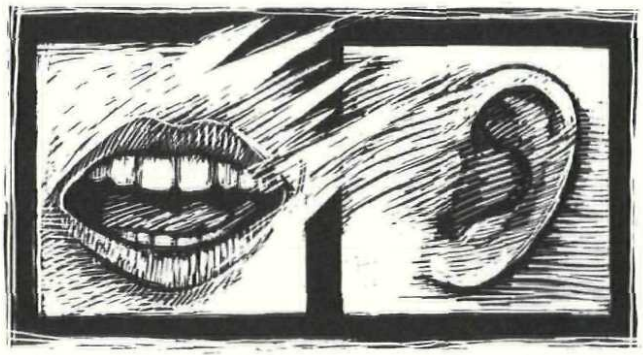
TRENDS & Ideas

CLINICAL CARE

Leaping the Language Barrier



According to the 1990 census, nearly 14 million U.S. residents do not have good English language skills. Because communication between patient and physician is so important in healthcare, many of those 14 million are medically at risk, write Steven Woloshin, MD, et al. in *JAMA*.

A language barrier interferes with the physician's ability to take a medical history and assess and evaluate symptoms. It can block that empathy between physician and patient that may itself be a form of therapy. On the patient's side, a language barrier can cause dissatisfaction, poor compliance, and inappropriate follow-up.

So vital is verbal communication that the U.S. Department of Health and Human Service's (DHHS's) Office of Civil Rights views as discrimination a health program's failure to provide interpreters for patients who speak little English. The DHHS regulation forbidding such discrimination is based on the Civil Rights Act of 1964. Some states have similar laws or regulations. But at both the state and federal levels, such regulations tend to be vaguely written and difficult and expensive to enforce.

Nevertheless, healthcare facilities increasingly find they must provide interpreters to ensure that patients with limited English skills receive the care they need. There are three primary ways facilities do this:

- They hire professional interpreters.
- They train bilingual staff members to be ad hoc interpreters.
- They contract with the ATT Language Line, a 24-hour service that provides interpretation over the phone.

Of course, all three methods are expensive, and patients with limited English are often unable to help defray the cost because they lack health insurance. But as managed care providers begin to compete for Medicaid patients, they may find that providing bilingual services is a way to attract them.

WELLNESS

California's Breast Cancer Early Detection Program

In 1995 alone it is estimated that 20,000 new cases of breast cancer will be diagnosed in California, and 5,000 women will die of the disease. These startling statistics have prompted California's Department of Health Services to use a two-cent-per-pack tax on tobacco products to fund the Breast Cancer Early Detection Program (BCEDP), which is expected to receive $34 million annually from the tobacco surcharge.

BCEDP was created to fight breast cancer mortality among low-income, underinsured, and uninsured Californians. Through the program, women can obtain free screenings and diagnostic services. To qualify for services, a woman must be older than 40, have a household income at or below 200 percent of the federal poverty level, and either be uninsured or underinsured. If cancer is detected, some women may become eligible for MediCal or other public programs. BCEDP can help these women find care.

BCEDP is asking care providers to seize every opportunity to discuss breast health with patients. Often, a low-income or uninsured woman does not seek well care. An urgent care visit "might be the only time that this woman will have the opportunity to get information that could save her life," says Kim Belshé, California health director. She adds that it is critical "for doctors, nurses, and other healthcare specialists to join this effort and help bring services to women who generally do not consider breast cancer a priority."

BCEDP offers providers enrolled in the program many opportunities to learn about breast cancer. Through BCEDP's comprehensive education program participating providers can learn how to perform clinical breast examinations and talk with patients about breast health. An information bureau helps providers obtain articles and other communications on breast health. Quality assurance assistance is also available: BCEDP will monitor clinical services (e.g., mammography) and design specific technical assistance programs to improve the rate of annual rescreening, screening of existing patients, follow-up, and case management.

Sim Gelman

ACUTE CARE

A Pathway for Stroke Patients

To reduce the average 11-day stay of stroke patients at William Beaumont Hospital, Royal Oak, MI, the staff created a clinical pathway for stroke patients, according to Beverly Hydo, RN, in the *American Journal of Nursing*.

A clinical pathway is a general plan for the evaluation and treatment of patients who share a medical problem. On it are plotted the key events and interventions of a specific hospitalization. Pathways, which are common for surgical patients, can help hospitals make effective use of their resources. But some Beaumont staff members argued that, because there was so much variety among stroke patients, a pathway approach would be inappropriate for them. Nevertheless, writes Hydo, the hospital went ahead with the plan.

Hydo, the project coordinator, soon learned that the hospital's stroke patients might be found scattered among as many as 170 medical unit beds, being treated by as many as 150 different physicians and residents. However, a review of 30 patients' charts did reveal some common components of treatment. Encouraged by that fact, the hospital formed a clinical pathway team comprising representatives from all disciplines involved in stroke cases. The team included physicians, nurses, therapists, and administrators.

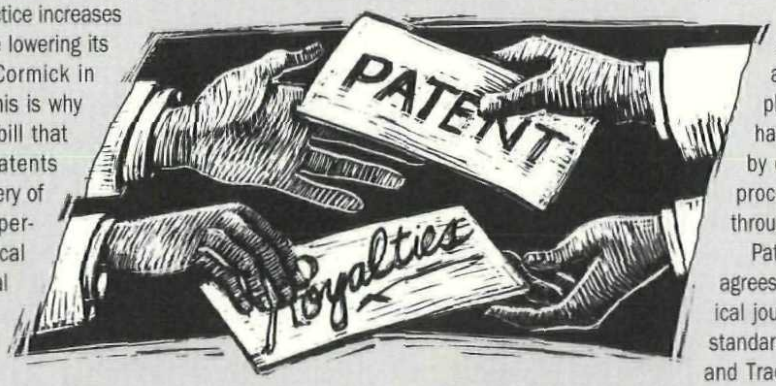
Realizing that strokes differed in nature, the team developed basic diagnoses and treatments for the pathway. A treatment chart was created, allowing team members to both focus on those parts of the pathway specific to their disciplines and follow the general course of treatment. This charting revealed several treatment problems, the most serious resulting from lack of coordination by different hospital departments. These problems improved after the hospital formed a dedicated stroke unit in 1993.

The team found that by focusing on patient needs, rather than on territorial issues between departments, the hospital improved its continuity of care for stroke patients. The new stroke pathway has also increased the confidence of the involved care givers. And the length of hospital stay for stroke patients has fallen from approximately 11 days to approximately seven days.

LAW

Patently Unethical

Will patients benefit if physicians are allowed to patent medical procedures and collect royalties from those who license such procedures? Reps. Greg Ganske, MD, R-IA, and Ron Wyden, D-OR, do not believe so. They assert that such a practice increases the cost of healthcare while lowering its quality, reports Brian McCormick in *American Medical News*. This is why the two are sponsoring a bill that prohibits the issuing of patents "for any invention or discovery of a method or process for performing a surgical or medical therapy, or making a medical diagnosis."



The American Medical Association (AMA) believes Ganske and Wyden are right on target. Last year the association's house of delegates found the practice of physicians obtaining medical and surgical procedure patents to be unethical, reports McCormick.

Opponents of the bill argue that the incentive of financial gain from royalties motivates some physicians to develop procedures that not only save money but also enhance quality of care.

Advocates of the Ganske-Wyden bill, however, point out that the Hippocratic Oath encourages physicians to freely share their knowledge with their colleagues. The patenting of medical procedures conflicts with this principle because it "limits free access to information that improves patient care," says Nancy Dickey, MD, of Texas.

John Glasson, MD, chairperson of AMA's Council on Ethical and Judicial Affairs adds that a physician in search of prominence has a better chance of achieving it by describing his or her innovative procedures in medical journals than through charging royalties.

Patent attorney James Longacre disagrees with Glasson, asserting that medical journals do not hold the same high standards maintained by the U.S. Patent and Trademark Office. "Nothing keeps a physician from withholding key portions of his or her research" when describing the procedure in a medical journal, notes Longacre.

Several medical associations are pressing for passage of the Ganske-Wyden bill, noting that such legislation would be in line with many countries' patent laws, McCormick reports. "More than 80 countries–including almost all of Europe–prohibit medical procedures patents," points out Nancy McCann, director of government relations at the American Society of Cataract and Refractive Surgery.