between Mrs. Guzman and the patient, the woman had conveyed a sense of happiness over her pregnancy. Now she sat slumped in her chair with downcast eyes. The four of us sat in silence for a while, until finally the question came from the nurse: "Ask her how she feels about the test. Does she want it?" Mrs. Guzman softly asked a one sentence question to which the patient answered with a turning of her head in a quick downward looking motion and a mumbled answer that Mrs. Guzman translated as, "She does not care much for it". At this point the nurse and translator conferred rapidly and agreed to tell the patient to go home and discuss it with her husband. The nurse and translator had decided between themselves that they were not going to allow the doctor to push the woman into it. So after this Mrs. Guzman simply walked the patient out of the clinic with instructions to come back and see her in two days, while the nurse went to tell the doctor that the patient had refused to make a decision today.

Two days later the woman walked into the clinic and stood by the door without saying a word. When Mrs. Guzman noticed her and went over to her in a warm greeting, the woman responded with a quiet "Hola". In answer to Mrs. Guzman's question if she wanted the test, she again answered simply, "si". Mrs. Guzman asked her again not believing her ears, and the woman again answered urgently, "Si, si". The public setting prevented any further questioning and the woman was quickly led away by the LVN to begin the processing.

At this point the chief resident asked Mrs. Guzman to call and make the appointment for the amniocentesis. Mrs. Guzman became upset and refused, saying that she was not supposed to do that, "I did that once and then I was told not to do it again". The chief resident answered: "Well, I want this done immediately". Mrs. Guzman attempted to avoid this responsibility by searching for the clinic's registered nurse and convincing her to handle the scheduling. But when she finally found the nurse and explained the task and its urgency, the nurse answered that she was too busy and could not do it right now. In exasperation, Mrs. Guzman turned to me and said: "See what I mean. Even she doesn't want to do it. They ask you a lot of questions and I don't know these things. I'm not a nurse -- that's their job!"

Mrs. Guzman eventually had to make the call because she could not find any one else who would accept the responsibility; but when asked questions that she felt were outside

the defined scope of her medical training, she demanded that the chief resident take the phone and answer the questions.

Case Example 4:

Mrs. Guzman acts as an acculturation counselor to her patients, explaining logistical adaptions such as how to use the city's bus system, shopping, banking, tactics for job hunting, and where and how to enroll in English classes. In addition, Mrs. Guzman sometimes advocates changes in values, behavior, and life goals. As I found with other Latina translators, marital problems are freely discussed between the patient and translator and figure importantly in a broad range of illness conditions with which Spanish-speaking woman present. The following case shows Mrs. Guzman acting as a cultural change agent and marital counselor.

> The patient is a 24-year-old married woman from Mexico who came into the gynecology clinic with complaints of pain with intercourse and possible vaginal infection. Mrs. Guzman had never seen this woman before, and so the interaction started out with just the proper social amenities and the securing of a brief medical history for the nurses' intake procedures. After the nurses completed their checking-in process, Mrs. Guzman accompanied the woman into the exam room to wait for the physician. During this "visiting" period, Mrs. Guzman found out where the woman was from, how long she had been in the United States and in San Francisco, who she came here with, what kind of visas they had, how they got the visas, and where the woman was living in the city.
>
> By the time the physician came into the room, Mrs. Guzman had obtained a social profile of the patient, as well as a detailed description of her medical problem. While the

physician elicited the medical information, nothing about the social profile was asked or volunteered by Mrs. Guzman. The resident conducting the exam was new in the clinic and Mrs. Guzman had not "decided what I think about her yet"; therefore, the resident was not yet considered trustworthy by Mrs. Guzman and the social information was not shared.

At the completion of the exam, Mrs. Guzman informed the resident that she was going to take the patient to talk with the health educator, so that the patient could have a better understanding of her body and the reasons for her problem. Mrs. Guzman then walked the patient into the health educator's office. The health education session included a detailed explanation of the female reproductive anatomy and physiology. Mrs. Guzman would translate after each paragraph of the health educator's explanation. But at one point, Mrs. Guzman stopped the educator saying: "Wait. Don't you want to include this, ..." to which the educator laughed and thanked her for catching her omission, and commented to me that Mrs. Guzman knew this material better than she did.

Since this patient had never been to SFGH before, Mrs. Guzman accompanied her to the laboratory to have her blood sample drawn. As we were walking down the hallway the young woman started crying. Mrs. Guzman ushered her into the family room whereupon the woman poured out her real concerns and reasons for coming into the clinic. The woman was afraid that the laboratory tests she was about to have would show that she was pregnant.

The patient recounted the conflict that this possibility was causing between her husband and herself. The couple had been unable to find work in the two months they had been in San Francisco, and were living with the woman's sister who was working and supporting them. The husband was demanding that the wife have an abortion or he would leave her. Their quarreling had involved physical intimidation by the husband. Mrs. Guzman listened to this grimly and then advised the young woman to "kick him out and start a new life". As requoted to me:

> I told her, you are young and pretty. You won't have any trouble finding another man. All your husband is doing is draining you. He isn't contributing or making money, so he has no right to act like the boss.

Once Mrs. Guzman had cued me in with this explanation, I excused myself from the room, telling her that I would wait for her in the clinic. Mrs. Guzman continued counseling the woman for an hour before taking her down to the laboratory. She later explained the rationale of her advice as being her own rejection of the woman's role in Latin

culture, which she described as follows:

> You always think about what they (husband and children) want, never about yourself. A woman in my country doesn't have a life of her own, and whatever the husband wants to do she has to put up with. He can beat her, run around and have all sorts of mistresses and bastard children, but she has to stay home at all times. If she takes too long coming back from the market -- he can beat her!
>
> But when women come here they don't have to live that way <u>anymore</u>. And I tell them,'The values are different here for women. You can take care of yourself first, and you should. You have a life of your own to live; enjoy it and don't take any more trouble off your man.' And that is what I told this woman. You see this country has changed me. I have learned a lot from being here.

Mrs. Guzman took an active role in this case and kept me informed of the outcome. Since the woman had no home phone, Mrs. Guzman gave her the clinic phone number and arranged for her to call or come into the clinic when she wanted to talk, which the woman did. The young woman decided to keep the pregnancy, and Mrs. Guzman gave her strong support in this decision. The decision resulted in her husband's disappearing for long periods; when he did come home they would quarrel, and often the quarrels would end with the husband beating the wife. As Mrs. Guzman explained to me, her strategy for helping the woman included enrolling her in English classes and constantly checking her progress, obtaining supplemental food for her to relieve some of the economic pressure, and urging her to become more assertive and independent of her husband.

<u>Case Example 5:</u>

I witnessed Mrs. Guzman acting as a patron towards her clients several times, sponsoring them in numerous ways, including giving them money when they had no food. I also observed this type of giving from other Latina translators who approximated the same sociodemographic characteristics as Mrs. Guzman.

A case that demonstrates this aspect of Mrs. Guzman's role function is that of a 17-year-old, unmarried girl who presented to the clinic eight months pregnant. The girl was here without family, visa, job or financial support. To guard against discovery of her pregnancy, the girl was traveling a great distance for her first prenatal visit to SFGH. In addition, due to her illegal immigration status, the girl would not give her home address or phone number, and to be eligible for care at SFGH these data are required. To make the girl appear as a San Francisco resident, Mrs. Guzman gave her home address and phone number and this strategy for obtaining care for the girl was worked out between Mrs. Guzman and the registered nurse counselor.

As well as directly sponsoring this girl so that she could pass the eligibility requirements for receiving care, Mrs. Guzman treated the young mother-to-be with great tenderness throughout the entire interaction. The girl was tense over having her first pelvic exam, and came close to fainting twice during the exam, and when she started to get sick, Mrs. Guzman brought her water and a cool wash cloth for her face. She admisistered to the girl as some mothers would have done.

She next took the girl for a prenatal class that she arranged specially for the girl with the nurse counselor. Following the class, Mrs. Guzman took her to the family planning clinic for vitamins and supplemental food. Since part of the dietary counseling revealed the girl had not eaten since the day before, Mrs. Guzman bought her lunch in the hospital cafeteria and sent her home with money for food.

In her usual way, Mrs. Guzman personally scheduled the girl's next clinic appointment with an explanation of why it was important that she keep the appointment. Mrs. Guzman gave the girl her home phone number to call if she needed help, and further instructed the girl that if she could not make the appointment to call her at home and she would reschedule for her. Mrs. Guzman ended the visit by escorting the young patient to the elevators, visiting gently with her as she would her own daughter.

Discussion:

Mrs. Guzman personalizes the services that Spanish-speaking women receive from the women's clinic at SFGH. Instead of hav-

ing to cope with an impersonal institution with a constantly changing medical staff and an assistant staff who tend to impersonally process all patients, regardless of their ethnicity, the Hispanic women experience the clinic through the permanently stationed intermediary -- Mrs. Guzman. She blunts the impersonalities of the clinic, ensures that all aspects of the patient's medical concerns are addressed by the medical and nursing staff available, facilitates patient education, secures future compliance, and provides a continuity of care.

Mrs. Guzman comes to personally know most of the clinic's Hispanic patients and the social and financial factors in their lives that bear on their health care needs. She takes the time to listen to her Spanish-speaking patients, and communicates her commitment to securing health care services for her clients by arranging the delivery of these services by medical providers, as well as by assuming a direct provider role herself as counselor (financial, cultural, medical, and psychological) and as a referral broker.

Translator #2:

Mrs. Luk is a 50-year-old mother of three -- a girl 21 years, a boy 19 years, and a girl 17 years. She met and married her husband in Los Angeles 22 years ago while she was visiting from her home in Taiwan. She and her husband first lived with the husband's parents in the outer Mission, and

when they were economically able to buy their own home, the Luks settled in the ethnically mixed area of Potrero Hill. Mrs. Luk worked as an accountant for the U.S. military before coming to the United States at the age of 27, but had not worked outside her home prior to her job as a translator at SFGH. Her two oldest children are attending a local city college and live at home, but future plans are for them to transfer to major U.S. universities that will take them away from home.

Mrs. Luk is a "floating" translator, meaning that she responds to dispatch requests throughout the in-patient units, out-patient clinics and the emergency room. Mrs. Luk speaks three Asian languages but is most often requested for Cantonese. At the time I accompanied Mrs. Luk she was working the afternoon shift. Mrs. Luk always begins her shift by checking in with the dispatch office in a building adjacent to the hospital/ out-patient complex for any translation requests or messages. If there are no requests, or if she has free time during her shift, Mrs. Luk sits in the out-patient lobby and "picks up" patients, rather than sit in the staff room in the dispatch office. As she describes this strategy:

> Quite often when patients come in they don't know who to speak their language, they are very happy when they see someone speaks their language there to help them out. They are new to the hospital and they don't know where to start. Quite often they are referred from Northeast Medical Center (in Chinatown) or a clinic. That's why I like to sit in the out-patient lobby and you can help people this way.

On this particular day two requests were waiting for Mrs. Luk, one in the orthopedic clinic and another in the maternity unit.

Case Example 1:

When we entered the out-patient lobby, a Chinese couple jumped up and hurried toward Mrs. Luk. Mrs. Luk knew they were waiting for her because she had prearranged their meeting in the orthopedic clinic. This strategy bypasses the MCP dispatch and guarantees she will be their translator, and is viewed by Mrs. Luk as a technique that she is forced to use to maintain continuity of care for those whom she defines as "her" patients.

As soon as this brother and sister saw Mrs. Luk, they broke out in big smiles and greeted her warmly. The woman frequently touched Mrs. Luk during their conversation by placing her hand on Mrs. Luk's arm. After the social greetings had been completed the woman pulled Mrs. Luk aside and started talking to her in a whisper very close to her ear.

Mrs. Luk would alternate between looking at the woman and down at the floor or off at the wall, but she kept a concerned look on her face throughout the woman's discourse, which she responded to from time to time with an "Ahhhh..." and a sympathetic shake of her head. The woman looked intently at Mrs. Luk all the while and talked hurriedly with urgent gestures. After about 10 minutes Mrs. Luk extracted herself from the patient, and with a crisp, "let's go!" to me, ended their interaction.

Case Discussion:

Mrs. Luk explained her system for meeting patients with previously scheduled appointments. In this case, the woman had needed to talk to her about her "female problem" prior to her clinic appointment. The woman was distressed over the fact that she had gone to a private physician who had done a complete

physical, charged her $100, but did nothing for her vaginitis, saying that it would go away on its own. The woman still had her "female problem", so Mrs. Luk advised her to go to the medical clinic in Chinatown rather than SFGH's Women's clinic because it would be easier for the patient to reach on public transportation from her home in the Richmond. More importantly, because there she would be taken care of by Chinese staff and this would avoid the need to depend upon a translator as well as the risk that the translator might be male.

In using this strategy, Mrs. Luk demonstrated her sensitivity to the importance placed on having a female staff for gynecologic problems in Chinese culture, as well as the desirability of being cared for by a Chinese-speaking staff.

Case Example 2:

Mrs. Luk answered a translation request in the maternity unit for a new mother who was waiting for discharge instructions. While we waited for the nurse, Mrs. Luk visited with the new mother and admired the new baby. The discharge instructions covered plans for getting formula for the baby, supplemental food for the mother, and a two-week follow-up appointment.

Mrs. Luk interceded to tell the nurse that the woman lived in Chinatown and that it would be better for the patient to have her post-natal care through the Chinatown health clinic. The nurse agreed and then made the proper arrangements. Without Mrs. Luk's intervention the woman's follow-up appointment would have been made for SFGH and most likely not kept.

After the nurse left, Mrs. Luk stayed and visited with the patient for about five minutes more. She appeared to be in no hurry. Mrs. Luk had been involved with this patient prior to the woman's delivery, which had been less than 24 hours earlier.

Once we left the patient, Mrs. Luk, who is five inches shorter than I, walked at a pace I had difficulty keeping up with in her urgency to check for patients in the labor and delivery unit on her next routine stop.

To my questions regarding the new mother, she explained that she had been reassuring the woman that everything would be all right and encouraging her to use the Chinatown health clinic when she went home. Mrs. Luk provided a brief social sketch of the patient. She was Laotan, but Chinese-speaking, because her family business in Laos dealt with Chinese clients.

The patient had married a Chinese and recently immigrated to the U.S., but as Mrs. Luk was recounting this social history, she looked at me sideways, half smiled and paused before concluding" "You know she is not Chinese, she just speaks Chinese". Mrs. Luk closed the case discussion by saying that the woman had had a hard time and that she had been through a lot since leaving her home and family in Laos.

Case Discussion:

Mrs. Luk communicated a warmth and caring to this new mother without assuming familiarity or superiority. In her conversation with the woman, she indeed addressed the patient's needs for nursing instructions, hygiene practices and follow-up health care appointments. But she went beyond that level of physical care in assessing the patient's entire care needs. As one pediatric resident described Mrs. Luk to me:

> She is professional without being cold or removed from the pain and suffering of the patient, or from the doctor's efforts to work with the patient. She does not impose her personal ideals or values on the patient in an untimely fashion.

In the above case, Mrs. Luk greatly assisted the providers' efforts by knowing that the patient lived in Chinatown and that therefore compliance would be enhanced by planning

follow-up care through the Chinatown clinic. Similarly to Mrs. Guzman, Mrs. Luk familiarizes herself with the social background and concerns of the patient. Then she attempts in a variety of ways to diminish the patient's stress and anxieties, and to plan resolution of pressing life problems. Significant in her depiction of this new mother was her statement: "You know she is not Chinese". Mrs. Luk understood only too well from her own life experience the marginality of this woman's status in Chinatown and within her husband's family. Consequently, in addition to her health care provider functions, Mrs. Luk assumed the role of empathetic supporter and friend to this alienated young woman because this was her prime health care need.

Case Example 3:

The following case demonstrates Mrs. Luk's extra role functions as a health care provider and labor coach. Mrs. Luk acquired this case as a result of checking the blackboard listing for the names of patients in labor during her routine afternoon rounds. In doing so she noted a Chinese last name, checked and found that the patient did not speak English, and thereupon assumed care of the patient.

As soon as Mrs. Luk and I entered the patient's room, one of the delivery nurses came in and said, "Good, now we have a translator". This puzzled me because there had not been a translator request filed at the dispatch. They had not called for a translator, and when I asked a nurse about this later, she admitted that they were too busy and if Mrs. Luk had not checked in they would have handled the delivery without any translation.

The delivery room nurse explained that due to their number of non-English speaking patients, and their heavy work load, they simply do not have time to secure translation services for their non-English speaking patients even though translators are available. So as a rule the nursing staff does not call for a translator.

Once Mrs. Luk was available for translation, however, the nurse used her to obtain the patient's previous obstetrical history, and to check on the patient's level of discomfort with her contractions, which were occuring every five minutes and lasting from 60 to 90 seconds.

The woman did not utter a sound during the contractions and appeared comfortable as if she was absorbed in thought. When asked by the nurse during her contractions if she was having pain, the woman waited until the contraction was over and answered to Mrs. Luk, who in turn said, "No, just feels like she has to move her bowels". To this the nurse replied, "Good, that means that the baby's head is coming down the birth canal", and then left the room. Mrs. Luk stayed next to the patient and quietly started "visiting" with the woman and getting involved with her physical care. The nurse returned in a few minutes to ask if the patient was hungry or wanted something to eat. Mrs. Luk translated back to the nurse that she wanted water, then added "hot water".

Mrs. Luk stayed with the woman for about 20 minutes longer, and then alerted me that we needed to go to another patient she knew was waiting for her in the orthopedic clinic. When we returned to the labor and delivery unit approximately an hour later, Mrs. Luk walked right into the patient's room even though there were two nurses working in the room. She did not ask their permission to enter. Mrs. Luk looked directly at them in a silent stare. The nurses were preparing to start an intravenous infusion on the patient.

One of the nurses said to Mrs. Luk as she was posed with the needle over the patient's arm: "Oh good, you can tell her that we are going to start an I.V.". Mrs. Luk spoke one sentence to the patient nodding at the nurses as she spoke. I stayed in the room long enough to note that the nurse trying to start the I.V. had never done the procedure before, and decided to leave. I told Mrs. Luk softly that I would wait outside until they were finished.

Twenty-five minutes later, Mrs. Luk came out with no expression in her face, but sputtered out that it had taken the nurse five tries to get the I.V. started. After a short pause she added: "I never knew that she was a nurse before. She has always been a clerk. Well maybe she is LVN", and shook her head in disbelief.

Mrs. Luk took me back into the patient's room. The woman who previously had been composed even during her contractions, now appeared frankly uncomfortable. Mrs. Luk spoke to her and then looked grimly at me, explaining that now the woman was having pain. As if she could not contain her displeasure over the I.V. situation, Mrs. Luk stated angrily: "I don't understand why they do that. She was fine before."

The woman proceeded to deliver a baby girl in the next 20 minutes with Mrs. Luk right at her side, instructing her in breathing techniques and sometimes demonstrating by example how the patient should be breathing. (Mrs. Luk had learned on her own to be a labor coach, as did many other women translators). And as the nurses or physician would give instructions or explanations to the patient, Mrs. Luk would translate.

The baby was wrapped in a blanket and placed on the mother's stomach. The mother showed no emotion as she viewed the baby. This worried Mrs. Luk. The mother had a hand on the baby to keep it from falling, and when the nurse asked her if she wanted to continue to "hold" the baby, the mother shook her head, "no". After the nurse left to take the baby to the nursery, only Mrs. Luk and I were left in the room.

The mother looked at us with expressionless eyes. Mrs. Luk immediately started caring for her. The woman told Mrs. Luk that she needed to move her bowels, so Mrs. Luk hunted up a nurse and received permission to put the woman on a bedpan. Once back in the room, Mrs. Luk found the bedpan and then placed the woman on it, which was no small feat. The task involved positioning the bed in two different positions, removing the woman's peri-pad, instructing the patient to lift up her hips, and then sliding the pan under her. Mrs. Luk performed this task like a trained nurse.

At this point the entire nursing staff were involved with an emergency situation down the hallway, leaving no one to attend to this new mother. After cleaning the bedpan, Mrs. Luk changed the bedsheets under the patient which were soaked from the delivery. Changing a bed with a person in it is not easy, and yet Mrs. Luk did not hesitate, and even demonstrated her expertise. After Mrs. Luk made the patient comfortable and brought her hot water to drink, we left to check on the baby in the nursery.

As we were leaving, however, the husband arrived, so Mrs. Luk invited him to come with us. As we went to the nursery Mrs. Luk and the husband exchanged polite sounding conversation. This was the couple's second child and second girl., and Mrs. Luk had told me that she was concerned that they might reject the female baby.

When we arrived in the nursery the baby was being examined by a resident distraught over having to finish someone else's work, which required her to work overtime. The distressed resident interrupted her diatribe long enough to ask the father if he wanted to hold the baby, as she thrust the baby towards him. Mrs. Luk translated, but it was not necessary. The father immediately reached out in response to take his baby.

The new father broke out in an uncontrolled and unsure smile, but as he continued to hold his baby the hesitancy disappeared. He held the baby as if he could not believe his eyes--very gently as one would hold a fragile object of immense value. Mrs. Luk was all smiles, relieved to see the father's acceptance of the baby.

The resident continued to talk to her colleague oblivious to the life drama around them. After the father returned the baby to the examining resident, we started towards the elevators. Once in the hallway though, the husband talked earnestly to Mrs. Luk for about 20 minutes, while I waited some distance from them.

I knew that the conversation was serious by the expression on Mrs. Luk's face. All the smiles were gone. She assumed a solemn, attentive expression and listened to the husband with a slow nodding of her head. After listening for a while, Mrs. Luk began to speak in her rapid, purposeful, excited manner that stands in such contrast to her social, visiting style. Shortly thereafter, they concluded their conversation and the husband returned to his wife while we prepared to make in-patient rounds. Mrs. Luk reviewed the case for me, explaining the husband's conversation as follows:

> "It is very unusual that someone will be that open with you about his troubles (nodding at the retreating husband). Usually they are much more (long pause) reserved. But he just talked to me about it openly. It is financial trouble. He has been out of work for some time, and now he finally has a job but it is paying only $500 a month. And he is worried how to make it.
>
> So I told him about food stamps, and suggested that maybe he should get some training so that he can get a better job. Go to school on one of these special training programs, and I told him where to go for the information. But he is worried about the money. You know that it is hard for people when they first come here. They may be professionals at home, but here their degrees don't mean anything. They have to start over. So I was able to help him by telling him where to go for English classes, how to get along with the American people, getting a house."

> (smiling at me self consciously) I tell everybody, 'Learn English, get a job. I tell the women too, 'Get a job. But the people that come here (SFGH) need a lot of help. And I know a lot about where they can go in the city, so that I can tell them where English classes are, where to send their children to school, what kind of financial help that they can get."

Case Discussion:

In the above case, Mrs. Luk functioned as a direct health care provider, labor coach, and as occupational and acculturation counselor. In addition, she anticipated the possibility of the parents' rejection of the female baby and its negative repercussions for the mother. In this instance the threat did not materialize, but I have worked with Mrs. Luk on cases in which it did. In these situations, Mrs. Luk directly confronts the cultural valuing of males over females, discounting it and presenting the concept of equality between the sexes. Similarly to Mrs. Guzman, she works as a cultural change agent.

As a labor coach, Mrs. Luk's presence had a direct impact on the quality of care the woman received. The difference made by the presence of a translator during the labor experience for a delivery patient is described below by a Spanish-speaking, fourth-year Family Practice resident. The resident included Mrs. Luk in her examples of translator/labor coaches who facilitate the physician's ability to manage the delivery process technically for non-English speaking patients.

"When you can't communicate with an O.B. patient, they have a harder labor. It's longer and they require more medication, and it's not a positive experience for them. It's more close to a nightmare for them. There is less familiarity. Everything is culturally alien, and they have no one to translate the technology and the culture of the Western medical world for them.

"It is a well-known point that if a woman is having trouble you get a labor coach and it calms the patient, and helps them with the delivery. And you would certainly try to get a labor coach before you would use medicines on her.

"A woman is more likely to have an episiotomy, or to tear, if you can't give proper instructions on pushing and breathing. Without being able to talk to the patient she is unable to follow your directions for breathing and pushing, or to understand what is happening with her. She has greater pain, duration, and intensity of labor.

"In O.B., the presence of the translator makes a clear-cut difference in the outcome of the patient's delivery. Translators like Mrs. Luk make the difference between a safe, familiar delivery, and one with potential complications due to the patient's tenseness and increased anxiety state."

This case also demonstrates Mrs. Luk's total care approach to the patient. In her initial visiting with the patient during the contractions, she elicited family and social background information for clues to the patient's private concerns and anxieties; e.g., attitude toward the sex of the baby, husband's occupation status, living arrangements, etc... In addition, Mrs. Luk displayed astute clinical assessment skills in her physical care of the new mother. In every aspect of her interaction with this couple, Mrs. Luk communicated empathy, caring, and a willingness to do whatever she could to help them. Undoubtedly, it was the husband's assessment of Mrs.

Luk as being trustworthy and kind that allowed him to confide his private concerns and ask for her help.

Case Example 4:

This patient was the same woman Mrs. Luk had greeted in the out-patient lobby when she had first started her day. Due to Mrs. Luk's involvement with another case she had been delayed in meeting this patient, so that by the time that we arrived in the clinic the exam was almost over. Even though Mrs. Luk knew that a young male translator was working on the case she maneuvered the situation so that she could relieve him.

After walking to the door and greeting the patient (who responded with something that sounded like, "Oh, there you are!"), Mrs. Luk inquired of the other translator, "You were called from the dispatch?". The male translator stepped back away from the door saying, "Yeah, but if you are here, I will go. I have my own patients in the clinic", and left. This is in direct conflict with the principle taught in their training that the same translator who starts a case should finish it.

Once the male translator left, Mrs. Luk immediately assumed care of the woman, going to her and physically examining the woman's legs. To my amazement the patient had long involved scars on both legs. It looked like the right knee had been repaired extensively, and that the left hip had been pinned. Once I saw the scars I understood Mrs. Luk's reference to a "long hospitalization", the length of their relationship, and Mrs. Luk's territoriality regarding this patient.

Mrs. Luk and the patient talked about her progress, with the patient demonstrating her improvement by moving her legs in different positions. The physician returned and reviewed with the patient her exercise schedule, stressed the importance of the exercises, reassured the woman that she would continue to improve and then planned for the next appointment.

Mrs. Luk translated immediately after each sentence spoken by the physician, gesticulating and emphasizing her words in imitation of the physician's nonverbal communication. The woman nodded her head and reassured them that she was doing her exercises and would continue to do them.

After the physician left, the patient immediately brought up her vaginitis concern. Mrs. Luk reassured her that the Chinatown clinic would be able to see her that week and instructed her to call as soon as she got home. Mrs. Luk escorted the woman to the waiting room where the woman's brother was sitting, and said her goodbyes to the couple.

Case Discussion:

In this case Mrs. Luk most noticeably acted to support the physician's exercise treatment plan and to ensure the patient's compliance by assuming great personal concern over the patient's progress. Underlying these aspects of the translator-patient relationship, however, were Mrs. Luke's direct provider relationship with the woman, her constancy as well as her availability for health care advice on concerns that the woman felt inappropriate to discuss with her male orthopedic physician.

Case Example 5:

After completing the above case in the orthopedic clinic, and without a word of explanation to me, Mrs. Luk started looking frantically through each exam room. It was only when she found a Chinese woman sitting alone in one of the rooms dressed in a patient gown that I understood what was happening. As in the above case, this was a patient whom

Mrs. Luk had been working previously and had scheduled for an appointment today with the promise given and accepted that she would be there to translate.

As soon as the patient saw Mrs. Luk her face lit up and she smiled a big smile. They spoke simultaneously in their greetings. The woman was in her mid-40s and attractive in her personal appearance. Her fingernails and toenails were meticulously polished. Mrs. Luk paused to tell me that this woman was a Vietnamese refugee but was Chinese, and that during her escape she had fallen and dislocated her shoulder. Months later when she had arrived in Hong Kong, a Chinese herbalist doctor tried many times to physically reduce the dislocation but without success. The herbalist advised the patient to have the conditions surgically corrected by a western doctor.

Due to her lack of financial resources, the woman had had to wait until she arrived in San Francisco to see a physician and by that time 18 months had elapsed since the original injury. As a result of the uniqueness of the woman's condition, the physical exam involved the entire clinic's house staff and attending physician.

The object of the present visit was to receive the medical staff's decision as to whether the condition was surgically correctable. The resident explained, through Mrs. Luk, that they had decided her shoulder was not correctable. After the house staff left, the resident attempted to explain the rationale behind their decision.

The resident outlined the anatomical reasons why her shoulder now worked the way it did, tracing the head of the humerus and the attached ligaments in an effort to show why surgery could not correct the now permanent damage to her shoulder. Mrs. Luk translated rapidly and without hesitation. She would allow him to speak until he had said all that she could retain and then she would cut in with her translation. When she stopped, the resident would continue until she stopped him again. Both felt comfortable with each other, and as I watched the smoothness of their team effort I sensed that this working style was the result of many previous interactions.

After this elaborate explanation, Mrs. Luk translated the patient's concerns back to the physician, her fears about her ability to work, whether the condition would worsen in the future, and about the possibility of pain (the patient was pain-free at the time).

The resident wrote a letter certifying her ability to work immediately and attached his card in case she or an employer might need to speak to him directly. Next he explained that due to the uniqueness of her injury they simply did not know how it would progress, but assured her that they thought she would do well; he told her to come back at any time in the future and they would continue to care for her.

Mrs. Luk informed me later that she had asked about the future because this was something that she thought the patient would want to know later. Mrs. Luk also confirmed my suspicion that she and this physician had worked together a lot and that she thought highly of him: "He is a very kind doctor. He cares about his patients. I think he is a doctor that anyone would like to have take care of them."

After the visit was over, we escorted the patient to the elevators, but now the topic between the two of them had changed to the woman's concern over getting a job and the need to get her 16-year-old daughter enrolled in school so that she could receive a high school diploma. The patient related to Mrs. Luk that the church people who were sponsoring her here told her that her daughter was too old to be eligible for high school enrollment.

Mrs. Luk recounted that she suggested to the woman that the church people did not know all the regulations, and recommended that the woman go directly to the Board of Education office on Grove Street. Mrs. Luk further counseled the woman in her rapid conversation about the proper places to plan on sending her daughter to college, job hunting strategies, and the type of work to do while learning English.

In addition to urging the woman to take English classes, Mrs. Luk outlined where and how to enroll in them. After we left the woman, Mrs. Luk told me heatedly that "these church groups all pretty much work the same way. I don't think they know very much about schools and jobs, and they give the wrong advice."

Case Discussion:

The medical terminology and anatomical and physiological knowledge of the musculoskeletal system required for Mrs. Luk to translate the orthopedic resident's explanation of the woman's injury, functional impairment, and the limitations

of surgery to correct it exceeded my own medical knowledge -- that of a registered nurse. I was dumbfounded not only that the resident would expect non-medically trained personnel to attempt such a technical explanation, but also that Mrs. Luk would undertake the assignment without hesitation.

In addition to these technical translations skills, Mrs. Luk engaged the woman in planning for basic self-sufficiency goals, e.g., English classes, job hunting and educational plans for the woman's daughter. In this capacity Mrs. Luk acted to assist new immigrants in their cultural, social and economic assimilation into San Francisco and U.S. society. Her anger at church groups for "giving the wrong advice" was also directed at what she perceived to be the outcome of that advice -- the immigrant's continued subservience to and dependence upon the sponsoring church institutions.

Case Example 6:

Mrs. Luk answered an urgent dispatch request for a translator to go to the emergency room for a trauma case. When we arrived we found an owner of a cleaning business who had been attacked and severely beaten in a robbery of his business. The man's wounds had already been sutured and was preparing to go home with his wife. Mrs. Luk determined that he had been treated up to this point without a translator, but that now the medical staff needed to instruct his wife in how to care for his concussion and stitches.

The striking features of this interactional dynamic, in marked contrast to the above case examples, were the logistical content of the interaction and the deferent manner in which Mrs. Luk related to the couple, as well as the couple's non-deferring manner of responding to Mrs. Luk. The couple talked mostly between themselves, addressing Mrs. Luk only when they needed information or help with logistical arrangements, such as locating the man's clothes. Mrs. Luk answered their questions in a deferential manner that belied her normal confident carriage.

At no time did this couple demonstrate any relief, joy or gratitude over her approach, or for her help in interacting with the English-speaking staff. They did not smile, bow or express any deference towards Mrs. Luk. And while Mrs. Luk did all that she could to help them, the interaction lacked the empathy and closeness I had witnessed with her lower socio-economic patients, who would touch her frequently, bow their heads slightly, laugh, and ask her advice. In contrast, this interaction was characterized by aloof politeness and independence from the translator. As soon as the logistical tasks were completed, Mrs. Luk excused herself with a polite farewell to the couple and we departed. There had been an absolute absence of social visiting between the translator and the patient and his wife. In addition, instead of discussing the case with me as we went on our way to the next task, as she usually did, Mrs. Luk responded to

my inquiries with a noncommital comment about crime rates. She had nothing to say about the case.

I had worked on many emergency room trauma cases with Mrs. Luk prior to this interaction, and none had these interactional characteristics. What did differ, however, was the social status difference between translator and patient. This couple were well dressed and the wife wore expensive jewelry. Mrs. Luk in contrast wore a loosely fitting homemade blouse and slacks, ankle socks and heavy-duty walking shoes. There was a marked social-class difference between the patient (couple) and translator which was mutually perceived and it interfered with the usual superiority position assumed by the translator in relation to the patient. In this instance, Mrs. Luk was assigned by the couple, and indeed herself assumed, the status of an unskilled worker performing a service similar to the "hired help" in any business.

Discussion:

Due to the floating and multi-clinical nature of Mrs. Luk's translator assignment, she had to develop different strategies for following "her" patients than did Mrs. Guzman, who was permanently placed. These strategies consisted of meetings, or simply going to the clinic at the time of the patient's appointment. Mrs. Luk assumed direct-provider responsibility for patients who required long-term care,

either in the in-patient units, or through the out-patient clinics for conditions that involved continued follow-up. These types of patients comprised her private "case load". One instance that demonstrates this definition of "private patient" was that of a young 16-year-old Vietnamese boy with whom Mrs. Luk had been working for six weeks. The boy was scheduled for an 8:00 a.m. medical conference meeting at which his future treatment plans would be decided and explained to him. Mrs. Luk asked permission from the MCP administration to rearrange her work schedule so that she could do the translation. Her request was denied since other translators would be available, and she was admonished by MCP administrators for becoming too involved with her patients. Mrs. Luk viewed the use of a "strange" translator as threatening the patient's confidence and trust in the medical services that she had worked so hard to win. Her angry response to the administration's policy of noninvolvement was, "What do they know about patients anyway?" and it was the last time that Mrs. Luk went through "proper channels" to ask permission to care for her patients.

In her capacity as a translator, Mrs. Luk acted as a career, educational, occupational and acculturation counselor, labor coach, health educator and advocate of western medicine. Not described in the above outline of Mrs. Luk's job performance are instances in which I observed her to function as a psychiatric interviewer, an empathetic comforter of distraught

family members, and a death-and-dying counselor to families. In contrast to Mrs. Guzman, Mrs. Luk avoided marital and family counseling, prefering to refer these problems to Chinese pastors. Nor was Mrs. Luk able to effect the same degree of health education as Mrs. Guzman, due to her multi-clinical coverage and lack of personal ties with clinic personnel. However, due to her heavy load of maternity patients, Mrs. Luk had learned about SFGH's policies on new-born care and family planning, and routinely instructed new mothers on these matters. As she observed:

> "Some doctors or nurses explain to the patient every detail of everything, but some don't. Some nursery nurses, when the patient is discharged, they explain to the patient. How to take care of the baby and how to bathe the baby, and even about the formula; but some don't. And whenever I have time, if this is the first baby for the mother and I tell the patient about those things.
>
> And if the doctor doesn't explain to the patient about birth control then quite often I talk to them about it. I pick up some pamphlets (from Family Planning clinic) in Chinese but there's no pictures, and I explain to them especially those who have two babies immediately."

Lastly, similarly to Mrs. Guzman, Mrs. Luk kept notes on the treatment plan and dates of clinic appointments on her patients. She gave out her home phone number to patients and physicians alike so that they could contact her for rescheduling needs and emergency situations. Mrs. Guzman and Mrs. Luk exemplify the sociodemographic profile of translators who gave the broadest definition to the role functions of trans-

lators. The different interactional styles of the two women can be traced to (1) Mrs. Luk's rejection of cultural insularity (i.e., residence in Chinatown) while Mrs. Guzman maintained long term ties to the Mission district and her native country; (2) cultural differences regarding discussion of family, sexual and marital problems with outsiders; (3) differences in structural demands of their clinical sites.

The next translator represents a contrasting sociodemographic type: a young single (or newly married) person with no (or young) children who was born and/or educated in the United States. It is this subgroup of translators which tended to give a narrower definition to the role functions of translators. However, this is not to say that this translator subgroup was any less dedicated, concerned or caring than that which gave a broader definition to the translator's role functions. On the contrary, there was <u>no</u> difference between the two "types" of translators. Rather the difference lay in their perceptions, interpretations, conceptions and assessment skills. Age and life experience greatly influenced these qualities in a translator, as did the learned role behavior of "maternal instinct", as well as the extent to which the translator had internalized the U.S. cultural values of automony, independence and self-reliance.

Translator #3:

Mr. Frugoli is a recently married 28-year-old who was born and raised in Santa Rosa. He lives in a residential area adjacent to the Mission district. When asked by patients about his ethnic background, he names the Latin American countries of his mother's and father's birthplace and indicates that they frequently visit "home" but omits that he is native-born. Mr. Frugoli is considered ethnically "Lanino" by his fellow translators due to his pride in his ethnicity and his orientation to the ways and traditions of this parents' home countries.

Mr. Frugoli speaks fluent, formal Spanish and at the time of his employment at SFGH, both Mr. Frugoli and his wife were finishing their Bachelor's degrees at a local university. By the time I did my observational rotation with Mr. Frugoli, he had been working as a translator for one year, and was then stationed at the Mission Emergency Room (E.R.). For the sake of his anonymity, I will not compare Mr. Frugoli's role functions in the E.R. with those he performed in his previous clinical placements.

In his work setting, Mr. Frugoli would stand at the front nursing station which faced the main ambulance entrance into the emergency room. This station served as the "triage desk" where all patients are first screened and then evaluated for

type and severity of their condition and assigned to the appropriate ward for treatment. If a patient's condition is judged to be not urgent, he/she is scheduled for an out-patient appointment. Thus, the work at this station consists of processing and dispersing patients to some other point in the hospital system. Mr. Frugoli fits into this system by receiving patients, taking their complaints and then relating brief medical histories to the nurse when the patients are evaluated. In addition to assisting with the triage procedures, Mr. Frugoli is required to help answer the constantly ringing triage phones. To handle the telephone traffic, Mr. Frugoli had to learn how to refer calls to the areas of the hospital desired, to triage medically and evaluate complaints, and most importantly, to advise patients medically. In order to obtain the medical training needed to work the phones, Mr. Frugoli completed a community college course for Emergency Medical Technicians.

Mr. Frugoli's efforts to become medically trained also stemmed from the occasional need for intervention when providers responded to patient's requests for care in "culturally inappropriate" ways. Mr. Frugoli then became the primary provider himself. Example, as he described it to me:

> "A woman (Latina) came up to the desk and the nurse told her coldly, 'You go up to the Woman's clinic at 1:00', and that would be that! No explanation, nothing! I couldn't do that kind of a translation back to the patient because from the culture that she comes from that's inappropriate, unacceptable.

She needs to be told what's wrong with her, what will be done for her up there, why she has to wait until then, and how it will -- So I found ways of being able to give better explanations to the patients. I was constantly trying to learn more, and that's one of the reasons why I took the course, so I could give back more information to the patients."

Aside from his translation functions, Mr. Frugoli assumed responsibility for a number of logistical tasks "because it is what seemed necessary to make things run smoothly". Mr. Frugoli served as the first triaging agent for the Hispanic patients, and sometimes English-speaking patients as well. He would alert the nurse to acute cases, or for non-acute patients he would by-pass the E.R. providers totally by scheduling clinic appointments for patients as E.R. referrals. Mr. Frugoli also monitored the waiting time of patients, kept patients informed of their waiting time and explained to frustrated patients the reasons for long delays, as well as called missed patients to the nurse's attention.

Mr. Frugoli's formal function of translating between English-speaking provider and Spanish-speaking patient is characterized by an interactional style that stands in marked contrast to the translators who share the sociodemographic traits and types of clinical settings of Mrs. Guzman and Mrs. Luk. In his own perception of his style of interacting with patients, Mr. Frugoli describes himself as differing from other translators in that he does not identify or become emotionally in-

volved with the patient, and encourages their independence rather than dependence. As he explains:

> "I don't think it is in their best interests to take them by the hand and lead them through the system.
>
> "It is best for them to learn that they can do these things for themselves, because they have to have that kind of self-confidence to survive in this society. And I think those survival skills start right here."

The following case examples demonstrate Mr. Frugoli's application of this philosophy in his manner of relating to the monolingual Spanish-speaking patient.

Case Example 1:

The patient was a muscular 45-year-old Mexican man in clean working clothes. Mr. Frugoli was called to translate only after the Spanish-speaking Anglo medical student had decided that she could not understand the patient's Spanish. The man's diagnosis from the triage nurse had been "Headache", and this intake complaint had been translated through Mr. Frugoli.

The medical student started the exam by asking why the patient could not wait for his clinic appointment this coming Wednesday (the day was Friday). The patient responded by going over in detail all his physical symptoms, even though this information had already been obtained in the two previous exams. What the patient described was a two-month history of right shoulder and back pain. Now he had developed pain in the back of his neck that radiated up into his face and gave him headaches.

In response to the medical student's questions about the dates and types of specialty clinics that had examined him, the man extracted from his wallet a folded piece of plastic in which he had carefully kept all the appointment slips.

Mr. Frugoli interrupted at this point to tell the medical student that he was having difficulty under-

standing the patient and was missing a lot of what he was saying. Mr. Frugoli then asked the man where he was from, and translated back the answer that he was from a rural part of Northern Mexico. Mr. Frugoli did not explain to the patient why he had asked this question in the middle of the medical history, nor did he reciprocate by telling him where his own Latin roots were from.

MD: "But Mr. ___________, why are you here today?"

Pt: "Because of this pain in my shoulder, and bad headaches."

MD: "But this is nothing new, is it? You have been having this for a long time, right?"

Pt: "Yes. It started some time ago, and it made my work very hard. I couldn't do it. And now everyday I have headaches and this pain that goes around from the back of my neck to the left side of my face."

MD: "But you aren't working now, right?"

Pt: "No, not now."

MD: "So you can stay home and rest it. That is the best thing for it anyway is rest."

Then the medical student looked at Mr. Frugoli and me, stating: "That doesn't tell me what he wants us to do or why he is here really. Ask him what he had been taking at home for his pain. Maybe that is what he wants, some stronger pain med."

Mr. Frugoli translates in a short sentence and answers back, "Patient is taking aspirin".

MD: (shaking her head with a frown) "Well I don't think that I'm going to change that."

She made this statement as she studied the patient's chart and nothing was translated back to the patient who during this phase was intently watching the faces of the medical student and the translator.

This man was extremely tense. He had a tight facial expression, his hands shook visibly, and he moved in jerky sudden motions. At this point, the medical student did a quick neurological exam, and gave (to no one in particular) her findings of "Nothing".

And again Mr. Frugoli did not translate. Next the medical student pounded down both sides of the patient's back. The patient gave no indication of pain or tenderness as she pounded over the area that he described as painful. The medical student was facing us and standing behind the patient, and when this occurred she mouthed the words. "Faking it", but said aloud, "No tenderness" (not translated either). And this concluded the physical exam.

Next the medical student left to confer with the attending physician after requesting that Mr. Frugoli explain her exit to the patient. I left also so as to leave Mr. Frugoli a chance to work with the patient alone, but to my surprise he followed us out of the room. The two of us waited with the medical student who was in line with others waiting to confer with the attending physician. During this period, the medical student reviewed the case to us. She concluded that she saw no change in the man's condition since she had last seen him, and since the patient wasn't working "it isn't so important to keep him pain-free and functional".

While the medical student agreed with my comment that I did not think we had obtained a very good idea of what the man's concerns really were, both she and Mr. Frugoli concurred that the man's dialect made it difficult to understand him and that subtleties were simply going to be missed.

Finally, the medical student presented the case to the attending physician by first saying that she did not think that it was necessary for the attending physician to examine the patient since this was not a new development (complaint of headache), that the patient had a clinic appointment in five days; he then concluded by saying that she felt the patient was here for paid medication.

The attending physician listened to this recitation at the same time that another resident was trying to get her clearance on his case. She nodded all through the medical student's presentation, and then asked:

Attending: "Just tell me this. Is there anything that indicates that this is a new development?" (medical student shakes her head "No") "Or is there anything urgent in his condition?" (Again medical student gestures "No") Okay then, I will not come in and examine the patient and what you have planned sounds great. Go ahead and write it up."

Once back in the exam room, the medical student explained to the patient through Mr. Frugoli the following:

MD: "We can't do anything further for you in the E.R., the experts are in the orthopedic clinic. Therefore, it is very important to keep your clinic appointment this coming week. They will be better able to tell you. I'm not going to change anything from what they prescribed. Keep using heat on your shoulder and take aspirin for the pain. They may decide to change your pain medication, but I will leave that for them to decide."

Mr. Frugoli translated this explanation after every two sentences with the medical student resuming after each pause. The patient began to show marked agitation during the explanation of "no treatment". The medical student noticed this and added at the end, "And tell him not to worry, he is going to be all right."

In response to this reassurance, the patient stated urgently and pleadingly: "What do I do if I can't make it until then?"

The patient looked nervously back and forth between the translator and medical student, while the medical student just studied the patient intently and conveyed a sense of resignation and frustration when she finally answered:

"If something happens, or new develops and if he can't wait til Friday, then come back and we will see him again."

As she was saying this the medical student was starting to leave the exam room. The patient answered as she reached the door, "Muchas gracias,", and we all left. The medical student went off to write up her notes without a word of parting to Mr. Frugoli. As we walked back to the triage station, Mr. Frugoli expressed his own relief that it was time to go home. He made no comment on the case, and to my probes he had no response. He then indicated that he was in a hurry to go home and so we parted after a few social amenities.

Case Discussion:

There were three striking examples of miscommunication

in this case. Firstly, the medical student perceived treatment as limited to pain medication, and then concluded that this meant the patient wanted narcotics. Secondly, was the categorization of the patient's illness as not legitimate (i.e., "faking it"). Thirdly, the absence of addressing issues such as (a) the patient's perception of what was wrong; (b) the significance of the condition to the patient; (c) what the patient wanted from his treatment. In order to avoid miscommunication it is necessary to ask time consuming questions, and understand the patients answer which can be difficult if the patients conceptual categories differ from those of the western medical provider. However, these questions require time to ask and to understand the patient's answer, especially when the patient's conceptual categories may differ from those of the western medical provider.

The importance of information exchange for a successful healer-patient interaction was clearly understood by Mr. Frugoli as evidenced in his description of the translator as a communication medium:

> "I would work very hard to understand exactly what the complaints of the patient were, using my medical training and the nuances of the languages. They (physicians) found out that I was capable of making those kinds of distinctions that they were not able to make with translators previously. I could pick up the social and the emotional history and relate that to the physician, just as I would give back information from the doctor to the patient.
>
> And if I didn't understand something I would ask the doctor so that I could give it back

to the patient. Sometimes I would even ask the patient a question to see if they understood their condition, and then ask the doctor as if it were coming from the patient. For all of this you have to know both the medical knowledge and the culture of the patient."

While provider fatigue, on the part of both translator and medical student, contributed substantially to the failure to elicit this type of information and to effect its exchange between patient and medical student, it is also significant that the translator and medical student shared the same western medical training, and therefore the same cultural categorization of disease causality, symptomatology and appropriate treatment measures. Thus, the translator saw no incongruity in requiring a demonstrable physical sign of impairment to diagnose the patient's illness as "real", or for treatment options to be confined to the administration of chemical substances.

Case Example 2:

In this case the physician knew the patient from the patient's previous visits to the emergency room. Here, Mr. Frugoli was being called to find out why the patient had come back for the same condition but had not kept the GI (gastrointestinal) clinic appointment scheduled for her after her first E.R. visit.

The patient was a slight, middle-aged Mexican woman who had recently immigrated to San Francisco with her husband and son. Her complaints were of abdominal pain and constipation, which in this case were not life threatening, but the woman's affect conveyed acute and severe anxiety. Using Mr. Frugoli,

the medical student did a complete systems check, and for each system the woman was able to report some impairment. Her symptoms ranged from heatache to a dermatologic rash. She presented the physician with a diffuse and detailed list of symptoms, none of which indicated a specific disease process. After the physical exam, the medical student reviewed the findings of the battery of laboratory tests he had run on her from her last visit, and repeated his former diagnosis to her: "Nothing is wrong".

The medical student advised the woman to go home but to keep her GI clinic appointment for a more thorough diagnostic work-up later in the month. Mr. Frugoli translated rapidly between the medical student and the patient so that the dialogue closely resembled a dyadic conversation. Eye contact was between the patient and the medical student, and no comments were directed towards Mr. Frugoli and me that excluded the patient.

After the medical student had pronounced the judgment of "Nothing is wrong,", the woman began to sigh deeply and appeared to be on the verge of tears, frequently dabbing at her eyes with her hankerchief. The medical student excused himself from the room, saying that he had to discuss her case with his resident. I excused myself since I also wanted to talk to the medical student. I was disturbed over the woman's affect and I felt obliged to try to help the medical student find out what the woman's concerns were. And again, instead of staying with the patient, Mr. Frugoli left with us.

Instead of immediately finding his resident to approve his diagnosis and treatment plan, the medical student walked over to a wall and sat against it staring down at the floor. To my opening comment of "This is a tough one", he answered explosively:

> "I don't know what else to do. There's nothing wrong with her, but she acts like she's going to die. I already checked out her family situation last time. No problems there. I met her husband and he's as upset about all of this as she is."

Mr. Frugoli listened and agreed with the medical student. I suggested that we try and find out what she thought was wrong with her, to which the frustrated medical student said: "Anything is worth a try". After conferring with the resident in an interaction similar to case 1, we went back into the exam room.

The medical student had been advised by the resident to treat each of her symptoms palliatively, e.g., headache - pills, constipation - stool softener, dermatitis - boric

acid soaks, etc., but most importantly he was to get her to keep her GI clinic appointment.

As the medical student was going through each of the treatment instructions, he suddenly stopped and gazed at the woman for a while and softly asked the translator, "Ask her why she is so sad?"

Her emotional upheaval finally acknowledged, the woman started crying frankly while talking nonstop. Her sister had recently died of stomach cancer and she was sure that she had cancer and that the doctors didn't know how to find it. She posed the same question as the man in Case 1, "What if I don't make it until the clinic appointment?", as well as the question, "If you can't find anything wrong with me, why would they (GI clinic) be able to?"

Case Discussion:

Once the medical student had elicited the patient's concern he was then able to give specific answers that satisfied and reassured the woman. But significantly, prior to the medical student's question, the woman, (like the man in Case 1) had not been able to tell the physician why she thought that her condition was an emergency, what her concerns were and what she wanted done. Due to Mr. Frugoli's style of relating to patients and his firm belief in maintaining the physician as the direct provider, if the medical student had not elicited the information it would have been missed. This interaction ended with a satisfied patient and provider. Each had had their needs met in the exchange.

Case Example 3:

Mr. Frugoli frequently took dispatch requests throughout the hospital when he was not translating in the emergency room. The following was a request for anesthesia consent from an 22-year-old woman who was scheduled for surgery the next morning. As Mr. Frugoli walked up to the nurses' station on the 5B Ward, one staff physician said to the other who had been waiting for a translator: "Oh you lucked out! You got the best, he's a pro!" Mr. Frugoli acknowledged the compliment with an embarrassed smile. The anesthesia resident greeted Mr. Frugoli as follows:

> "I know it's not your fault, but I've been waiting for you for 15 minutes and now I only have 5 minutes to get this done. So I'm going to explain it and if you would get her to sign the form and then just put it on the front of her chart, I'd appreciate it. (Mr. Frugoli nodding his head in assent) Thanks."

This was being said as we entered the patient's room and was concluded over her bed with the patient looking back and forth at all of us. The resident immediately began his explanation without any introductions.

> "Explain to her that tomorrow before the surgery she will get a shot in her vein and she will go to sleep instantly and stay asleep until after the surgery is over. This is what we call a general anesthetic."

Mr. Frugoli translated but first greeted the patient politely and then explained my presence and why the physician had asked him to come up and speak with her. The resident continued:

> "Explain that she will sleep most of the day after she comes out of surgery and that she may feel sick to her stomach but that it will

pass the next day. She will have an IV in her arm until she can drink. But most important - that she won't know anything or feel anything from the surgery. When she wakes up it will be over.

Translation followed, and the patient nodded her head in response:

Resident: "Ask her if she has ever had any anesthetic before.

Frugoli: "She says 'No'."

Resident: "Ask her if she is allergic to any drugs or medicines."

Patient shakes her head "No" to Mr. Frugoli's question.

Resident: "Fine. Tell her that everything will go well. Once in a while someone has a reaction to the anesthetic but that it happens so rarely as to be negligible. And that I will be there to give her her anesthetic tomorrow."

The resident smiled at the patient, patted her arm and left the room, saying "Thank you for your help" to Mr. Frugoli.

Mr. Frugoli then translated this last part of the explanation and handed the patient the consent form and a pen to sign. She asked a short question as to where she was to sign. After the woman signed the form, Mr. Frugoli thanked her and wished her well, and left with a "Let's go" to me.

Case Discussion:

This interaction so appalled me that I could not maintain my role as a non-interferring observer; on our way back to the E.R. I asked Mr. Frugoli if he had ever been instructed in what constitutes informed consent. He in turned looked uncomfortable, said he had not, and as I proceeded to explain

the criteria and the legal rights of the patient which I felt had just been bypassed, he became visibly upset. Mr. Frugoli had expressed many times in our informal discussions his strong convictions regarding the rights of non-English-speaking patients to the same quality of health care received by English-speaking patients. In response to my explanation, he decided to go back to the patient after his shift was over and check to see if the patient understood what was going to be done, her options, the risks and her rights to decide her preferences. Mr. Frugoli reported to me the next day that she indeed had a number of questions. After this experience, Mr. Frugoli became quite sensitive to the issue of informed consent and in his work strove to effect the information exchange and create the understanding that differentiates between consent and informed consent.

Discussion:

Mr. Frugoli was less social with his patients than translators like Mrs. Luk and Mrs. Guzman, and often omitted the ritual "visiting" that I observed to characterize most translator-patient interactions for the older translators. In part, this lack of visiting was due to the structure of the emergency room. Contact with an emergency room patient represents a one-time-only interaction. There was no long-term relationship, Mr. Frugoli therefore had no "caseload", and thus no need to be concerned about issues such as continuity

of care. In addition, Mr. Frugoli usually entered the exam process with the physician waiting; this precluded the pre-exam visiting allowed in other clinical settings. However, the opportunity to visit with the patient inevitably occurs when the physician has to leave to confer with the supervising attending or resident. During these time lapses Mr. Frugoli would leave the exam to check back with the triage desk, to assist waiting patients or to keep the nurses posted on his whereabouts as well as to ensure that an emergency case had not come into the trauma ward in his absence. Mr. Frugoli explained to me that the pressures to be ever available at a number of different points in the E.R. operations meant that to remain with one patient for any length of time would result in the neglect of others. Without a doubt the unique demands of the E.R. setting decreases the personal contact between translator and patient, but I must emphasize that this tendency to leave with the physician also characterized the interaction styles of other translators similar to Mr. Frugoli in age and life stage. This pattern held true across ethnicity and sex categories.

From these and other observations I conclude that the translator's visiting prior to the physician's exam is crucial to relaxing the patient and to gaining the patient's trust in the translator, which in turn is central to the patient's trust of the physician (see Chapter VI). Similarly, it is during the time that the physician steps out of the exam room that

patients tell translators what is really on their minds, what they think about their problem and what they want done. While Mr. Frugoli is always exceedingly polite in his interactions with patients, he is also reserved and he avoids personal involvement; thus he seldom assumes a direct provider role as do translators like Mrs. Guzman and Mrs. Luk. While Mr. Frugoli's commitment to his people is absolute, acculturation influences, structural demands of the E.R. setting and his sex and youth effected minimal patient bonding, but strong provider bonding.

Mr. Frugoli was widely accepted and trusted by nurses and physicians in the emergency room. He is a provider's translator, and excelled in conveying a partnership identification with direct providers in translation interactions. To win the acceptance of the nursing staff, Mr. Frugoli assessed their needs and then went about demonstrating his usefulness to them. Similarly, with physicians, Mr. Frugoli would acknowledge the time pressures under which they operate in the emergency room and would assure them that he would do his best to elicit a concise yet accurate and complete medical history. Mr. Frugoli credited his success with hospital personnel to his ability to work with others and work in a non-threatening manner.

> "I'm different than the other interpreters because I was raised dominantly English in this culture. And I think that's why I'm more politely aggressive and capable of achieving what needs to be done. I observe and see how things go so that I can learn to work through the system."

How the bond which is formed between the patient and the translator affects the outcome of the patient-provider interaction is the subject of the next chapter.

CHAPTER VI

THE PATIENT-TRANSLATOR-PROVIDER INTERACTION

Introduction:

This chapter contains the analysis of the triadic patient-translator-provider interaction and focuses on the needs that each participant is dependent upon the others for fulfilling in this social exchange. The first section outlines the conditions required for a satisfactory exchange between patient and provider as well as the reasons why the relationship breaks down by examining the interactional dyads of patient-provider, patient-translator, and translator-provider. The second section of Chapter VI enumerates the strategies used by providers and translators to compensate for indirect communication and to control the communication content when trust is absent in the translator-provider relationship.

The Social Exchange between Provider and Patient:

In order to understand the vulnerability of provider and patient when their direct communication is blocked, it is helpful first to conceptualize the dynamics of a successful patient-healer interaction as being a social exchange. Both patient and provider bring to the interaction a set of needs that only the other can satisfy; and communication is the medium through which this exchange process occurs. The

patient's needs center on securing a knowledgeable expert who will assume responsibility for returning the person to health. This expert is obliged to explain what is wrong (name the illness), why it went wrong, and what must be done to effect a cure -- all in concepts that are consistent with the patient's ideas of how disease is caused. The practitioner is expected to elicit the social and medical information upon which this assessment and evaluation is based in a courteous and concerned manner, yet maintain the proper social distance (also culturally defined) necessary to support the healer role image. In a successful healer-patient interaction, the patient leaves with his anxieties relieved, hope restored and with a strong expectancy that now he will get well. The data below show that this interaction requires the healer to be able to communicate directly with the patient.

Western medical practitioners primarily need their patients to allow them to provide health care as they have been trained, and this involves performing highly technical tasks with a craftsman-like skill according to set scientific standards. To be allowed to practice their technical skills, providers must secure the patient's trust in their clinical expertise, acceptance of their diagnosis, and cooperation with their treatment plan. The rapport that the provider must build with the patient to gain the patient's trust and cooperation is based on his/her ability to communicate a sense of concern, emphathy and caring for the patient. This requires both time

and direct verbal communication.

The delivery of medical services in the United States is structured not to allow providers the time they need to build patient rapport. In out-patient clinics, a physician or nurse practicitioner is allowed 15 minutes to examine, diagnose and treat a patient. In surgery patient rounds, each patient is given two minutes: non-English speaking patients are asked "How are things going?", given a smile and a pat on the head. The medical staff does not have the time to wait for a translator to receive the patient's answer. Nurses in the emergency room and in the out-patient's clinics are held responsible for processing patients through the system in as time-efficient a manner as possible. In-patient units assign a nurse-patient ratio that physically exhausts the nurse just to perform the technical/physical tasks for which nurses are legally accountable. Health care providers do not have the time to talk to patients: there is time only to perform concrete physical and technical tasks.

Add to this existing structure the non-English speaking patient, a situation that removes the patient's and healer's ability to talk to one another causing an increase in the time required to elicit basic physical data, and the social exchange between patient and healer disintegrates. The breakdown in information exchange can be complete, as when no translator is available, or partial as when a translator is available.

The former state is described below by a third year Family Practice resident:

> "Without a translator, our practice of medicine becomes like veterinary medicine. Only this is worse, because you don't even have an owner that you can explain what is wrong and what you are going to do.
>
> When you can't communicate with the patient that reduces our medicine and the practice of our art to veterinary medicine, a mechanical level. You touch the person like you would an animal that can't talk to you to find out where it hurts. And _if_ someone gets treated under this kind of system _for_ what is actually wrong with them, it is totally _coincidental_." (emphasis speaker's)

Providing health care through the translator intermediary does elevate the practice of medicine to a technical, physiologic level, but was unequivocally described by providers as being qualitatively different from the care that they can provide to English-speaking patients. The following explanation of this difference comes from a 35-year-old medical attending who is white and male.

> "It's frustrating to have to work through a translator. As you try to go beyond the technological type of service, the greater the frustration. You simply can't do it.
>
> For me the rewarding part of my work is getting to know the patient. Not as a gall bladder, but for the person. And this is very difficult to do through a translator. This is not to say that with a good interpreter you can't do good health care -- a good history, physical exam etc., but to go beyond that, in the broadest human sense, you need to be able to relate to that person as an individual. And you can't do it through an intermediary.
>
> You see making the diagnosis isn't the most important thing for me. It's the contact, and

without that it blocks my own personal needs. It is that humanistic exchange that gives me the energy to do my work. If it is there, then my patient contact energizes me. It's an energizing contact, but without it, the patient contact becomes a drain. It drains me of energy, it becomes drudgery, work."

The two practitioners above are addressing different levels of provider needs in the patient-provider interaction that the non-English-speaking patient threatens. At the most basic level is the interference with their ability to diagnose and treat a patient, since approximately 90 percent of the diagnosis is estimated to be based on the information obtained in the history-taking. This threat strikes at the heart of the practitioner's reasons, motivations and needs for being in the healer role. And whether it is due to linguistic or cultural barriers, when the patient does not allow the practitioner to perform his or her scientific art, it provokes intense emotions in the practitioner -- frustration, anger, and avoidance of the patient or that type of patient in the future.

The second level of provider need is much more subtle and involves the social and emotional needs that providers bring into the patient-provider interaction. The medical attending physician quoted above is addressing the need that some providers have which it to establish "meaningful contact" with the patient. While the degree of social contact needed by providers may vary with personalities and by clinical speciality, basic to all providers is the need to feel that

they have effected a positive change in the patient's health status (a full recovery is the ultimate testimony of the healer's skills). A secondary need, but also important to providers' over time is the need to have patients express appreciation and gratitude for their services. If a patient is uanble to speak to the provider this often results in the provider being blocked from making "meaningful contact" and unthanked, as well as feeling unsure that he or she has satisfied the patient. A second year pediatric resident describes this uncertainity in comparing the English and non-English-speaking patient:

> "To compare the two types of interaction, I would have to say that there is a remarkable sense of incompleteness (non-English-speaking patient with a translator). You watch the patient go out the door after it is all over and you feel that there is something possibly very important that didn't happen. And that's not good for the physician.
>
> It leads to feelings on the MD's part of self-esteem. You don't feel good about it. Your satisfaction about your ability to give them good care. And it comes down to that you aren't willing or able to expend the energy caring for the non-English and foreign patients that you can for those that you can talk to.
>
> There is an undeniable value of talking directly -- for both the physician and the patient.

Given the severe time constraints under which the health personnel at SFGH operate, the extra time required by the non-English-speaking patient, and the barrier to direct communication that follows, I found that the non-English-speaking provider interaction generally was unsatisfactory for both patient and provider. During the time of my field-work providers estimated that the majority of the non-English-

speaking patients still had to be treated without translation services, or inadequate services, so that all levels of providers' needs were compromised, as was the quality of patient care.

Consequently, what I found in this setting was a frustrated hospital staff who stated that the situation allowed them to practice at best a veterinary standard of medicine on human beings; and patients who were anxious, frightened and sometimes hostile, and who for the most part had all but their grossest health care needs go unmet. While the inability to receive medical care for a perceived health concern often does not prove fatal for the patient, it can (and does) subject the ill person to a longer illness period and greater physical and psychological discomfort.

The Patient-Translator-Provider Triad:

In the presence of the translator intermediary, the confidentiality, intimacy and rapport inherent to the patient-healer relationship are severely detoured through the filtering effect of this third party. The patient and provider cannot respond directly to one another, and as a result are unaided by the subtle cues of non-verbal communication on which we normally depend to give meaning to the spoken message. Instead, the social person receiving and relaying these messages

becomes closely watched and reacted to, so that the provider and patient notice each other through their interaction with the translator. The stress that the communication barrier places on the provider is aptly summarized by this 40 year-old, female medical attending physician in the emergency room:

> "You see, a lot of the communication that goes on between the physician and the patient is non-verbal. It's the tone of voice, the way that they put their words together, the words that they choose. And with an interpreter, he helps you to get the facts, but not ... He's not able often to interpret what's going on with the patient.
>
> So you ask yourself, 'Do they really mean what they are saying, are they really having pain?'. So what we have to do with the non-English-speaking patient is to use the interpreter to decide if the patient is sick or not. They have to tell us what they think and we have to depend upon their judgment. Some can handle it, and others can't."

The patient's illness, concerns and symptoms are projected to the provider through the translator. Because the physician and patient see each other through the translator, the translator not only acts as the communication medium but also as a filter through which the provider and patient view each other. For this reason the translator's personality and character, as well as the type of social person that the translator is, plays an important role in the way the provider and patient view each other. Thus, the relationship that the provider and patient have with the translator determines the effective limits of their rapport.

In the triadic patient-translator-provider interaction,

the translator substitutes as the direct health care provider in terms of establishing trust and rapport with the patient; and in positive translator-provider relationships that rapport is then extended by the translator to include the provider. The phenomenon of the translator functioning in place of the provider is clearly outlined in the following translators' characterization of the purpose and importance of their pre-exam "social visiting":

> "Before the doctor comes into the room I've not only gotten to know the problem that they have and we've let off that problem, we've already talked about it, now we're talking about how, one of the things is their own social life, how do they interact, what do they do for a living, to survive, what's their lifestyle, how many children do they have, are their children grown. You know, whole realms of things that sort of sound like it's nosy work but it really is not.
>
> Then the patient questions me, wants to know the same things, but I answer without really exposing myself. We visit, you know to get to know one another. Where they come from, about their food, and customs, where I come from, how long I've been here. It makes them feel relaxed, comfortable. I open myself so they can open themselves a lot more and then I can get this to the doctor.
>
> The interpreter breaks the ice for both the doctor and the patient so that they can really talk to one another. When the doctor comes in we are relaxed and joking, I tell the patient to tell the doctor the same things that he told me. It makes the process all so much easier, just those few minutes of socializing before the doctor comes in.
>
> Because I know that when I come into a room and the patient's already anxious to begin with, he doesn't know what he's going to hear and to bring a stranger into a room it brings more anxiety to the patient, he sort of clams up and he doesn't know how to say it, at that

> moment he thinks that he doesn't know how to talk." (emphasis added, see Chapter V, Translator #3, case examples 1 and 2 for a demonstration of this patient behavior).

The transference of information only occurs if the translator trusts the provider and has a good working relationship established. As another translator elaborates on this interactional dynamic of the patient-translator-provider relationship:

> "The patient still remains unknown to the doctor. I have all the information, but if it's the right kind of doctor that I can work with, well then I try to summarize all this information for the doctor. I will not go through the pain of interpreting our entire conversation. But I will try to give them a sense of who this patient is as a person and what's going on in their life. I will summarize it, which will give him (doctor) a little bit of an insight but not the whole thing. A lot of information is still being held.

The practice of visiting with the patient prior to the physician's exam (or, if that was not possible, during the physician's absence or after the examination was over), was used extensively by translators, with the exception of those few who limited their functions to translation and escort services. The content and purpose of this "visiting" is described by another translator as follows:

> "I always made a point that I would go into a room about two minutes ahead of the doctor, more if I had the time, and talk with the patient by himself or by herself. And get enough background, introduce myself, and make it relaxed enough so they won't feel that, let's say, the wall between a

> doctor and himself, and I always made it a point to do that.
>
> And it wasn't just conversation, it was just getting information out that I needed to know. When the doctor came in I felt that he had not asked questions that I felt were needed to be asked, I would say, 'Doctor, the patient has said, so and so, this and this and this, way before you came in, and I feel that you should hear it."

The pre-exam visiting between the patient and translator serves the very important function of making the translator and patient people to one another. The translator must demonstate his cultural orientation, value system, and concern for the patient in this information exchange before the patient can evaluate the translator as "trustworthy". Once the translator has established this rapport, or the two of them have become "people" to one another, the groundwork is then laid for a positive and satisfactory patient-provider exchange, given that a trust relationship has been established between the provider and translator. Thus, the optimum of need satisfaction is achieved in the triadic patient-translator-provider interaction when each of the actors trusts the others; but the trust bond between the patient and provider is dependent upon their respective trust bonds with the translator. Trust is defined here as the feeling that one can depend upon the other to fulfill his role obligations -- in short, that the prescribed goods or services will be delivered to the recipient.

The exception to the dominance of the translator-patient bond in the triadic patient-translator-provider interaction

occurs when the provider and the patient have had previous contacts and the translator is unknown to them. Then a direct bond is formed between the provider and patient, so that in the triad interaction the patient and provider tend to direct their gaze and conversation toward one another and the translator's functions are limited to literal translation. In the majority of cases, however, the physician house staff are on a continuous rotation schedule that changes their placement every three months; consequently this exception applies only for the permanently stationed faculty attendings, nurse practitioners, nurse-midwives and physician assistants. Thus, translators who were permanently placed in clinics or in-patient units tended to establish the primary trust relationship with the patient, as is evident in the translator examples of Mrs. Guzman and Mrs. Luk (see Chapter V), and in these types of interactions the health care providers function <u>to assist</u> the translator to care for the patient. (See below and Example 2, Chapter VI, p. 179).

Trust between translator and provider centers on their mutual evaluation of each other's technical competence and willingness to help the patient. As one translator defines the criteria of a "good doctor":

> "I consider him a good doctor because of the fact that he not only asks the questions that need to be asked, but he goes beyond that. He goes beyond because he tries to be a one-to-one. He becomes a friend. He becomes all those things in one. And when you see a doctor, you need all those things. You don't need that

> white-coated stiff fool that stands out and just asks, you know, 'Does it hurt here?', and that's it!"

Translators often times found themselves in a position of badgering, maneuvering and threatening providers to deliver all the health services that they assessed the patient as needing. Consequently translators became watchful for the "getting-by-doctor", and this discrimination is evident in the next translator's definition of a "good doctor".

> "A doctor has to be willing to <u>take the time</u> to explore other areas beside <u>just the physical</u> complaint. I have seen some shitty doctors that I would say they're just for the money, nothing else. And fortunately, I have worked with good doctors, doctors that are caring and not only for the physical problem that the patient has, but for the emotional also and their home life. This is very important for these doctors because they know that these are always a part of the physical problem." (emphasis added)

Translators did not judge provider's technical competence so much by their clinical skills as by their demonstration of caring, kindness and willingness to address the patient's concepts of the nature and cause of his/her illness, even when these differed from the provider's perceptions of what was wrong. This evaluation of a provider usually required two to three interactions, but the judgment of a "bad doctor" would be made without hesitation after one interaction if the translator felt the provider had refused to properly care for the patient, or had insulted the patient in any way. While the provider's friendly, respectful and congenial support

toward the translator was highly valued and sought by the translator, it was not <u>essential</u> to securing the translator's working cooperation. The tranlator's perception of the provider's dedication to good patient care, however, was <u>essential</u> to that working cooperation.

Providers base their judgment on the accuracy and effectiveness of the triadic communication in a manner similar to the translators' evaluation of providers' clinical competence. They search for a feeling of commitment to the patient's care from the translator, a patient advocacy posture, and a non-judgmental attitude. If these conditions are present, then providers feel confident about the accuracy of the information exchanged, and trusting that the translator will elicit all of the patient's concerns as well as secure the patient's cooperation with the treatment plan. Providers leave these types of interactions feeling a minimum of frustration, and are satisfied that they have done as good a job as possible -- for an interaction using indirect communication between patient and provider. When working with an unknown translator, a provider evaluates the translator's linguistic accuracy by additional criteria such as: the appropriateness of the translated answer that they receive to their questions, and/or if the patient's body language communicates satisfaction with the provider's responses and explanations.

Providers' Responses to the Intermediary Interaction:

The following excerpts from physician interviews outline the strategies used by physicians to evaluate the trustworthiness of the unknown translator.

Example #1: A white, male, 33 year-old Hematology fellow:

> "My trust of a translator is judged on if they demonstrate that they trust and respect the patient, whether they are acting as an advocate for the patient, if not, then I don't trust the interpreter's communication. But if I sense that then I feel real good. And I trust our communication."

Example #2: A female, 28 year-old Family Practice resident:

> "I trust translators who are involved with the patient, who has his best interests in mind, and wants to get the best possible care for them. In these instances I know that the interpreter will make sure that I understand what's wrong with the patient.
>
> They have to be willing to take on a patient advocate role. They have to care enough to see that the patient's concerns are understood and cared for. If they are for the patient, it can compensate for any distortions in the translation, and the blocked communication between patient and physician. They actually become the providers and <u>we</u> help <u>them</u>. (emphasis speaker's)

These views were also shared by the cross-section of medical faculty interviewed. In the following quotation, the medical director of the emergency room describes the translator as a health care provider, and explains the importance of the patient advocacy role to the translator-patient bond.

> "If I don't already have a good relationship established with the interpreter then I look for their relationship with the patient. It's essential that the interpreter establish a bond

> with the patient. The patient needs it to be able to get good care and to feel that they can trust the system. You have to have this kind of relationship between the patient and the interpreter to have a patient advocacy thing going. And basically because we are cut off from them due to the language, it's the only thing that the patient has going for them.
>
> The patient really doesn't have a chance without the interpreter's personal involvement with them. It makes the critical difference of them getting the care that they need, or not getting it, or getting only a part of it taken care of."

The reason why the non-English-speaking patient does not have a chance without the direct intervention of the translator is two fold. First, the energy and time commitment required from the translator to effect a complete and accurate information exchange between provider and patient does not occur without the patient advocacy bond, nor in situations in which the translator functions as a literal "United Nations" translator. The translator must interpret the patient's culture for the provider. And the culture of Western medicine for the patient, the translator must also do exploratory questioning of patient and provider to effect the level of information exchange that will allow the provider to correctly assess, diagnose and treat the patient (see Fig. 2 in Chapter VII), and to gain the patient's trust in the provider's judgment as well as acceptance of the planned treatment.

Secondly, the situations of the non-English-speaking patient blocks the provider's emotional/social needs for direct patient contact, threatens the ability to clinically

assess and treat patients, and takes control away from the provider and places it with the translator intermediary. For all of these reasons, the non-English-speaking patient evokes dread and avoidance responses in house staff and attending physicians, nurse practitioners and physician assistants. Consequently, providers use a variety of strategies to minimize patient contact or to avoid it altogether. For example, when a patient's chart that is marked "non-English-speaking" comes up in rotation for examination, a resident may use any of the following strategies: make an attempt to locate a translator in the clinic and do the exam; if a translator is not available, pass the patient over or do the exam without communication; place the chart at the bottom of the waiting list, or place it in another resident's pile of assigned patients; or give it to a colleague that is bilingual (bilingual staff complained bitterly that they never get to see English-speaking patients during their SFGH rotations). If contact with a non-English-speaking patient is unavoidable, then providers tend to prefer Western cultural groups over Eastern cultural groups because conceptual communication is possible with the former but not the latter.

The amount of time spent with the patient is directly related to the communication level that the provider is able to establish with the patient. Thus English-speaking patients would receive the most time from providers, followed by the non-English-speaking Western culture patients with a transla-

tor, then Eastern cultural groups with a translator, and lastly, non-English-speaking patients without translators. A provider's communication level with patients is determined by the following factors ranked in order of importance: the availability of a medically trained translator, quality of the translator-provider working relationship; the cultural background of the patient; and the quality of the translator-patient relationship. The following exerpts from provider interviews illustrate the dynamics of the providers' avoidance response to non-English-speaking patients.

Example #1: A 42 year-old white male, in the Department of Medicine and long-term faculty member at SFGH:

> "It is the rare physician who enjoys taking care of non-English-speaking patients. It's subtle racism, but it is there. As the waves of immigrants come into this country I have found that the type of patient that we enjoy taking care of the least changes. (emphasis speaker's)
>
> In the past, it was the Spanish but now almost every doc would prefer a Spanish patient to, well almost to any of the others. As long as it's not Korean, it's okay."

A number of other faculty members in the surgery department, emergency room and the adult medical clinic agreed with the above speaker's categorization of the least desirable non-English-speaking patient. In response to why Koreans represent the least desirable patient, an attending in the medical screening offered the following explanation:

> "I would say that the Palestinians and Arabs are next to the Koreans as being the least desirable patients. The reason why they are dreaded is because their culture is vastly different, and

they have different ideas about medical beliefs, whereas the Spanish are basically Western culture, We can understand them much easier than someone from a non-Western culture.

You know, it's like everything about the Eastern patient is couched in vaguery. They don't express their symptoms as Westerners do. And in the translations with interpreters -- because if we don't have interpreters for these patients there is nothing that we can do -- the real issues aren't mentioned, and its not addressed by the unsophisticated interpreter."

Example #2: An east coast, 28 year-old white male attending in the emergency room:

"Of all the non-English speaking patients, I found the Chinese to be the most difficult. After I finished a case I was never satisfied that I had really gotten at what was wrong, not totally.

I was never sure if I had understood exactly what it was that they were trying to tell me, and I never felt comfortable that they understood what I was doing for them, why and about the medicines.

They were always so polite, they were hard to read. The Chinese have such a different affect, its just impossible to know how you are coming across. Or if they are satisfied.".

Example #3: A 39 year-old white male attending in the pediatric clinic:

"You will hear, 'Oh my God, no!' when a resident picks up a chart that says 'non-English-speaking'. And that's because you know immediately that it's not going to be that simple. It's going to be hard to get information, and what would normally take you 10 minutes to do is now going to take 30 to 40 minutes. And that's time that you don't have. So you get angry and everybody suffers.

I know that physicians have this reaction to these patients from my own reaction when I get out there and help, but also from my observations of house staff."

Example #4: This is a young, recently appointed surgical attending, who completed her surgical residency at SFGH:

"The average M.D. when taking a history through an interpreter takes less time than when it's in English. And it <u>should</u> take exactly twice as long to do a history <u>through</u> an interpreter than in English, but what happens is that they leave out things. They go for the key questions, and asides that are used to allay a patient's fears are left out (emphasis speaker's).

This tendency to cut corners in the history taking happens at all levels in the hierarchy, regardless of the level. It's due to the time, but also due to the doctor's feelings of discomfort working through an interpreter. They don't like it, it is unpleasant and uncomfortable.

I can tell you that it takes half the time, from what I have done in the past as a resident over all the years, and from my observations of other residents. It's what happens."

Thus, from these faculty's descriptions of the motivations behind the "getting by" strategies and the frequency with which they are used by providers, the conclusion has to be drawn that in instances in which translators simply translate, the patient receives a markedly poorer quality of health care than when the translator assumes direct provider responsibility for the patient's care. The prevalence of these avoidance strategies required that translators be medically knowledgeable about symptoms, diagnostic categories, diagnostic tests appropriate for types of complaints, and the treatment modalities for specific types of conditions. Translators had to know this information in order to cover for providers' omissions or refusals to care for the patient (see Fig. 4 in Summary). It was only with providers who exhibited concern and interest in the patient, as well as a willingness to spend time with the patient, that translators could relinquish their direct provider

responsibilities to the health care professional, The tendency to assume direct care responsibility for patients represents the main strategy used by translators to compensate for a "bad doctor", or to instances in which a good working rapport had not been established and/or time-saving strategies were being used by the provider.

The Untrustworthy Translator:

If the provider perceives that the translator does not care about the patient, he/she then attempts to compensate for mistrust of the translator by demanding a literal sentence by sentence interpretation throughout the history-taking, physical exam, treatment and prescription instructions. This was a common strategy used by house staff, attendings, nurse practitioners and physician assistants, and is conveyed in the following description by this chief resident in pediatrics:

> "If I don't sense this trust and rapport between the interpreter and patient then I do very precise things to get an accurate translation. I tell the interpreter my expectations of him. I tell them that I want them to translate exactly my words. When this is most important is when I am giving instructions, and that is when I really insist that they give a verbatim translation.
>
> What I often experience is this. Their first sentence is just slightly longer than mine. And then the second sentence will be just a little longer yet. Then my third sentence they will say: 'I've already told them than.' That's the reuslt of the interpreter not trusting the doctor.

He (translator) tells them how to get through the system and doesn't give me a chance to tell them because he doesn't trust that I will do it. Because he doesn't know me, he feels that I don't care enough to do this (emphasis speaker's).

After a while, when we get to know each other both of us can settle down in the situation and things go a lot smoother, and its better for the patient too when the doctor and the translator know and like each other. After they get to know me and know that I care about the patient, then things go better. They translate more exactly as I say, and we work together better.

Rapport between the doctor and interpreter is very important for communication accuracy. I'm presenting this as if it were a one-sided thing. It's not. The interpreter needs to trust the doctor to be able to . . . but that's not always right. There are a lot of insensitive doctors around that don't care and in those instances the interpreter can't trust them and has to watch out for the patient. So I don't know."

Another issue that haunted providers was not the trust condition, but the translator's language skills and medical knowledge. Without medical terminology skills in both their native language and English, they were simply unable to understand the information that the physician needed elicited. An attending physician in the adult medical screening clinic describes this problem below and the strategies used to compensate for the linguistically limited translator.

"For many of the interpreters, English is their second language, and their language limitations are slightly less than the patient that they are translating for. What that means and why it's impossible to get a good history through most translators is that the interpreters can't understand what to ask the patient when I ask the question, because he can't understand what I've said (emphasis speaker's).

> And when you have to work this way it means that the history becomes less important, you can't trust it. You consequently have to order more lab work and put greater emphasis on the physical exam."

Not uncommonly when the provider was in doubt over the accuracy of the history data, he/she leaned heavily on physical indices of physiologic functioning. In these situations a greater stress is also placed on the physical exam in making the diagnosis than in the care of English-speaking patients, and is heavily supported by laboratory tests that only crudely provide data that ordinarily would be obtained in the medical history. This is costly in terms of both money and time, but more importantly, it exacts a high psychological toll on the provider due to the threat of making an inaccurate diagnosis and a nagging uncertainty that he or she may have missed something important. Under these conditions, the non-English-speaking patient threatens the most basic need of the provider -- to deliver clinically accurate, scientific health care. And not surprisingly, the tension generated by the provider's uncertainty generally makes this type of interaction unpleasant for all three of the participants. The effectiveness of the provider's practice of the art of healing is drastically reduced, the patient's inclination to believe in the prescribed treatment is felt to be highly questionable, and neither the provider nor the translator receive appreciation or thanks for their efforts to help the patient.

The Trust Bond between Translator and Patient:

Trust between the translator and patient is based primarily on the patient's perception of the translator's cultural identity. This information is obtained at the initial contact between the patient and translator (or as soon as possible during the examination process), and starts with a ritual of neighborly visiting, by means of which information is exchanged regarding their native countries, and how they (or their families) earned livings there. This information exchange is handled cautiously and serves to identify for the patient the translator's cultural orientation, as well as the social status of each in his or her native country. It is not until these characteristics have been established that the two can comfortably relate to one another. If the patient and translator mutually perceive themselves as similar culturally and of equal social status, then maximum trust, rapport, and empathy ensue with the translator assuming a strong patient advocacy role towards the patient. In the instances in which the patient and translator fail to establish the positive patient advocacy bond, the patient receives a markedly poorer quality of health care.

If the translator indicates that he or she is oriented toward U.S. culture and rejects or feels ashamed of his/her ethnic origins, then the patient-translator relationship is

marked by patient mistrust and unease, with only minimal conversation covering the physical concern for which the patient is presenting (see Figure 3 in Chapter VII). Also, if the translator is viewed by the patient as being from a native culture other than the patient's (e.g., mainland China versus Taiwan) a similar impairment may result.

In the event that the translator holds a superior social status in the native country to the patient, then the patient advocacy bond is easily established. However, should the patient demonstrate any mistrust, be critical and/or demanding in any way, then, the outcome is that the patient advocacy bond is only minimally formed, and the only service rendered is a literal translation. If the patient is of equal or higher social status than the translator, such behavior is tolerated better by the translator.

As this 28 year-old Hong Kong born translator describes behavioral expectations and their consequences for the translator-patient relationship:

> "But if that patient crosses me from the very beginning and I don't feel she is my equal, that ... she is not accepted by me, then I will go ahead and not protect her. But 80 percent of the time I'm a protector of the patient more than I'm with the doctor."

If a patient advocacy bond is not formed by the translator with the patient and there is a lull in the processing

of the patient, the translator may actually leave with instructions to call for another translator when the provider is ready to continue. Otherwise, the translator simply leaves as soon as the provider-patient interaction is concluded, as in the example of Mrs. Luk and the business owning couple in the emergency room (Chapter V).

If the patient has the superior social class standing and receives deference from the translator, and in turn acts respectfully and expresses appreciation to the translator, then the positive patient advocacy bond is easily established. Should either the translator fail to show the appropriate degree of deference, or the patient adopt a flagrantly superior attitude, the helper-receiver relationship is strained by patient mistrust and mutual hostility. The result is that the translator functions strictly as a literal "United Nations" translator as described above.

<u>Summary</u>:

An intensive analysis of the conditions needed for trust bond formation in the dyad relationships within the patient-translator-provider triad and their consequences for health care delivery are presented in the following chapter. This summary emphasizes major points and conclusions regarding health care delivery and translator's role development. In the case that the provider does not wish to care for the patient (due

to time constraints, dread of the communication barriers, or ethnic prejudices) and a patient advocacy bond has not been formed between the translator and patient, and patient simply does not get care. However, if the bond has been formed, then the translator will be able to secure physical care for the patient. If the translator and provider have a good working rapport, the patient will receive the best quality of care that the system is capable of delivering; but even that quality of care is limited to the technological/physical aspects of the health care problem, and thus, constitutes a lesser quality of care than the system is capable of providing to English-speaking patients.

In the course of my work with translators, they commonly expressed to me their defensiveness towards the rejection that they witnessed the non-English-speaking patient to experience at all levels in the health care system at San Francisco General Hospital. This rejection stemmed from structural constraints, such as time limitations, cultural differences in medical belief systems, and ethnic prejudices against the latest immigrant groups. As a result of this experience, translators viewed the ideal of "health care for all" as really meaning "health care for the deserving", which excluded those from their social groups. Even though the translator's presence ensured that physical care would be given to the patient, the patient's contact with the health care system and the professional provider was not always health enhancing.

Thus, translators who entered the Multicultural Program without a political or ethnic community orientation, came to develop strong community loyalities and a clear sense that they worked "for their people" and not the health care institution of San Francisco General Hospital.

CHAPTER VII

THE PATIENT-TRANSLATOR-PROVIDER INTERACTION: SITUATIONAL ANALYSIS WITH IMPLICATIONS FOR APPLICATIONS

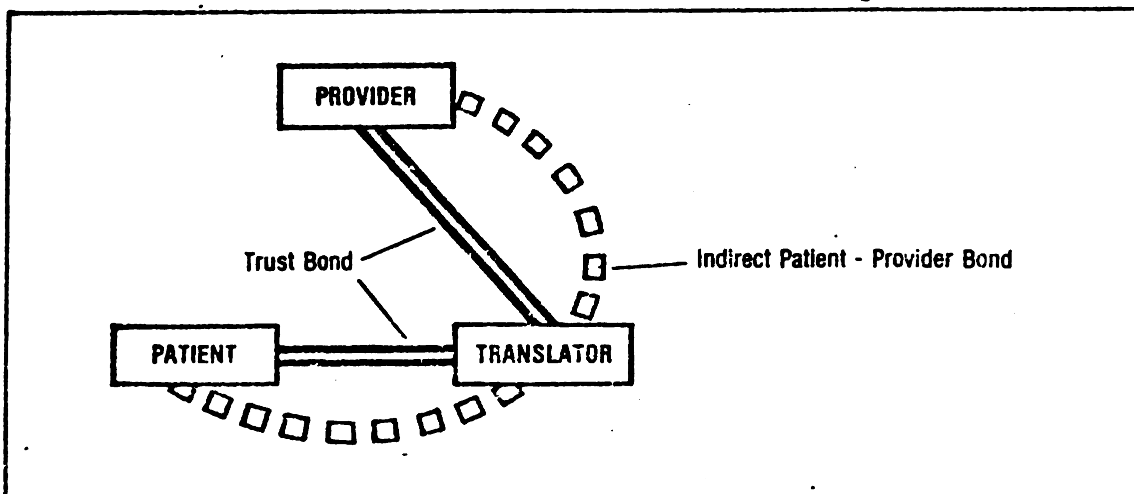
The following analysis is presented to assist translators and health care providers in understanding the dynamics of the patient-translator-provider triad, and to outline the consequences of these dynamics for health care delivery. Hopefully, this analysis will shed light on patient interactions obscured by the hecticness of clinical settings. Information is a powerful tool in problem resolution, and it is my hope that this analysis will contribute towards both the understanding and resolving of problems associated with the care of non-English-speaking patients. This analysis also serves as an example of social sciences ability to identify the patterns of social interaction, the forces that create these patterns and their consequences of these patterns for individuals involved in a particular social system, e.g. San Francisco General Hospital.

The conditions basic to a successful patient-translator-provider interaction are presented in Figure 1. Figure 1 emphasizes the direction of the dyadic bonds that are formed within the triadic interaction and shows that the provider-patient bond _must_ be bridged through the translator's bonds with both the patient and the provider.

Trust is the nature of the bond formed in each of the

dyads, however, the criteria for establishing the trust bond within each of the dyadic role relationships differs markedly. The criteria for the patient-translator trust bond is cultural, based on identification with the native culture and respective social statuses in that social structure. In the provider-translator dyad, however, trust is dependant upon their mutual perception of the other as caring toward the patient. Knowledge and technical competency are equated to the other's demonstrated concern for the patient. The absence of direct bonding between provider and patient is indicated in Figure 1 by the broken line that connects the two through the translator. Both the provider and patient are dependent upon the translator to establish the conditions that allow for the information exchange that is central to a successful healer-patient interaction.

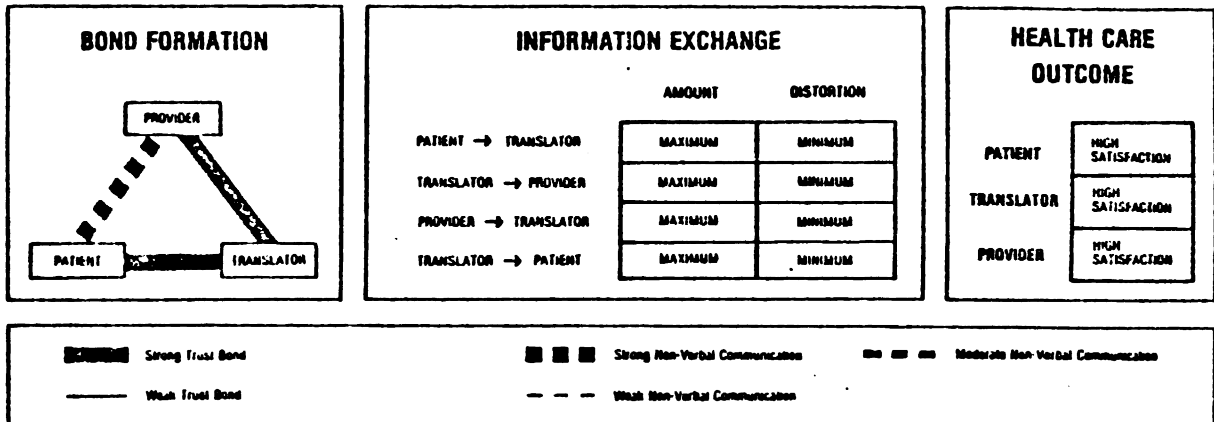
FIGURE 1. DYADIC TRUST BONDS WITHIN THE PATIENT - TRANSLATOR - PROVIDER INTERACTION



The diagrams presented in Figures 2,3,4, and 5 illustrate the dependent relationship between the types of bonds formed within the patient-translator dyad and the translator-provider dyad (Bond Formation Column) to the quantity and quality of information exchanged in the triadic interaction (Information Exchange column). The significance of the quality of the information exchange to health care delivery and to the participants' need satisfaction is outlined under the Health Care Outcome column.

While I recognize that the information exchange within the patient-provider interaction takes the form of questions and answers, for clarity I have diagrammed the process linearly. Under the Information Exchange column, the direction of information flow is shown as starting with the patient and going to the translator. The translator filters this information and relays it to the provider. The provider in turn interprets these data to fit western medicine concepts so as to diagnose and treat the patient. The provider's evaluation and recommendations are sent to the translator to relay to the patient. It is important to realize that distortion occurs at each relay point in this process in the form of conceptual change, and/or missed or added data. Both the quality of information and the degree of distortion at each relay point are strongly influenced by the types of bonds formed between the patient-translator and between translator-provider. The conditions of bond formation and information exchange effect the degree to which each participant is satisfied with the interaction. Figures 2,3,4 and 5 show the variance of bond formation types and the consequences of this condition for information exchange and health care delivery.

FIGURE 2. INFORMATION EXCHANGE WITH TRUST BONDS PRESENT



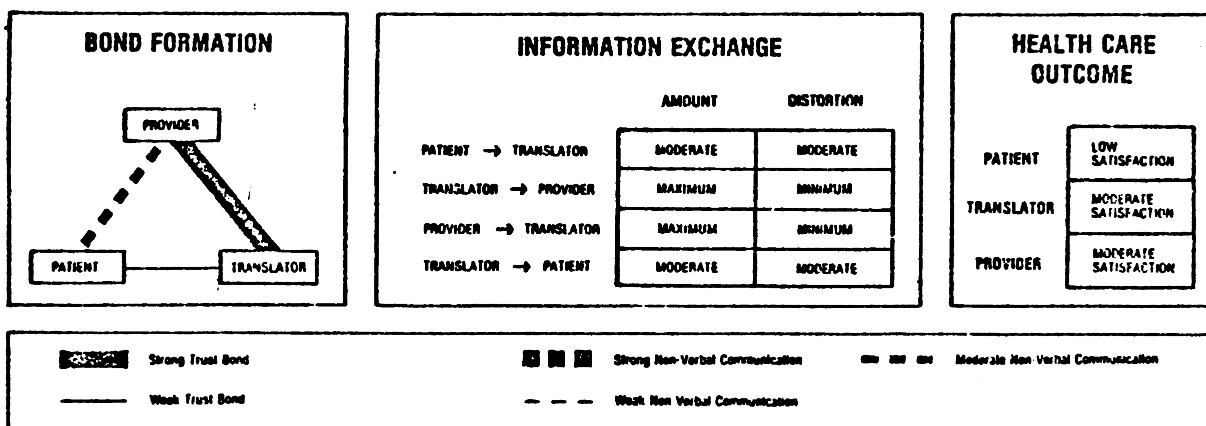
In the conditions outlined in Figure 2, optimum trust bonds have been formed within the patient-transaltor and the translator-provider dyads. The translator and patient establish social and cultural identities that extend beyond the formal translator-patient role. This allows the translator to elicit a detailed social and medical history, as well as a full understanding of the patient's motivations for seeking health care at this time and the concerns that he/she wants addressed in the healer-patient exchange. This information exchange results from the translator taking the time to visit with the patient before doing the business of the medical exam in the presence of the provider. This social visiting allows the translator and patient to become "people" to one another, and this in turn ensures the patient's acceptance of the translator's instructions (e.g., tell the doctor everything that you have tole me) and recommendations for treatment. In interactions characterized by a dual trust bond, the translator translates literally and conceptually, ensuring that the provider and patient understand each other (to the best of the translator's ability. The translator also explores

clinically relevant areas independently to present the clinician with a clear and complete medical history. This type of interaction tends to approximate the technical quality of care that providers are able to deliver to English-speaking patients. It also approximates the amount of time spent with patients in which direct provider-patient communication is possible. In a quantitative way, the time factor correlates with the quality of the information exchanged between provider and patient. It serves as an index of providers' ability to communicate empathy, caring and understanding of the patient's health concerns and their willingness to address these needs in the treatment plan. It means also that the provider and translator have explained the patient's health problem and medical treatment so that the patient understands and agrees with the plans. In the therapeutic partnership that results the patient receives culturally appropriate health care and the provider is allowed to function both as a healer and skilled clinician. Similarly, the dual trust bond allows the translator to "deliver" for both the patient and the provider, enhancing his/her collegial relationship with the provider.

The situation in which the translator and provider have a good working rapport, but the translator-patient bond has not been formed is diagrammed in Figure 3. The conditions under which this type of bond formation can occur are the following: when unacceptable cultural identities are established in the social visiting; when a translator is uncaring

or acts "American" by omitting the visiting ritual and/or questioning the patient in a hurried, impersonal manner; when the patient criticizes or contradicts the translator's translation, withholds information or falsifies data; or, when the patient fails to express the appropriate degree of deference and respect in the initial visiting.

FIGURE 3. INFORMATION EXCHANGE WITH TRUST BOND ABSENT IN THE TRANSLATOR - PATIENT DYAD



In the absence of a patient-translator bond, it is the provider-translator bond that keeps the translator from adopting a "literal translation only" posture toward the patient, and from withdrawing from the interaction at the first available opportunity. Due to their mutual commitment to each other, the translator and provider will attempt to perform technically so as not to disappoint the other. However, in these types of interactions, translators translate in such a way as to communicate their disinterest in the patient to the patient. This inhibits the patient from volunteering information, other than that which the translator elicits, and

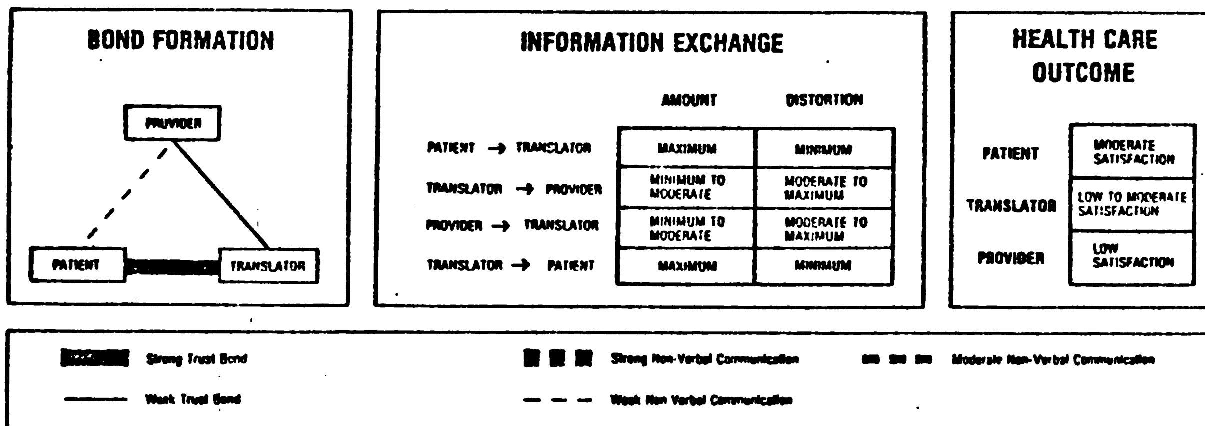
usually this is limited to the physical functioning information that medical providers find useful for their conceptual categories.

The collegial relationship between provider and translator results in the translator receiving detailed medical explanations and information on treatment strategies. However, due to the translator's disinterest in the patient, only a minimum of this information is related back to the patient, and it is at the translator-patient relay points that distortion is greatest. Under health care outcome, the patient's physical complaints are accurately addressed and treated according to Western medical standards, but the patient's medical beliefs and treatment expectations are omitted, and the non-physical aspects of the illness problem are not addressed. The information sent back to the patient from the provider is not conceptually translated by the translator so there is a high risk of nonacceptance of treatment. Patient satisfaction and compliance are felt to be questionable by the provider so that the provider leaves the interaction frustrated.

Situations in which a strong trust bond is formed between translator and patient, but not between provider and translator are illustrated in Figure 4. This type of bonding occurs when the translator and provider are unknown to each other, but the patient and translator have established a prior relationship. This also happens when the translator and provider have had

previous negative work experiences so that the provider is evaluated as "getting by", or "bad" by the translator; or when the translator is evaluated as linguistically incompetent, uncaring or hostile to Western medicine by the provider. Under

FIGURE 4. INFORMATION EXCHANGE WITH TRUST BOND ABSENT IN THE TRANSLATOR - PROVIDER DYAD



these conditions the translator assumes the responsibility of a primary care provider. In the social visiting, the translator will elicit a detailed social and medical history, but due to the provider-translator mistrust most of this information is held back from the provider.

In this type of interaction, the translator will conceptually interpret the patient's responses to the provider's medical history questions to ensure that the patient's physical problems are understood and addressed by the provider. Even through there is minimal information returned from provider to translator, the translator broadens it (within the limits of

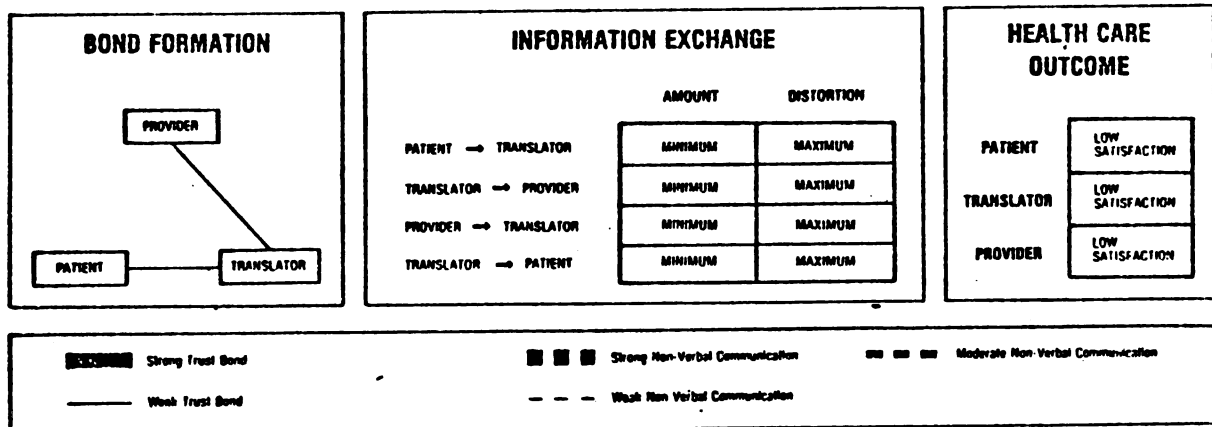
his/her medical knowledge) to cover health education and preventive measures, an explanation of medical findings, etc.

In interactions lacking the translator-provider trust bond no bonding occurs between provider and patient (weak, non-verbal communication line) because of the mistrust communicated by the non-verbal, and sometimes verbal, responses of the translator toward the provider. Due to the unpleasantness of this interactional situation, providers spend a minimum of time with the patient. The patient's physical complaint is addressed and treated because the translator takes whatever action is necessary to secure treatment; however, the treatment secured may not coinside with the practitioner's medical belief regarding appropriate treatment. This triadic interaction is formal and may be marked by provider hostility directed toward both patient and translator, or the provider may express his/her hostility by withdrawing and rejecting the patient's complaint. There is minimal health enhancement that ensues from the patient's contact with the health care professional, despite the translator's intervention and buffering function, the ego-deflation incurred by the patient has to nullify the patient's expectancy of cure.

Figure 5 illustrates those interactional situations in which there are no trust bonds formed between the triadic participants. The interaction is characterized by the fact that neither the provider nor the translator wish to care for

the patient. This attitude may be both the cause of the trust bond not being formed, or the effect, as when one views (e.g. provider) the other (e.g. translator) as uncaring and becomes overwhelmed with the responsibility that this implies for him/her. For the provider, the uncaring attitude may be due to time constraints, dread of the communication barriers, ethnic prejudices, or previous negative work experiences with the assigned translator. For the translator, this position may be the result of any or all of the conditions outlined in Figure 3 as well as translator fatigue or personal dislike of the patient.

FIGURE 5. INFORMATION EXCHANGE WITH TRUST BONDS ABSENT



In interaction where both trust bonds are absent, the provider and translator focus only on the physical complaint, discourage the patient from offering other types of data, and attempt to make the interaction as short as possible. The translator functions as a literal "United Nations" translator

causing marked conceptual distortion in the information received from the patient and relayed to the provider. The provider's own disinterest results in the disregard of the unintelligible medical history data, and adoption of any number of "getting by" strategies, e.g., reliance on laboratory data for making the diagnosis, or rejection of the patient by referring the patient or by rescheduling the patient, or by dismissing the patient's complaint. Thus, the information flow from provider to translator is minimal, and this information is in turn maximally distorted and constricted in the process of being relayed through the translator to the patient. As a result of this impaired information flow, the patient's complaint may or may not be comprehended, addressed or treated by the provider. Even if it is understood and treated, the patient may not feel that his/her condition is being properly diagnosed and treated. Alternatively, the patient's complaints may be judged as invalid (not real), or belonging to some other specialty clinic so that the patient may be dismissed without treatment, referred with a far-off appointment date, or denied access to the system. The only situation which could exceed this degree of impaired information exchange is that in which no translator is available, and the provider is equally uncaring.

In summary, when there is a positive trust bond between patient and translator, and between translator and provider, there is good information exchange and quality health care delivered. When the patient-translator bond is absent, the

quality and quantity of information exchanged is compromised and limited to a physical model of illness causation and treatment. Conceptual translation is not given to the patient, and consequently, the treatment runs the risk of being viewed as culturally inappropriate and rejected by the patient.

The patient is protected from this cultural "lack-of-fit" between medical models in interactions in which the patient-translator trust bond is present. In these types of interactions the translator will ensure that the patient's concerns are addressed, even though this may not include the correct clinical care by Western medical concepts. The translator is placed in the primary provider role by the health care provider's disinterest, and delivers health care within the limitations of his/her medical knowledge. Thus, while patients may leave satisfied, the appropriate clinical care may not have been delivered, and providers are negatively affected by the frustration of their need to perform as skilled clinicians and "healers". In those instances in which there are no trust bonds formed in the triadic interaction, all participants are negatively affected and patients run a high risk of not receiving even the simplest level of clinical care for their physical concerns.

CHAPTER VIII

CONCLUSIONS, SUMMARY AND RECOMMENDATIONS

Review of the Role Evolution for Language Translators:

The Multicultural Program at San Francisco General Hospital ended July 17, 1981, with the Reagan Administration's reduction of the CETA program. The role evaluation for the language translators in the Multicultural Program described herein, however, was stopped in December, 1979. As outlined in Chapter IV, the structural impingements tied to the CETA funding and the lack of administrative commitment within the Department of Public Health resulted in the dissolution of the initial broad-spectrum role functions performed by translators, that I found to be essential for the non-English speaking patients to receive quality patient care.

The change in the translators' role performance occurred as a result of administrative policies and threatened their ability to deliver services and that created intolerable working conditions. These administrative policies in turn resulted from limited funding, heavy training responsibilities to CETA within a service obligated program, continuous personal turnover due to marginal wages, lack of benefits and no permanent job positions. These features required the program administrators to manage the Multicultural Program

in a way that caused them to be perceived by the translator staff as insensitive to and uncaring of the health care needs of non-English speaking patients. The ensuing internal strife developed into an acute labor/management altercation by June, 1979. Time and energy that previously had been directed toward caring for patients came to be spent over the next four months in a highly emotional battle with program and hospital administrators and city officials. At issue were permanent job positions for translators (a condition agreed to in the contract negotiated by the Civil Rights Office, but not yet implemented) and the separation of the patient representative personnel and its administration from the language service program. Due to the immediacy of the expiration of their CETA tenure (September, 1979), most of the translators felt that even if they did succeed in securing permanent job positions, they would not be the ones hired.

During the summer and fall of 1979, I observed even the most dedicated translators evolve elaborate avoidance strategies to elude patient contact. Their demoralization and emotional upheaval blocked the translators' ability to care for needy others, and they could no longer tolerate the emotional demands that accompanied their helper role. Thus, they withdrew from patients, and when frank avoidance was not possible many translators reverted to a literal-translation-only role, and would leave the triadic interaction at the first available opportunity, much to the distress of both provider

and patient.

The administrative changes that resulted from this prolonged confrontation between the MCP translator staff and its management were positive, and with the end of the CETA funding, an efficient, rationally managed language service program eventually emerged. San Francisco General Hospital now has a language service program that has been incorporated into its permanent civil service structure.

However, its personnel number only a third of the original MCP staff and providers report to me that the availability of translation services reflects this two-thirds reduction in translation personnel. So while the language service program may be efficiently managed, the reduced number of personnel are insufficient to handle the ever increasing numbers of non-English speaking patients that utilize SFGH as their primary source of health care. This shortage of translator personnel persists despite the hiring of about five of the first and second groups of MCP translators as permanent Health Workers in the out-patient clinic at SFGH, and the attachment of bilingual requirements for new positions having direct patient contact. Health care providers feel that in terms of providing health care to non-English speaking patients they have lost rather than gained ground since the inception of the MCP translator program in April, 1978 (communications as of September 1981). Providers attri-

bute this regression to the July, 1981 decrease in language translator personnel, but more importantly, to the marked increase in San Francisco's non-English speaking populations (Hispanics, Southeast Asians, Koreans and Filipinos).

In conclusion, the CETA funding with all its binding ties were deadly obstacles to the healthy functioning of the Multicultural Program and caused its early demise -- a demise that occurred long before it was formally dismantled. In the setting of San Francisco General Hospital, language translation services continued after the end of the CETA funding, not out of concern for the quality of patient care or the toll that such interactions take on the providers, but rather due to the unrelenting ethnic community pressure and to the coercive effect of federal and state civil rights legislation.

The Future Need for Language Translation Services:

The present social reality of cultural and linguistic diversity is the result of the early cultural insularity enforced on non-white cultural groups by the white/non-white dichotomy in the social structure of the United States. As outlined in Chapter II, those groups designated as non-white in San Francisco's past were denied historically the opportunities for social mobility allowed "white" ethnic groups. Consequently, a social, economic and occupational separation

evolved reflecting the white/non-white dichotomy in U.S. society that has carried into the 1980's. The long-standing cultural separation, as well as the recent, voluminous immigration of "non-white" and non-English-speaking peoples has resulted in marked cultural and retention of lingustic diversity in the major urban centers (e.g., Los Angeles, San Francisco, New York, Miami) (Fishman 1980).

The political reality of state and federal civil rights legislation, and the enlightened militancy of Blacks, Latinos, Chinese and others means that cultural sensitivity and language services will be increasingly required in the public health care sector, and at major university medical centers. The Chinese and Latino communities' demand for language services at San Francisco General Hospital and the University of California, San Francisco exemplify a trend in the politics of health care that is occurring throughout the United States. Thus, the following recommendations are offered for administrators and health care planners, and health care providers.

Recommendations:
Health Care Planners and Administrators

Health agencies or institutions that require translator personnel should ensure that they receive training in anatomy and physiology, medical terminology and professional ethics. Medical and anatomical terms should be taught in both languages,

as well as converted into basic lay person's terms in the native language. Given the dependence of the health care professional on the ability of the translator to explore and elicit fine distinctions in the patient's history presentation, it is of crucial importance that the translator possess these linguistic skills and medical knowledge. Translators must also be bicultural. The patient's acceptance of treatment is based on the translator's ability to relate the provider's medical findings and treatment recommendations back to the patient across linguistic and cultural boundaries in terms and concepts appropriate to both the provider's and patient's cultural world (for an excellent description of the difficulty of this task see Kendall 1981).

I would also recommend that in recruitment of translator personnel particular attention be paid to their social skills, the demonstration of strong ethnic pride, and empathy for their people. This requires subjective judgment, but these qualities are of equal importance to training, due to the role that they play in the trust bond formation between translator and patient in the triadic interaction (see Chapter VI). If either the knowledge skills or the cultural identity and empathy traits are missing in the translator, the provider's ability to deliver quality health care will be severely impaired.

Lastly, the funding source for such programs or personnel should be from stable, hard monies, and not short-term, soft government monies so that translators can be incorporated as permanent members of the health care team. The importance of their role to the delivery of health care services should also be reflected in their salary level and their status within the institution. If these measures are used to define the translator's role and status, the result will be satisfied patients and satisfied providers. In terms of wasted time, redundancy in diagnostic laboratory work, non-compliance in follow-up and treatment regimens, provider absenteeism or poor work performance, these measures will save institutions money and survive the most stringent cost-effective analysis.

Recommendations: Health Care Providers

When working in multi-ethnic, multilingual settings, it is important for providers to recognize that in addition to language differences, patients will hold different beliefs about disease causes and treatment than the Western medically trained provider. In literal translations of the provider-patient interactions, the receivers miss and/or do not understand the information being sent because it is presented in concepts and relationships that do not exist in the receiver's culture. Thus, conceptual translation must accompany the literal in order for provider and patient

to understand one another, and for the conditions of a successful healer-patient exchange to occur.

As shown in Chapter VIII, the presence or absence of trust bonds in the triadic patient-translator-provider interaction determines the quality and quantity of information exchanged between provider and patient. In order for providers to receive a conceptual translation as well as a literal one, a good working rapport must be established with the translator. Thus, it is important for the provider to get to know the translator and for them to develop a mutual sense of trust. It is also helpful for the provider to be aware of his or her dependence upon the translator's bond with the patient. Providers must be aware that translators need to demonstrate a strong ethnic pride and empathy toward their people in order for a trust bond to be formed between patient and translator, and that the provider's relationship with the patient is dependent upon that bond.

The bicultural, bilingual translator represents a rich source of cultural expertise upon which providers need to draw upon in order to deliver Western medical care in a way that is culturally acceptable to the patient. Once the provider has established a good working relationship with the translator, he/she will be of great assistance in transforming treatment recommendations to fit the cultural beliefs and expectations of the patient; however, the more

information, in terms of dietary practices, beliefs about diagnostic test, or antibiotic therapy, that the provider knows the better he/she can anticipate and plan for potential problem areas in the cross-cultural patient-provider interaction. Armed with both a trustworthy translator and a good cultural background of the patient's medical beliefs and health practices providers will be in a position to tailor health care delivery so as to be culturally compatible, acceptable and beneficial to the patient.

I wish to stress, however, that the principle of presenting and delivering medical care in a way that is culturally acceptable is basic to a successful healer-patient relationship with English-speaking patients as well as the non-English-speaking patients (Foster 1956; Frank 1961; Saunders and Hews 1953; Torrey 1972). The role that information exchange and trust bond formation play in the non-English-speaking patient and English-speaking provider interaction only represents an exaggeration of the interactional dynamics and conditions that are basic to all successful provider-patient relationships.

In conjunction with a physician, I have already presented in a published paper techniques for working with limited or no translation services (Weaver and Sklar 1980), and these techniques will be only briefly reviewed here. The most immediate coping strategy is the use of a bilingual

flash card system that covers physical examination questions and possible responses from which the patient can choose. There should be two sets of cards developed. One for the provider to use and another for the patient to use. The provider's cards have the foreign language written in phonetic English for ease of pronunciation, and the patient's cards can be in the proper form for those capable of reading and selecting the appropriate response. In instances in which the patient does not read, the provider will have no choice but to recruit translation services from whatever resources are available.

If staff volunteers are used as translators, these personnel should be bilingually trained in medical terminology, as well as in the nuances of language as it applies to medical terminology and history-taking. In working with these types of translators, it is also helpful for the provider to outline for the translator at the beginning of the interaction exactly how they wish the translator to translate, e.g., every two sentences, paragraphs literal only, conceptually, or the general expectation that the translator obtain the history and present it to the provider. The least immediate but most potentially effective coping strategy is for providers to take language classes and learn the language of the major ethnic group within their patient population.

SOCIAL SCIENCE'S CONTRIBUTIONS TO MEDICINE

Challenge to Social Scientists:

Over the course of this fieldwork many providers would acknowledge the importance of my research topic only to dismiss it with statements like: "But your findings won't have any impact or change things"; or, "There are so many problems in the physician-patient relationship and they've always been there and they always will be there because it starts in the way we are trained"; or, "In all the history of man, the only thing that has improved the relationship of man to man is technology. As an anthropologist you must know that the only thing that stands between civilization and savagery is technology". I interpret these provider's cynical views of the ability of social science to effect a positive change in the provider-patient relationship as indicating social science's failure to demonstrate what it can do in the applied world of medicine. Particularly this is due to a past reluctance in social science to address the question of motivation in the behavior of all the system's participants, as well as the social scientists' avoidance of the day-to-day work scene.

To effect interventions in health care as a social system or in the delivery of services, social scientists must go to the source of power within the system, and that is the physician provider and the medical training institu-

tion. It is not enough to describe the problems and inadequacies of the United States' medical system in social science journals so that health care providers are justified in describing social scientists as sophistic critics who lack solutions or suggestions as to how to solve problems of human interactions. It is easy to describe behavior patterns within the health care system; but the presentation of the cultural and structural factors that underlie the motivations behind that behavior stresses the objectivity and field work skills of the social scientist by requiring close contact with the "villain" in addition to a focus on the "victim".

Traditionally, anthropologists have studied down (Nader 1969), presenting only the side of the downtrodden and not that of the "downtrodders". As long as this tradition is maintained in medical social science research, our work will have limited theoretical value and little applicability, because it lacks the key information necessary for devising interventions. To be effective, resolution strategies must fit the constraints under which the actors perceive themselves to be operating; in order to devise these interventions we must first learn what those constraints are from the world view of both provider and patient. This will require medical social scientists to study the power elite and the decision-makers in this social system in order to formulate interventions; but it will also require our willingness to work in the stress of the clinical setting for their implementation.

The Contribution of the Clinic-Based Social Scientist:

The phenomenon of the "wounded healer" has been recognized since Hippocrates' time (Balint et al. 1966; Pfifferling 1980), but the contemporary Western medical healer has the added burden of the legal and peer demands of a highly complex technology. Physicians and other health care providers are held accountable for the practice of technical skills that must be performed according to set scientific standards. This focus on technical expertise consumes the major part of health care providers' time and energy. However, research on the patient-provider relationship indicates that patients expect, and need, their general life situation to be addressed in the healer's explanation of the cause of their illness and in the treatment plan (Balint 1957; Engel 1973; Kleinman 1980; Roter 1977; Zola 1972, 1973) Western medical system providers in the United States are placed under severe time constraints and expected to be all things to all people. Providers simply cannot deliver at this level on a full time basis, year after year. Since accountability in health care delivery focuses only on the technological aspects of diagnosis and treatment (Strauss et al 1964), providers tend to function largely in this realm in their interactions with patients. The result is a high prevalence of patient dissatisfaction (Kleinman et al 1978; Lander 1978; Reinhard 1976). In unsatisfactory patient-provider relationships the patient often behaves in ways that block, to varying degrees, the clinician's ability

to practice his/her technical skills. Since the primary need of providers in the patient-provider relationship is to be able to practice their clinical expertise, patient satisfaction is an essential condition to provider satisfaction. It is for this reason that a satisfied patient means a satisfied provider; and likewise, a dissatisfied patient means a dissatisfied provider.

The central problem of our healer-patient relationships is the built in "Catch-22" situation that characterizes the U.S. health care system. Providers are caught between stringent technological performance demands and time constraints imposed by the system's concern for monetary profits and the humanistic needs and expectations of patients. In this health care system providers are not allowed the time or the emotional support to meet all the socio-emotional needs that their patients bring into the healer-patient interaction. The applied training of physician providers emphasizes the technological-physical model of disease causation and treatment (Jonas 1978) to the exclusion of the socio-emotional components of the "illness" experience (Kleinman et al 1978), and to the detriment of the physician-patient relationship (Engels 1977; Freudenberger 1974; Maslack 1977). Over time, the toll taken by emotional demands and patient dissatisfaction impairs and wounds the healer, and it is exactly at this point that the medically trained social scientist can intervene to "help the helper" to prevent this impairment process

and indirectly to assist them in their delivery of patient care.

Caplan (1972) envisioned the need for social scientists to act as "helpers to the helpers" in the early seventies. Other researchers too have demonstrated the occupational hazards of the helping professions by relating them to social morbidity indices (e.g., suicide, alcholism, divorce rates, death rates) (Desole et al 1969; Guralnick 1963; Mausner and Steppacher 1973; Vaillant et al 1972) and work performance and avoidance strategies (AMA Council on Mental Health 1973; Maslack 1976). The intervention that medically trained social scientists can offer to providers is their consulting expertise in addressing the socio-cultural needs of patients, their availability as resource persons for discussion of difficult patient interactions, and treatment strategies (Alexander 1980; Harwood 1981; Pfifferling 1981; Lorber 1975), and lastly their research expertise in studying problems in human interactions.

One of the features that struck me in my fieldwork was the cathartic release that the interview situation seemed to present for providers. It became clear to me that there is rarely anyone within the health care system who listens to or cares about the problems, worries or concerns of the provider. As an interviewer I represented a willing and empathetic listener, and consequently, the interview

afforded providers with the opportunity to talk to a safe outsider about _their_ problems, vulnerabilities, and needs (Ablon 1977). This situation describes house staff more than attending physicians, but despite the social and age distance between the attending faculty and myself, this interactional characteristic also occurred in some of my interviews with attending physicians. This cathartic release characterized my interviews with all levels of the nursing staff.

Not uncommonly my interview sessions with providers ended with their thanking _me_. It struck me then, as it does now, as a ominous commentary on the United States' health care system. The technological emphasis in the U.S. medical system, couched as it is in a minimum of contact time between provider and patient, dehumanizes the most humanistic of man's arts - the art of healing. The United States' form of Western medicine strongly values technology and monetary profit (Geiger 1975). Consequently, the humanistic aspects of the healer-patient interaction have been sacrificed to the physical model of disease causation (Engel 1977), technological advancement (Howard and Strauss 1975), and fee-for-service requirements (Veatch 1976).

Medical science needs social science to help re-introduce the humanistic aspects of the healing arts into medical practice. This endeavor represents the most promising con-

tribution of social science to medical science, but to accomplish this goal social scientists must be both medically trained and clinically placed. It is my experience that medical providers are open to the possibilities afforded by the application of social science principles in medical practice, to the extent that they have requested explanations outlining these possibilities for publication in a medical journal (Dunn 1980), as well as soliciting applied demonstrations in clinical settings (Maretzki 1981). As I see it, the challenge has been offered by medical science and now lies at the feet of social science. It is time to pick up the gauntlet.

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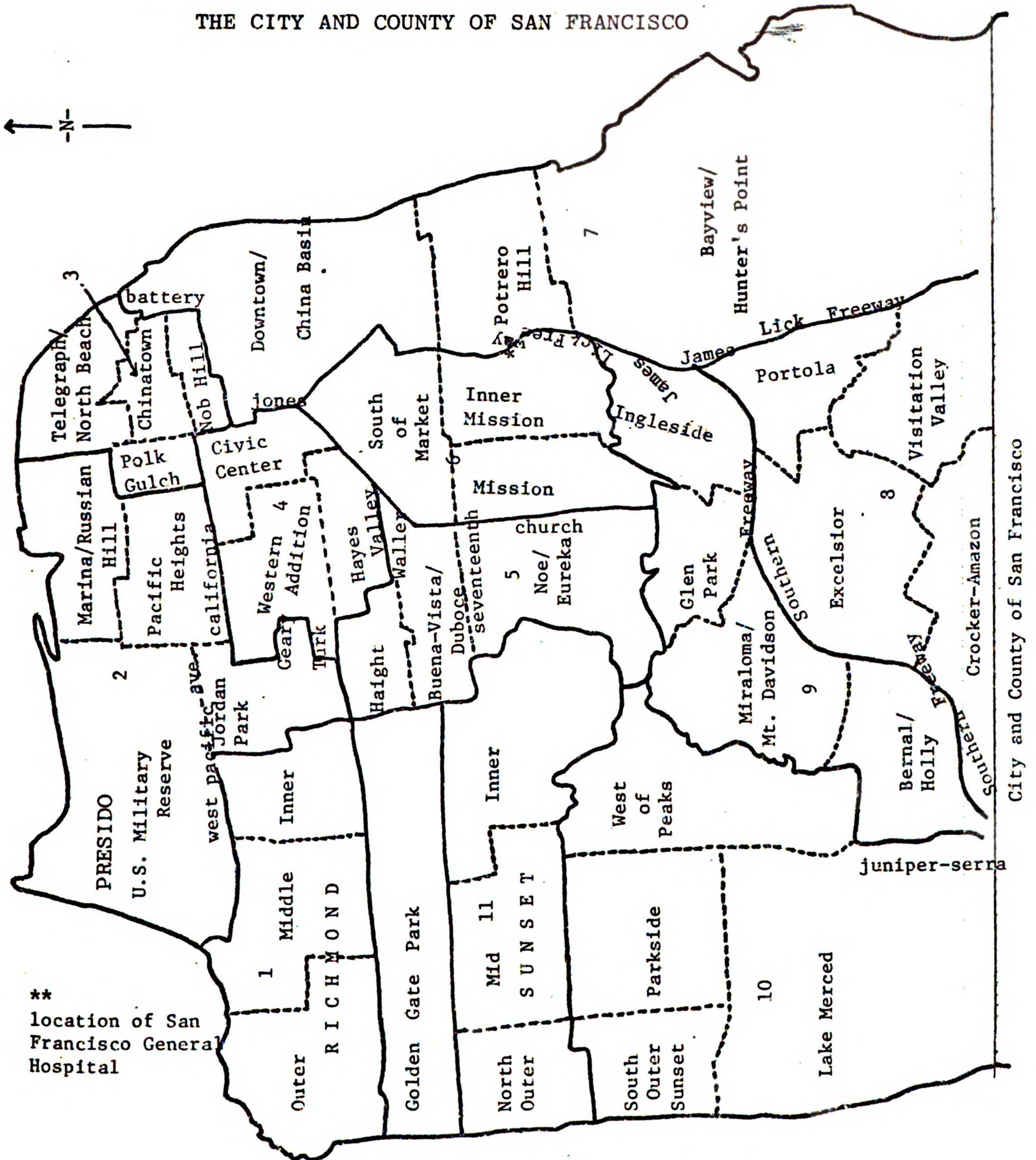
APPENDICES

APPENDIX "1"

SUPERVISORIAL DISTRICTS BY NEIGHBORHOOD DISTRICTS OF THE CITY AND COUNTY OF SAN FRANCISCO



APPENDIX "1"

THE NEIGHBORHOODS OF SAN FRANCISCO BY SUPERVISORIAL DISTRICTS**

District 1
- Outer Richmond
- Middle Richmond
- Inner Richmond

District 2
- Marina/Russian Hill
- Pacific Heights
- Jordan Park

District 3
- Telegraph/No. Beach
- Chinatown
- Polk Gulch
- Nob Hill

District 4
- Civic Center
- Western Addition
- Hayes Valley

District 5
- Noe/Eureka
- Buena-Vista/Duboce
- Haight

District 6
- South of Market
- Inner Mission
- Mission

District 7
- Downtown/China Basin
- Potrero Hill
- Bayview/Hunter's Point

District 8
- Portola
- Visitation Valley
- Excelsior
- Crocker-Amazon

District 9
- Miraloma/Mt. Davidson
- Bernal/Holly
- Glenn Park
- Ingleside

District 10
- Lake Merced
- South Outer Sunset
- Parkside
- West of Twin Peaks

District 11
- North Outer Sunset
- Mid Sunset
- Inner Sunset
- Twin Peaks

** source: Coro Foundation 1979

Appendix 1 (cont.) General Socio-Economic Characteristics of San Francisco's 11 Supervisorial Districts.

District	Total Population	White	Black	Spanish American	Other Races	Families Below Poverty Level	Unemployed
1	62,016	39,070 63%	1,472 2%	4,904 8%	16,172 26%	1,011 9%	2,890 5%
2	58,480	3,336 57%	3,040 5%	3,370 6%	3,346 6%	698 9%	2,444 4%
3	61,691	25,910 42%	596 1%	2,524 4%	32,098 52%	1,453 18%	4,342 7%
4	63,412	36,144 57%	23,856 38%	3,722 6%	6,714 11%	1,989 25%	6,590 10%
5	60,811	35,272 58%	9,829 16%	9,416 16%	6,022 10%	1,259 15%	5,184 9%
6	59,893	23,358 39%	3,411 6%	24,937 42%	7,739 13%	2,236 23%	5,369 9%
7	60,501	25,411 42%	23,894 40%	6,502 11%	4,889 8%	2,303 24%	5,502 9%
8	61,174	34,257 56%	6,644 11%	14,414 24%	7,151 12%	1,529 14%	3,421 6%
9	59,521	24,403 41%	14,077 24%	14,376 24%	6,042 10%	1,317 12%	3,382 6%
10	59,322	50,423 85%	681 1%	4,645 8%	3,780 7%	644 6%	2,192 4%
11	57,550	44,889 78%	1,119 2%	5,405 9%	6,233 11%	677 9%	2,797 5%

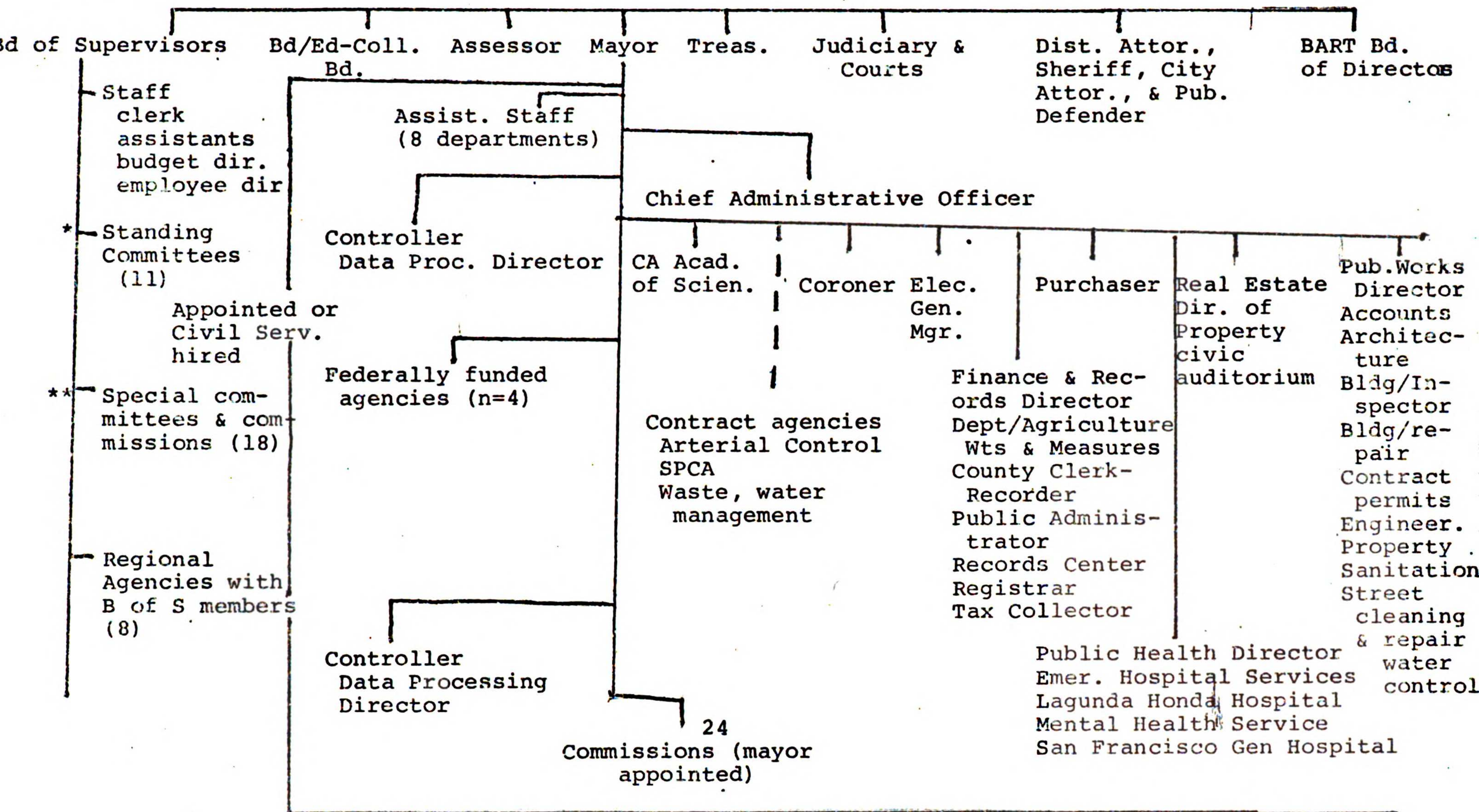
Appendix 1 (cont.) Composition of Selected Neighborhood Districts by Ethnicity and Family Income Levels in Percentages

	Western Addition	Pacific Heights	Chinatown	Marina/ Russian Hill	Inner Mission	Twin Peaks
Ethnic Groups						
White	27	86	22	87	26	84
Black	59	3	1	3	7	4
Hispanic	5	6	3	6	55	4
Chinese	2	2	71	2	2	5
Other Asian	6	2	2	1	6	3
Family Income Levels*						
Under $4	28	9	23	8	24	7
$4 - $10	41	20	36	28	42	17
$10 - $15	16	20	19	26	23	30
$15 - $25	10	28	13	25	9	35
Over $25	5	23	9	13	2	11

* Annual income in thousands of dollars

(data source: Coro Foundation 1980 based on 1970 Census data and 1976 Estimates by Department of City Planning).

Appendix 2 Location of San Francisco General Hospital within the Government of the City and County of San Francisco



APPENDIX "2" cont.

Mayor-Budget

Board of Supervisors

CAO-Budget

Budget Office
Health Committee

Finance
Committee

Director Public Health-Budget

Controller

Assistant Director of
Institutions & EMS

Laguna Honda

Administrator-SFGHMC / Deputy Director of Public Health*

Deputy Director*

Hospital Departments

Operational Aspects of the
Department of Public Health

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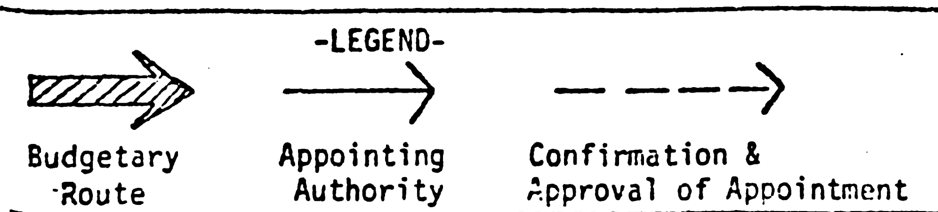

source: West Bay Health Systems Agency 1980:53

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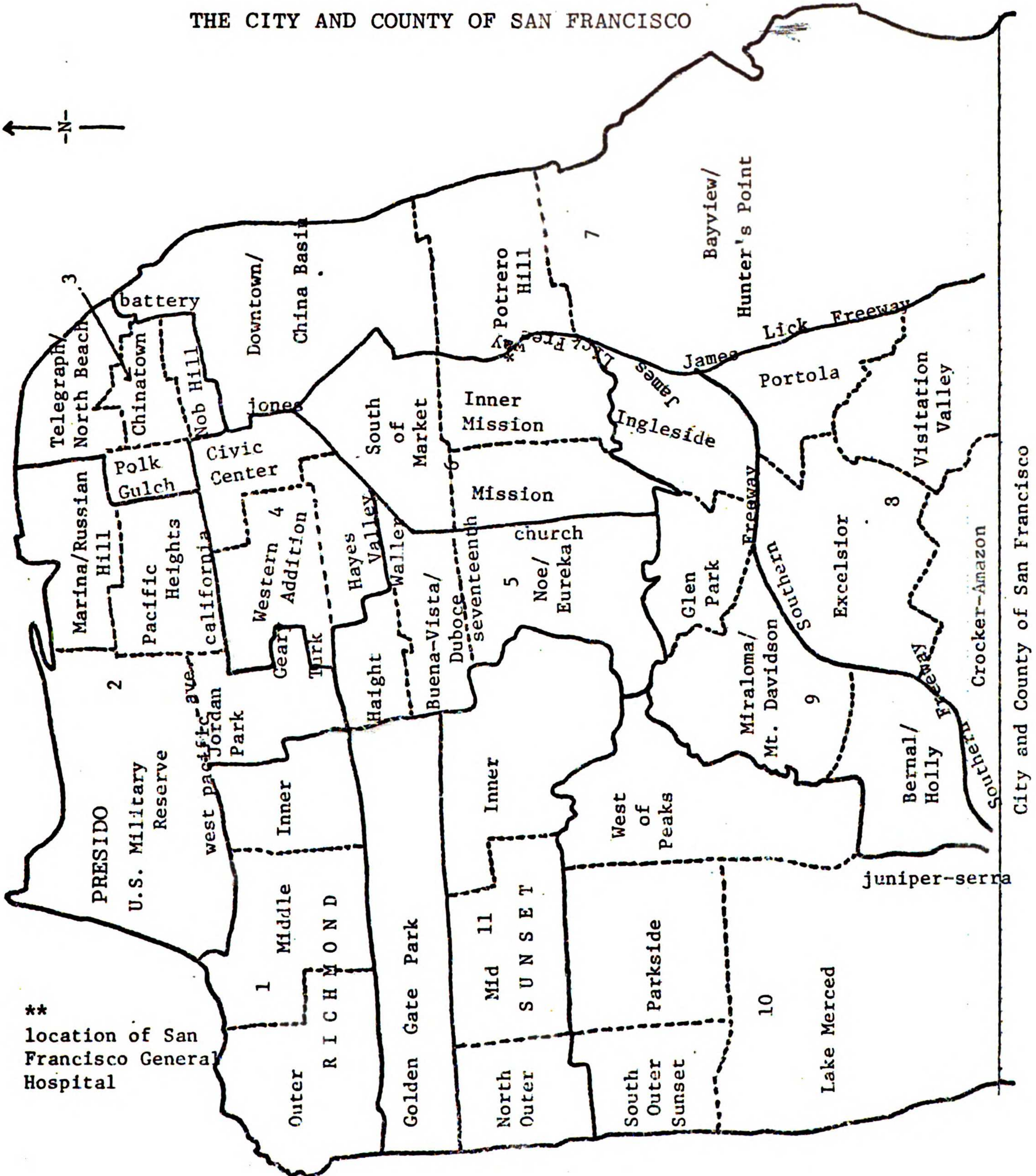

**
location of San Francisco General Hospital

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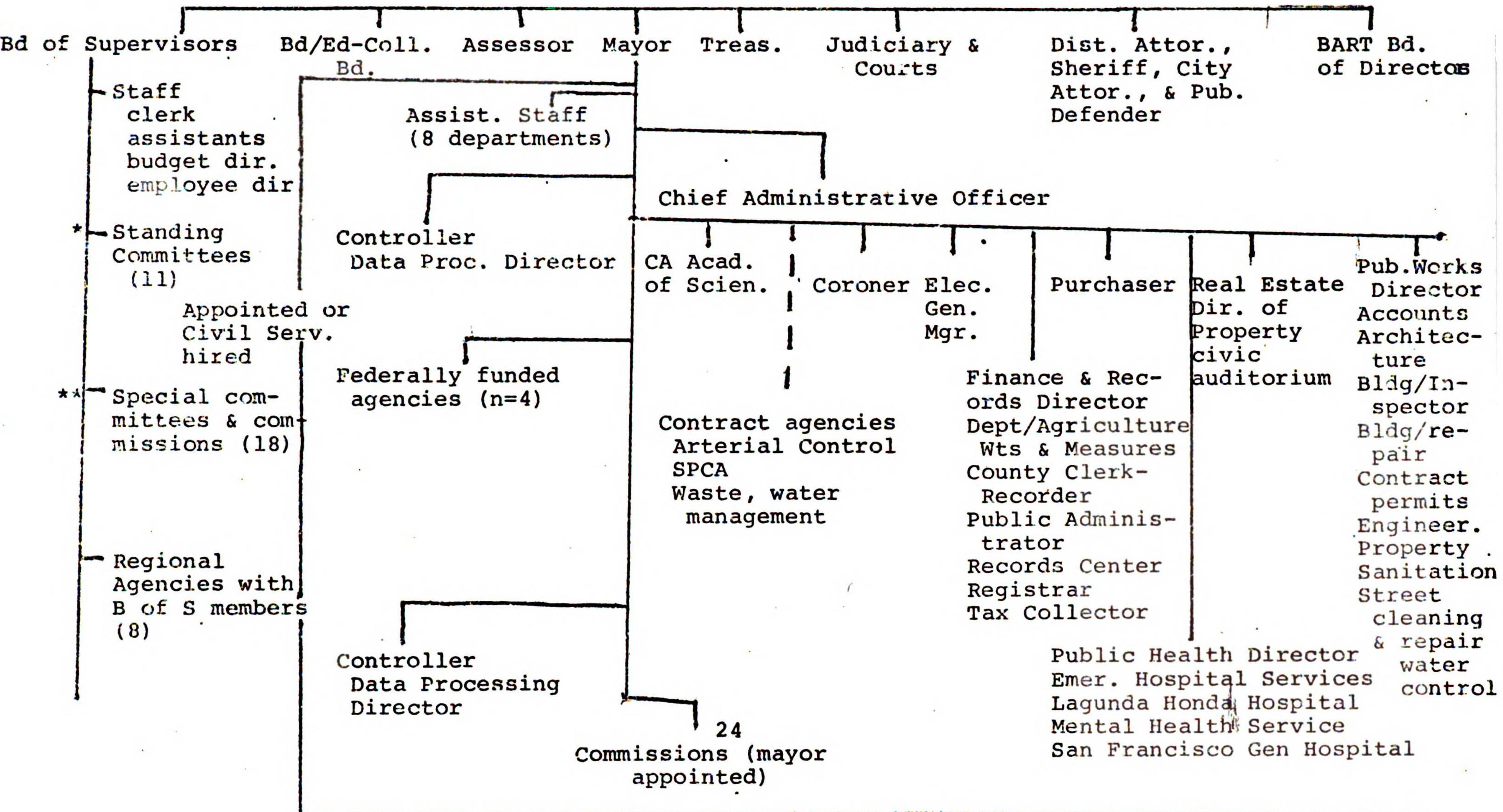

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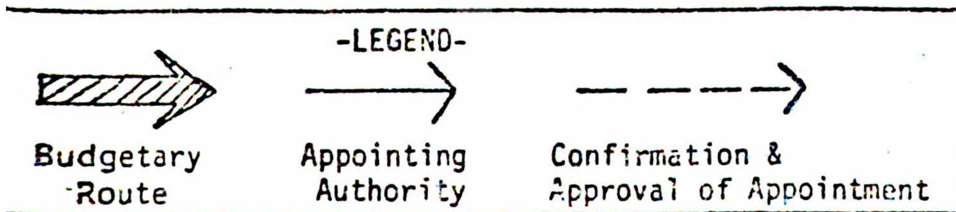


source: West Bay Health Systems Agency 1980:53

APPENDIX "3"

Out-Patient Clinics, Clinical Specialities and Special Programs at San Francisco General Hospital

Out-patient services provided at San Francisco Medical Center are divided between pediatric, women, adult and family health services. Adult out-patient services include the general clinical areas of medicine, surgery, adult health screening, and employee health services. Medicine and surgery include speciality clinics such as, hypertension, diabetes, hematology/oncology, renal/hepatic, infectious diseases, orthopedics, eye-ear-nose-throat, and urology.

The Family Health Center gives a single source of health maintenance and care to families seeking this type of service.

The pediatric clinic cares for children from birth to adolescence in general medicine as well as clinical specialities, e.g., infectious diseases, respiratory, in addition to special programs for adolescent counselling, psychiatric consultation for children, and child/adolescent sexual abuse treatment.

The woman's health center offers prenatal, obstetrical and general gynecology care. Speciality clinics include high-risk mothers, displasia, infertility, and special services provided are abortion counselling, therapeutic abortions, tubal ligations, prenatal education in nutrition, prenatal education and counselling for pregnant teenagers,

and prenatal exercise classes.

Dental services are provided in the form of general dentistry, oral surgery, and 24-hour emergency dental services.

Special Programs:

Northern California Sickle Cell Center

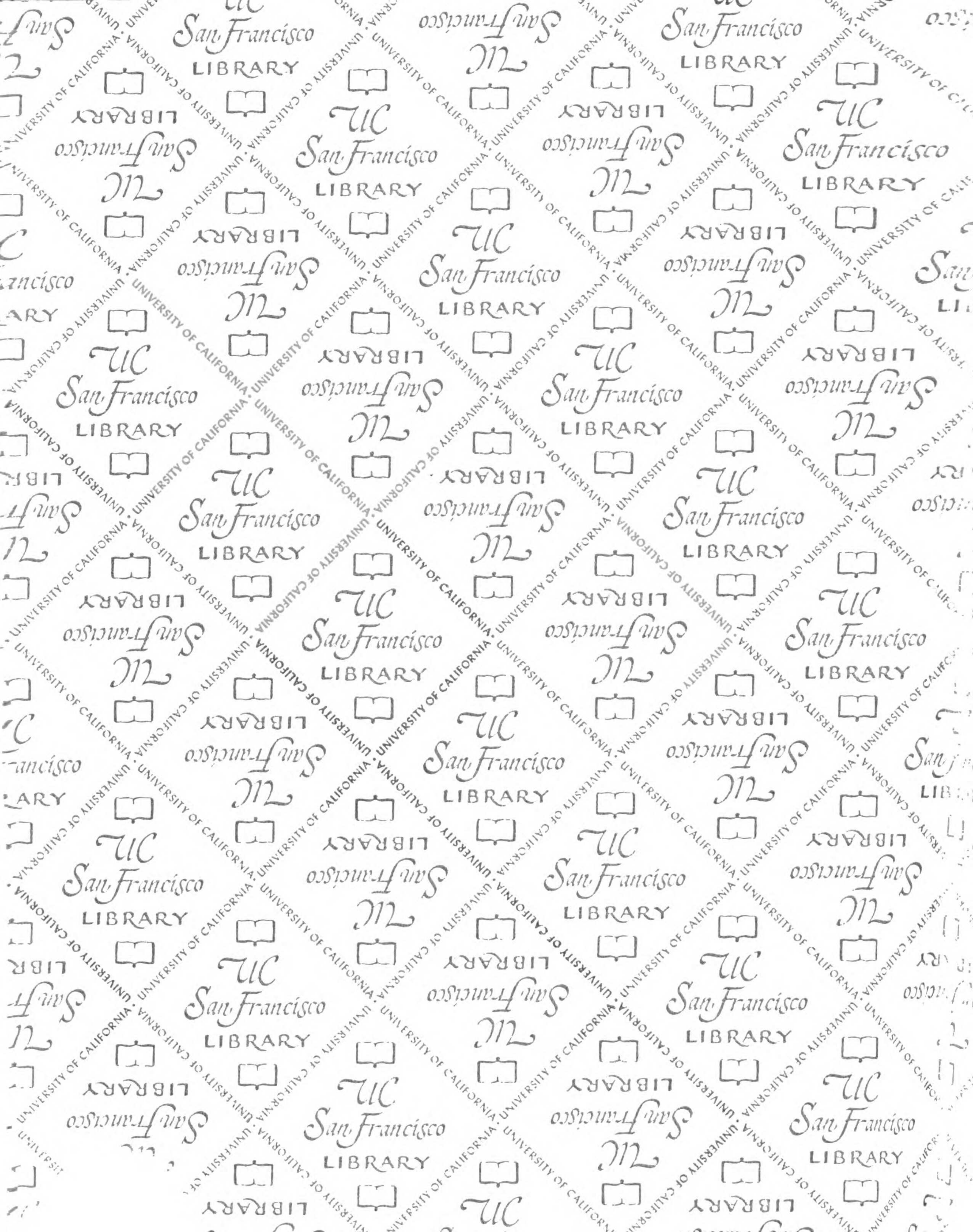
This center coordinates patient care services to sickle cell patients, provides genetic counselling and testing, patient and family counselling, health education for public schools and for high risk community groups.

San Francisco Bay Area Regional Poison Center

The Poison Center serves a popualtion of about four million residents and health care providers. It offers 24-hour information, consultation and referral service for practitioners. The center also counsels public callers regarding accidental poisiong, substance abuse, animal or insect bites, food or mushroom poisoning, drug and overdose reactions.

Alternative Therapies Clinic

This clinic offers non-traditional forms of treatment for chronic illness conditions drawing from eastern medical systems and western psychotherapy modalities.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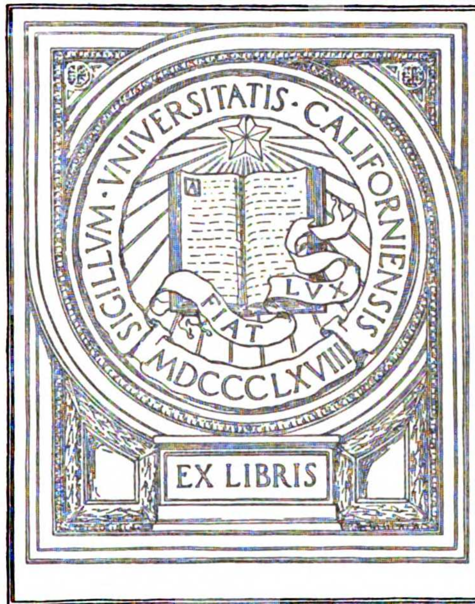

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