

Lost in translation: Caring for limited English proficiency patients



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CASE SCENARIO

A 40-year-old Spanish-speaking woman with limited English proficiency presents to Dr Expert's busy academic clinic for a whole-body rash. She is accompanied by her 14-year-old son who is fluent in English. The son begins the encounter, assuring the physician that he always translates for his mother. The patient does not seem to object, and Dr Expert is running an hour behind schedule.

Dr Expert should:

- A. Ask the patient to wait until a trained, certified interpreter is reached.
- B. Use a bilingual staff member fluent in Spanish to interpret.
- C. Use the patient's 14-year-old son as an interpreter.
- D. Proceed without any level of interpreting.

DISCUSSION

Approximately 25.1 million people, or 8.5% of the US population, are considered limited English proficient (LEP). LEP is defined as anyone with limited ability to read, write, speak, or understand English.^{1,2} Previous studies have demonstrated that LEP patients have worse quality of and access to medical care, have increased medical errors, are more likely to miss appointments and present to emergency departments, and have increased drug complications and adverse events.^{3,4} LEP patients are also limited in their ability to give informed consent.⁵ They might also feel pressured to submit to physician preference or not fully comprehend the risks and benefits of the proposed procedure and treatments. Building therapeutic alliances, explaining diagnoses, and discussing treatment options and regimens are all critical aspects of patient care affected by language barriers.

Using trained medical interpreters has been shown to improve LEP patient satisfaction and outcomes, decrease communication errors, decrease hospital stays and 30-day readmission rates, and lower malpractice risk. Furthermore, trained medical interpreters can act as cultural liaisons to clarify meaning beyond language and assist patients in navigating the complicated health care system.²

Title IV of the Civil Rights Act of 1963 requires interpreter services for all patients with LEP who are receiving federal financial assistance, with the exception of Medicare part B.² More recently, Section 92.201, Chapter 45 in the Code of Federal Regulation requires that in nonemergency situations, providers offer specifically qualified interpreters to individuals with LEP when reasonably necessary for providing care and prohibits the use of adult companions of the patient to interpret unless the patient specifically

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requests them.⁶ The rule also explicitly prohibits the use of child interpreters in nonemergencies. Currently, the Department of Health and Human Services establishes competency requirements for qualified interpreters. Qualified interpreters are defined as interpreters who adhere to generally recognized interpreter ethical principles; have demonstrated written and spoken proficiency in specified languages; and have the ability to effectively, accurately, impartially, and confidentially translate using necessary terminology.⁷ Formal certification programs such as The National Board of Certification for Medical Interpreters or the Certification Commission for Healthcare Interpreters can be used to satisfy these competency requirements.

Larger hospital systems commonly provide professional interpreter support staff, although less than a quarter of them mandate staff training on their use.⁸ A study on small group practitioners found that physicians are well informed on the need for interpreters but are reluctant to work with them or LEP patients, citing time and financial constraints, despite not understanding actual financial costs.⁹ Though in-person interpretation can be cost prohibitive, especially for small practices, commercially available language phone line and video interpreter services might be an acceptable alternative. These services, such as LanguageLine or CyraCom Language Solutions, start at roughly \$2-\$4/minute and can be used with or without a contract and purchased in fixed price-blocks of \$30 to encompass a 30-minute encounter. Ideally, the costs of such services would be reimbursed by payers so as to make LEP patients as close to revenue neutral as possible, particularly in light of evidence that the use of interpreters can decrease overall health care utilization and malpractice costs.^{10,11} Unfortunately, Medicare, Medicaid, and most private insurers do not pay for these interpreter services.¹² California is the only state that

requires interpreter coverage from private insurers.¹³

Interpreter pooling or sharing is another cost-effective model for practices. A successful example is the Health Care Interpreter Network, a hospital-based network that shares interpreters in a remotely accessible pool to cut costs by minimizing downtime and overhead. One study analyzing the network's model found videoconferencing and language line services cost members \$2.35/minute.¹⁴ Another cost-effective alternative is to encourage existing bilingual office staff to undergo additional training to meet the qualified interpreter standard. Available research shows that 1 in 5 untrained bilingual staff, including physicians, currently used for ad hoc language support are unable to pass an exam developed to assess medical competence in that language, further highlighting the need for additional language training.¹⁵ Studies have shown that bilingual physicians generally have a good understanding of their own language limitations. Feedback from Spanish-speaking patients regarding a physician's language abilities highly correlates with the physician's own self-assessment when the latter rate themselves as having better than fair fluency.¹⁶ Kaiser Permanente has developed a commercially available program specifically to assess linguistic and cultural competence of physicians in multiple languages and cultures.^{17,18}

While trained interpreters should be offered to LEP patients from an ethical and legal standpoint, we must recognize and respect that there will remain patients who prefer to use adult family members or friends as ad hoc interpreters. Patients from more collectivist cultures may prioritize the decision-making of the family unit over their own individual goals and desires. In these situations, the patient's wishes should be respected and a waiver for trained interpreter services should be signed to legally protect the practitioners.

ANALYSIS OF CASE SCENARIO

Choice A is the preferred answer. Dr Expert should direct his staff to secure a trained, certified interpreter while he sees other patients to minimize disruption to the schedule. A note should be made in the chart that prompts coordination of interpreter services for this patient before any future appointments.

Choice B is only acceptable if the staff is formally certified as a qualified interpreter via the programs mentioned above. Ad hoc interpreters have been shown to increase medical

errors, often through improper translation, cultural discrepancies, and the lack of medical terminology and confidentiality training.^{8,11} The use of ad hoc interpreters should be avoided unless the patient specifically requests them. A waiver should be signed in such situations.

Choice C is only acceptable in emergencies according to Section 92.201, Chapter 45 in the Code of Federal Regulations as discussed above. Using the patient's son, a minor, in this situation is not only illegal but also violates nonmaleficence. Children have been found to

be poor ad hoc interpreters, as they might not fully comprehend the scope of adult issues and situations. They are also more likely to make errors, editorialize, or omit relevant information

and can lead to the patient avoiding discussing sensitive issues relevant to care, such as sexual practices.^{8,11}

Choice D is both illegal and unethical.

BOTTOM LINE

There is strong evidence that LEP patients without language support have worse clinical outcomes. Physicians with bilingual skills are generally able to assess the suitability of their own language capabilities, but any doubt should be addressed with a formalized assessment tool or the use of an interpreter. Professional interpreters are superior to ad hoc interpreters, but there are some scenarios in which it is acceptable to use ad hoc interpreters. Minors should never be used as interpreters except in emergency situations in which a trained interpreter is not available. Despite the added financial barrier and time constraints, dermatologists without competent bilingual skills are legally and ethically obligated to use trained interpreters when caring for LEP patients in their clinics.

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