



# Lost in Translation: Misinterpretation of Verbal Symptoms and Non-Verbal Cues in Multilingual Patient Populations



**Published:** August 30, 2026

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## Introduction

Effective clinical communication is the foundation of accurate diagnosis and safe care. When a patient cannot describe symptoms in the clinician's language or a clinician cannot read nonverbal distress, diagnosis is compromised. A systematic review of 42 studies across Europe, the Americas, Asia, and Australia found that poor communication contributed to 24% of patient safety incidents. However, the authors rated the strength of this evidence as low (Keshtkar et al., 2025). The World Health Organization similarly reports that diagnostic errors occur in 5-20% of encounters, with communication breakdown a leading factor (WHO, 2023). This article traces a pathway: from communication barriers to misread symptoms to diagnostic errors to patient harm. Dr. Pooya Beigi, founder of the Misdiagnosis Association and Research Institute (MARI), termed this pattern of harm "mismatch": any medical act that results in harm or fails the standard of care (Blissy, 2024). The central question: how does verbal and non-verbal misinterpretation in multilingual patients causes diagnostic error, and what changes can reduce the harm?

## What Is the Error? Mismatch Through Communication Failure

Dr. Beigi coined mismatch to capture medical failures that produce harm, extending beyond malpractice to communicative and systemic breakdowns (Blissy, 2024). The mechanism this article traces is a chain: a patient reaches for words they lack or expresses distress through a gesture the clinician misreads; the clinician, under time pressure and without interpreter support, fills that gap with assumption rather than fact; the assumption becomes a diagnostic error; the error causes harm. Each link is a point where mismatch can take hold. This pattern is well documented in Canada: the Canadian Adverse Events Study found 7.5% of acute care patients experience a serious adverse event, over one-third preventable (Baker et al., 2004), and a CMPA review found communication breakdown in 76% of internal medicine cases involving peer criticism (CMPA, 2022). Harvard's CRICO Strategies found communication failures contributed to 30% of 23,000 malpractice claims, rising to 40% by 2025 (CRICO Strategies, 2015; Candello, 2025).

## Prevalence and Impact

Per the 2021 Census, nearly 3 in 10 Canadians speak a language other than English or French, with Punjabi among the most common (Statistics Canada, 2025). Patients who speak neither official language have a 30% higher rate of harmful events in Canadian hospitals (CIHI, 2024). Hospitalized Ontario home care recipients who did not share a language with their physician had worse safety outcomes (Seale et al., 2022). Canadian legal precedent underscores the stakes of unaddressed communication barriers: in *Eldridge v. British Columbia (Attorney General)* (1997), the Supreme Court held that failing to provide sign-language interpreters for Deaf patients violated their equality rights under the Charter, since the resulting barrier increased their risk of misdiagnosis. That ruling applies specifically to Deaf patients and sign-language interpretation;

Canada has no equivalent enforced right to interpretation for speakers of other non-official languages, and provision remains inconsistent, with clinicians often relying on family or untrained staff. In the US, 8.6% of the population has limited English proficiency and faces elevated adverse-event risk from communication problems (AHRQ, n.d.).

## Verbal Symptom Misinterpretation

Untrained interpretation is a major source of this risk: a study of pediatric encounters found an average of 29 interpretation errors per visit, 63% with potential clinical consequences, including one mistranslation that had a mother place antibiotics in her child's ears instead of giving them orally (Flores et al., 2003). de Moissac and Bowen (2019) documented that Francophone minority patients in Canada experienced poorer assessment and delayed treatment linked to language barriers. In mental health specifically, cultural idioms of distress - culturally shaped expressions of suffering that do not map onto standard diagnostic categories - can cause misdiagnosis or underdiagnosis when clinicians are unfamiliar with them (Kohrt & Rasmussen, 2015). A further Canadian case, discussed below, shows how a verbal misunderstanding alone can lead directly to serious harm. Each of these cases follows the same pathway: communication barrier, misread symptom, diagnostic error, harm.

## Non-Verbal Cue Misinterpretation

The non-verbal dimension is equally consequential. Clinical assessment relies on cues such as facial expression, posture, and pain behaviour, but these are not culturally universal. A review of cross-cultural pain research found that patients from cultures that value stoicism may underreport pain verbally while still displaying it through subtle behavioural cues clinicians can fail to recognize (Okolo et al., 2024). Coelho and Galan (2012) found physicians were less accurate reading South Asian patients' nonverbal cues than Caucasian patients', and lower decoding accuracy correlated with lower patient satisfaction. A British Columbia study adapting a knee-symptom tool into Punjabi found significant comprehension gaps between the English source and Punjabi patients' understanding of their own symptoms, showing that even structured clinical tools can misrepresent patient experience across languages (Suryaprakash et al., 2025). These disparities compound existing inequities: minority cancer outpatients have twice the odds of receiving inadequate pain treatment compared with white patients (Fisch et al., 2012).

## Real-World Example

A documented Canadian case illustrates this chain directly. A man in British Columbia with limited English proficiency had his leg amputated following a misdiagnosis that was attributed to language barriers between him and his care team (Bowen, 2015). While the full clinical record is not publicly detailed, the reported sequence follows the same pathway traced throughout this article: a communication barrier prevented an accurate exchange of symptoms, the resulting

misread symptom led to a diagnostic error, and the diagnostic error produced severe, irreversible harm. A second Canadian case reported in the same review found that language barriers contributed to the death of a pregnant Vietnamese woman (Bowen, 2015). Both cases are de-identified in the source literature and are cited here as documented instances of mismedicine rather than as fully detailed clinical narratives; they nonetheless demonstrate that the pathway described in this article is not merely theoretical but has produced real, serious harm in Canadian care settings.

## Prevention and Solutions

Addressing this requires clinical, educational, and systemic action aimed at breaking the chain from communication barrier to harm at its earliest point. Trained interpreters must be present at triage, not only during formal consultations, and Canada should extend a more consistent, enforced right to interpretation beyond the protections currently established for Deaf patients (de Moissac & Bowen, 2019; Eldridge v. British Columbia, 1997). Medical education must include cross-cultural non-verbal communication training, equipping clinicians to recognize that stoicism reflects cultural norms rather than low symptom severity. Culturally validated tools, like the Punjabi-adapted KOOS, show existing clinical instruments can be adapted for Canada's linguistic diversity (Suryaprakash et al., 2025). Organizations must treat language-discordant encounters as higher-risk, given evidence that these breakdowns are increasing, not resolving (Candello, 2025). MARI contributes by investigating these communicative dimensions of mismedicine and building the evidence base for accountability (Blissy, 2024).

## Conclusion

Misinterpretation of verbal symptoms and non-verbal cues in multilingual clinical encounters is a pervasive, underrecognized form of mismedicine. The pathway is consistent across the evidence reviewed here: a communication barrier leads to a misread symptom, the misread symptom leads to a diagnostic error, and the diagnostic error leads to patient harm. Language does not merely carry information-it shapes how illness is felt and understood, and when clinicians lack the tools to receive it accurately, diagnosis is compromised at its first step. Dr. Pooya Beigi's concept of mismedicine names this failure systemically, moving accountability toward the institutional structures that allow these gaps to persist rather than resting solely on individual clinicians (Blissy, 2024). A valuable future direction would be a prospective Canadian study comparing diagnostic accuracy in language-discordant versus language-concordant encounters, examining whether cross-cultural non-verbal training reduces error rates.

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Provided and edited by the members of MARI Research, Error in Medicine Foundation, and MISMEDICINE Research Institute, including Loveleen Singh, Gia D'Andrea, Bukky Alausa, Rojina Nariman and Dr. Pooya Beigi, MD. MSc