Chapter 26
Providing Care to Patients Who Speak Limited English

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Objectives

- Describe the limited-English–speaking population in the United States.
- Highlight the clinical consequences of language barriers.
- Review policies pertaining to linguistic access in health care.
- Describe institutional responses to overcome language barriers.
- Summarize strategies to address language barriers in clinical practice.

We clinicians are better educated and more scientific than ever before, but we have a great failing: we sometimes do not communicate effectively with our patients or with their families.¹

The current health care system offers some of the most technologically advanced medicine in the world. At the same time, millions of Americans have limited access to the most basic feature of good medical care: adequate communication.² Effective patient–provider communication is essential to providing good medical care. Taking an accurate history is fundamental to being a diagnostician; the history is the key to the final diagnosis in 56% to 82% of cases.³ The quality of communication also affects patient and physician satisfaction, patient adherence, and clinical outcomes.⁴ Unfortunately, many people in the United States are unable to reap the benefits of effective communication because they cannot speak English well.

The ability to navigate the US health care system depends in large part on the capacity to speak and understand English. Language barriers can hinder care from simple communications such as calling for an appointment, to emergent situations such as explaining symptoms to an ambulance paramedic, to more nuanced exchanges such as discussing treatment risks and benefits with a doctor. The consequences can be dire.

This chapter is designed to help readers understand the impact of language barriers on both patients and clinicians, and provide guidance to overcome them. It begins with an overview of language barriers in health care, including who faces these barriers, how language barriers affect health care, and current policies regarding linguistic access in health care settings. It concludes with practical suggestions clinicians may draw from to better care for limited-English–speaking patients.

LANGUAGE BARRIERS IN HEALTH CARE

Mikhail Tupikov immigrated to the United States 5 years ago. Despite working long days, he takes English as a second language (ESL) classes in the evenings and on weekends. He is able to say and understand basic things in English, but this becomes more difficult when he is under stress. When he presents to the emergency department with an episode of recurrent nephrolithiasis, he does not know enough English to share his past medical history, alert the nurse of his codeine allergy, or describe his symptoms in detail to his doctor.
LIMITED ENGLISH PROFICIENCY

Limited English proficiency (LEP) refers to patients such as Mr. Tupikov who cannot speak, read, write, or understand the English language at a level that permits them to interact effectively with health care providers. Since 1980, the US Census has used a set of standardized questions to ask about language ability. Anyone who reports speaking English less than “very well” (that is, “well,” “not well,” or “not at all”) is considered to be LEP.1

In clinical settings, LEP status is most reliably ascertained by asking patients whether they need an interpreter, or asking what language they prefer for their health care encounter. As in the case of Mikhail Tupikov, basic command of English that may suffice at the grocery store or post office may be inadequate to communicate in health care settings.2 Given that communication is bidirectional, another important gauge of a patient’s LEP status is whether or not the clinician feels confident of the quality of communication.

THE LIMITED ENGLISH–SPEAKING POPULATION IN THE UNITED STATES: LARGE, DIVERSE, AND GROWING

According to the US Census, the number of Americans aged 5 years or older who spoke a language other than English at home grew from 23.1 million in 1980 to 47 million in 2000. The percentage who were considered LEP experienced similar growth, increasing from 4.8% in 1980 to 8.1% in 2000.3

More than 380 different languages are spoken across the United States.4 Although Spanish accounts for nearly 60% of people who speak a language other than English at home, because of changes in immigration patterns, other languages are increasingly likely to be encountered (Fig. 26-1). Between 1990 and 2000, Chinese jumped from the fifth most commonly spoken non-English language to second. The number of Russian speakers nearly tripled in the same decade, while the number of French/Haitian Creole speakers more than doubled.5

Among these various language groups, the proportion of people who are LEP varies considerably. For example, about 50% of Asian and Pacific Island language and Spanish speakers are LEP, whereas only about one third of Indo-European language speakers are LEP. The greatest concentrations of LEP residents are in the western states, particularly California, where according to the 2000 census, one in every five people is considered LEP. Other states with high percentages of LEP residents include Texas (13.9%), New York (13%), Hawaii (12.7%), New Mexico (11.9%), Arizona (11.4%), Nevada (11.2%), New Jersey (11.1%), and Florida (10.3%).5 However, the greatest increase in LEP populations has been in southeastern and western states such as Georgia, North Carolina, and Nevada, all of which experienced a >200% growth between 1990 and 2000.6 Given the relative lack of established language access services in these “emerging” LEP communities, clinicians working in these high-growth states may face particular challenges in caring for their LEP patients.

LEP individuals are more likely than English-speaking members of the same ethnic group to be older, less educated, low income, and to have been in the United States for a shorter period of time.7 Given these demographic patterns, clinicians caring for LEP

patients often encounter concurrent challenges of poverty, uninsurance, and low functional health literacy and cross-cultural communication. However, although these issues are often intermeshed, they are also distinct, and require sensitivity to the individual patient’s background. For example, a patient may speak little English, but be highly educated, literate in her or his native language, and accustomed to and accepting of western biomedical concepts.

LANGUAGE BARRIERS HAVE CLINICAL CONSEQUENCES

Ha Lang, an elderly Cantonese-speaking woman, is hospitalized because she took too much warfarin. Late at night, she gets up to go to the bathroom. A nurse on duty stops her and tries to get her back into bed. When Mrs. Lang persists in wanting to go to the bathroom, the nurse thinks she is agitated. Instead of calling for an interpreter, the nurse has Mrs. Lang put in arm restraints and gives her a sedative.

Impact on Access to Care

In studies with a wide range of LEP health consumers, language barriers are often reported as being one of the most important, if not the most important, barriers to accessing care. When compared with English speakers, limited English–speaking patients are less likely to be insured or know about public health insurance programs, and their children are less likely to have a usual source of care. Limited English–speaking patients are also less likely to receive physician visits, dental care, eye examinations, mental health visits, or referrals from the emergency department after discharge.

Impact on Provider–Patient Relationship

Even when limited English–speaking patients are able to access care, they have been found to be less likely to understand what transpires in the clinical encounter, from basic medical terminology to discharge diagnoses, to prescribed medications. They are less likely than patients who do not have language barriers to engage in active exchanges with their providers or feel as if they played an active part in decision making. Perhaps as a result, they are less likely to be satisfied with their medical encounters, their individual providers, and the institutions that provide care.

Impact on Quality of Care

In nearly every clinical setting that has been examined, language barriers appear to result in lower-quality care. Limited-English–speaking patients are less likely to receive recommended preventive care such as mammograms, pap smears, colon cancer screenings, and influenza vaccinations. In psychiatric settings, LEP status has been shown to result in inadequate evaluation and diagnosis. In palliative care settings, LEP patients are less likely to have adequate symptom control; and in obstetrical settings, they are at higher risk of experiencing a nonsterile delivery. Once LEP patients present to the emergency department, they receive more diagnostic tests, and tend to have a longer length of stay than English-speaking patients with similar conditions.

PATIENTS HAVE A LEGAL RIGHT TO LANGUAGE ACCESS IN HEALTH CARE

There are a number of federal and state laws that give limited English–speaking patients a legal right to language assistance services in health care settings. On the federal level, Title VI of the 1964 Civil Rights Act has been interpreted by the US Department of Health and Human Services (HHS) to mean that any health care organization that receives federal money—for example, Medicare or Medicaid payments—is obligated to ensure linguistic access for its LEP patients. More recently, HHS’ Office for Civil Rights has issued guidelines for health care providers to follow in determining what type and extent of language assistance services to offer. The Centers for Medicare and Medicaid Services (CMS) also has issued regulations that require Medicaid health plans to make interpreter services available to their enrollees free of charge.

On the state level, 40 states have laws that require or encourage health care providers to address language barriers, often for a specific setting or medical condition. California alone has 63 different laws supporting linguistically appropriate care, covering settings as diverse as acute care hospitals, adult day care centers, mental health rehabilitation centers, and correctional facilities. In the private sector, organizations such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which accredits hospitals, and the National Consortium on Quality Assurance (NCQA), which accredits health plans, have developed and are refining standards for language access.

Despite legal mandates, limited-English–speaking patients continue to face barriers when they attempt to access health services. In part this results from incomplete coverage and inconsistent enforcement of federal and state laws, limited availability of trained health care interpreters, and lack of adequate financing for language access services. In the face of these challenges, it is critical that health care providers understand how they can optimize their communication with LEP patients.
Common Pitfalls in Health Care for Limited English-Speaking Patients

- Language is one of the most significant barriers to health care for immigrants in the United States.
- Limited English-speaking patients understand less of what occurs during health care visits than English speakers.
- Limited English-speaking patients receive lower quality of care than those who speak English very well.
- Using interpreters has been shown to improve understanding and quality of health care.
- Despite growing numbers of limited English-speaking patients and legal mandates requiring provision of interpreter services, these services are often lacking or inadequate.

BRIDGING THE LANGUAGE BARRIER

Michelle Nguyen was admitted from the emergency department for management of preterm labor. She was crying and distraught. Because she only spoke Vietnamese, her husband interpreted for her, reporting that she was frightened as this was her first pregnancy. A few weeks later, she was seen for follow-up care by a nurse practitioner; this time, Mrs. Nguyen’s 12-year-old daughter, in tears, was able to convey that the reason her mother had come to the emergency department was that her husband had assaulted her, causing the preterm labor.

In a survey of over 4000 uninsured patients in 16 cities, more than 50% of those who needed an interpreter reported that the hospital was not able to provide one in a timely fashion. A second survey of 70 hospitals from 11 regions across the country found that 56% of the time, no Spanish speaker could be found to respond to a volunteer tester’s call. These findings are not surprising given that another study of public and private teaching hospitals found that only 25% employed any full-time, professional interpreters. The majority used bilingual hospital staff, volunteers, and family members and friends; several reported that in emergencies, staff often called local ethnic restaurants to find someone to interpret. As Mrs. Nguyen’s case demonstrates, using untrained (also referred to as “ad hoc”) interpreters can be problematic.

WHO IS THE MEDICAL INTERPRETER?

The distinction between ad hoc untrained interpreters and trained medical interpreters is critical. Ad hoc interpreters have been shown to make frequent errors, including omissions, paraphrasing, use of incorrect words, substitutions, additions, and inappropriately providing their own personal views. Family members and friends are particularly unsuitable when domestic violence or a potentially embarrassing symptom needs to be evaluated. Minor children should never be used as medical interpreters, because it often places them in uncomfortable and frightening positions.

In contrast, trained medical interpreters are expected to have fluency in both English and a second language, have a command of medical terminology, understand basic medical concepts, have the necessary skills to manage a three-way conversation, be committed to interpreting accurately and completely without adding their own opinion, and abide by a code of ethics that respects patient confidentiality. Frequently they are trained in how to deal with difficult situations, such as cases of domestic violence, as well.

Each type of medical interpreter should be carefully weighed before deciding how best to proceed (Table 26-1). The following sections provide guidance on when and how to use bilingual skills, professional medical interpreters, and ad hoc interpreters. Clinicians also should check their organization’s policy about the use of interpreters. Some organizations require the exclusive use of staff interpreters, and prohibit the use of ad hoc interpreters.

USING YOUR OWN BILINGUAL SKILLS

Ismelda Garcia speaks a little English, and her doctor knows a few words in Spanish. She leaves her doctor’s office with a new prescription for “pression alta” (high blood pressure), which she was instructed to “take once cada dia” (each day). When she ends up in the emergency room a day later feeling lightheaded, the emergency department nurse brings in the hospital’s Spanish interpreter to take a history. It turns out that the word written as “once” in English means “11” in Spanish.

Not surprisingly, when they can, LEP patients choose clinicians who can speak their language. Language concordance between physicians and patients has been shown to increase patient satisfaction and recall, self-reported health status, ratings of care, and medication adherence. Given these benefits, a variety of programs have been developed to teach medical students and residents medical Spanish, ranging from 20 hours of basic language instruction to intensive, longitudinal immersion experiences. Patients appreciate their clinicians’ efforts to
learn their language, and respond with increased levels of trust. At the same time, it is important for clinicians to have an accurate sense of their own language proficiency, and be aware of their own limitations. As in the preceding vignette, false fluency can be confusing or lead to significant miscommunication with clinical consequences.

Clinicians can gauge whether they need an interpreter by considering: (a) how they learned the language and in what context, (b) how often they need to search for alternate ways to express themselves or ask patients to repeat themselves, and (c) the content and emotional tenor of the clinical exchange (See Box 26-1). An additional consideration, particularly for clinicians who grew up speaking another language at home, is familiarity with medical terminology, such as appendix, thyroid, or computed tomography scan?

The level of proficiency required may vary depending on the content and emotional tenor of the clinical exchange. A clinician with moderate language skills may be able to successfully diagnose and treat an otherwise healthy 27-year-old with a sprained ankle, but may need to call on a trained medical interpreter to evaluate an episode of syncope in a 78-year-old with multiple medical conditions. If you are uncertain, ask for an interpreter.

**Table 26-1. Types of Medical Interpreters**

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<thead>
<tr>
<th>Interpreter Type</th>
<th>Advantages</th>
<th>Disadvantages</th>
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| No interpreter (e.g., bilingual clinician) | • Direct communication between patient and clinician is quicker and allows for better rapport  
• No concerns about confidentiality, as third party is not involved in the encounter  
• Patients appreciate their clinicians’ attempts to converse in their language | • There are a limited number of truly bilingual clinicians  
• Risk for miscommunication and misdiagnosis if clinicians overestimate their language skills |
| Bilingual staff (e.g., secretary, medical assistant, custodial staff) | • Convenient  
• No additional salary costs  
• Patients are often comfortable with health care staff | • Disrupted patient flow and inefficiencies, as staff cannot interpret and perform other duties simultaneously  
• Risk for inaccurate interpretation if staff do not have sufficient bilingual skills or know medical terminology |
| Professional interpreter (trained and tested) | • Less likely to make interpreting errors  
• Trained in ethics  
• Patients may be more likely to share sensitive information with a professional | • May require wait, particularly if there is institutional imbalance of supply and demand  
• Salary costs of hiring professional interpreters  
• Patients may not be comfortable with having a stranger involved in their communication |
| Ad hoc interpreter (e.g., patient’s family member or friend) | • Convenient  
• Free for provider and institution  
• Patients may prefer to communicate through friends or family members | • Usually have inadequate bilingual language and interpreting skills  
• High rates of errors and omissions  
• Communication may be modified to suit the interpreter’s agenda  
• Loss of confidentiality  
• Use of minor children is unethical |

**WORKING WITH PROFESSIONAL MEDICAL INTERPRETERS**

A day in the life of an interpreter: “Before going into the room, the physician expresses to me his concern about whether the health problems claimed by this woman are real or imagined. She has been in the clinic three times before, each time with different vague and diffuse complaints, none of which makes medical sense. As we learn, the poor woman has a fistula in her rectum. In her previous visits, she could not bring herself to reveal her symptoms in the presence of . . . her son as he interprets for her. She tells me that she has been so embarrassed about her condition that she has invented other symptoms to justify her visits to the physicians. She confesses that she has been eager to have a hospital staff interpreter from the first visit, but her hope had not materialized until now.”

Professional medical interpreters are beneficial in a number of clinical arenas. They make fewer errors of clinical consequence, improve the patient-centeredness of encounters, reduce disparities in the use of preventive health services, decrease the use and costs of emergency department testing, and are associated with higher-quality care, as well as enhanced physician and patient satisfaction with the encounter.
Part 3 / Populations

A clinician can work with an interpreter who is either physically in the same room (a face-to-face or in-person interpreter) or is located outside the examination room (most commonly, a telephone interpreter). Although working with an in-person professional interpreter is preferred by both clinicians and patients, many institutions may only have easy access to professional telephone interpreters. There are important considerations in deciding whether using a telephone interpreter will be sufficient for your needs (see Table 26-2). Similar skills are used in working with both types of trained interpreters (see Core Competency).

A caveat: the field of medical interpreting is relatively new in the United States. Although a number of medical interpreter associations have recently developed or are in the process of developing professional standards and codes of ethics, with the exception of Washington state there is currently no formal certification process for health care interpreters. As a result, some professional interpreters may have received little or no formal training and assessment in medical interpreting, and should be treated more like ad hoc interpreters, as described in the following.

WORKING WITH AD HOC INTERPRETERS

Sometimes a trained interpreter may not be available. Although the level of communication may be limited by the ad hoc interpreter’s skills, observing certain guidelines (see Core Competency) can improve the quality of the interpretation. It is important to consider the importance, sensitivity, and urgency of communication when determining what kind of interpreter you use. If it is an emergency situation and there are no trained in-person interpreters immediately available, you should use a telephone or ad hoc interpreter rather than waiting for an in-person interpreter. With a sensitive subject, such as exposure to sexually transmitted diseases, using a trained interpreter rather than a family member or friend is more likely to elicit the critical information you need. Except in life-threatening situations, young children should never be used as interpreters.

Table 26-2. Choosing an In-person or Telephonic Interpreter

<table>
<thead>
<tr>
<th>In-person</th>
<th>Telephonic</th>
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<tbody>
<tr>
<td>When delivering bad news.</td>
<td>When in person not available.</td>
</tr>
<tr>
<td>With patients with significant hearing loss.</td>
<td>With relatively straightforward encounters.</td>
</tr>
<tr>
<td>With patients from cultures unaccustomed to using telephone.</td>
<td>When access to an interpreter is required immediately.</td>
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<tr>
<td>For conversations with more than one person; e.g., family conference.</td>
<td>When privacy and confidentiality is critical, particularly in small communities.</td>
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<tr>
<td>For psychiatric encounters psychosis is present or communication affects critical.</td>
<td>When health of patient where mandates minimal exposure, e.g., immunocompromised patients.</td>
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</table>

*In small communities interpreters and patients often know each other. Using an interpreter from a telephonic interpreter service almost always guarantees patient privacy.

Adapted from: Roat C. Addressing language access issues in your practice: A toolkit for physicians and their staff members. San Francisco: California Academy of Family Physicians, 2005.

Box 26-1. Assessing Your Bilingual Skills

For clinicians who use their own bilingual language skills in the patient encounter, doing a self-assessment is critical.

Is the clinician able to do the following?

- Formulate questions easily and effectively, without frequently being stuck on vocabulary.
- Ask questions in a different way if not understood.
- Understand the response, including regional variations, nuance, and connotation.
- Explain relevant health care concepts.
- Negotiate and agree on a course of action.
- Inspire trust by communicating competence.

Adapted from: Roat C. Addressing language access issues in your practice: A toolkit for physicians and their staff members. San Francisco: California Academy of Family Physicians, 2005.

KEY CONCEPTS

- Adequate interpretation is essential to the delivery of care to patients with limited English abilities.
- Learning to work with different types of interpreters is an essential clinical skill.
- Bilingual clinicians should learn to evaluate their language abilities and the clinical situation before forgoing the use of a trained interpreter.
- Use of professional interpreters improves quality of care.
- Except in life-threatening emergencies, young children should never be used as interpreters.
CONCLUSION

The recent increase in ethnic, cultural, and linguistic diversity in the United States has been accompanied by a great need for language access services in health care settings. A growing body of research shows that language barriers result in decreased patient access, satisfaction, comprehension, and adherence, as well as an increased risk of errors, inappropriate utilization, and higher costs. Access to competent interpreter services can address these risks. Unfortunately, many health care organizations have not yet developed the internal capacity or infrastructure to provide coordinated, consistent language access for their patients. Clinicians must learn how to care for LEP patients within these limitations by recognizing the boundaries of one’s personal language skills and learning how to work with both trained and untrained interpreters.

CORE COMPETENCY

Working with Trained and Ad Hoc Interpreters

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<tr>
<th>Setting</th>
<th>Ad hoc interpreter</th>
<th>Trained interpreter</th>
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| Before beginning the clinical encounter | 1. Assess the ad hoc interpreter’s English skills and familiarity with medical concepts.  
2. Be attuned to the interpreter’s limitations in the non-English language, particularly with younger people whose primary language is English.  
3. Explain to the untrained interpreter that she or he will be your ears and your voice.  
4. Ask him or her to interpret accurately and completely, avoid paraphrasing or answering for the patient, and let you know if she or he needs you to slow down, explain, or repeat something.  
5. If the interpreter is a family member or friend, it can be helpful to let him or her know that you welcome the interpreter’s opinion, but he or she needs to differentiate between his or her personal opinion and the patient’s.  
6. Give the untrained interpreter permission to stop and let you know if she or he is having difficulty interpreting something you or the patient is saying. Otherwise, out of fear or embarrassment, she or he may gloss over difficulties and contribute to miscommunication. | 1. Briefly explain the purpose of the encounter to the interpreter. For example, “Mr. Ukomadu is here for routine follow-up of hypertension and diabetes,” or “Mrs. Saleb is here to discuss her biopsy results; she has cancer.”  
2. Remember the interpreter is not a clinician. It is not appropriate for the clinician to hand the interpreter an informed consent form for the patient to sign, then leave the room. The patient may have questions that the interpreter cannot answer.  
3. Consider the appropriateness of the interpreter. There may be historical animosities between ethnic groups that may make an interpreter unacceptable to a given patient, or regional dialects that make communication difficult. Particularly for sensitive issues, patients may feel strongly about having an interpreter of the same gender. |
| During the clinical encounter | 1. Speak slowly and clearly, pausing between each sentence.  
2. Use simply constructed sentences and plain English; avoid medical terminology and professional jargon (e.g., “workup”).  
3. Speak to and look at the patient.  
4. Be attuned to interpersonal dynamics between the patient and interpreter, particularly if the interpreter is a family member or friend.  
5. Check in frequently with the patient using the “teach back” method. For example, after conveying a new diagnosis of diabetes, ask the patient to explain what she or he understands.  
6. If the interpreter and patient get into an exchange that is not being interpreted, gently remind the interpreter that you need to know everything that is being said. Similarly, if the interpreter answers for the patient, remind the interpreter that you need her/him to interpret, even if s/he knows the answer to the question. | 1. Look at and talk to your patient, not the interpreter or telephone. For example, ask Mr. Rodriguez, “How are you doing?” rather than asking the interpreter, “How is he doing?”  
2. Ask one question at a time.  
3. Speak at an even pace, in relatively short segments. Pause regularly to allow the interpreter time to interpret.  
4. Avoid interrupting the interpretation. Many concepts have no linguistic or cultural equivalent in the patient’s language, so the interpreter may need extra time to explain.  
5. Pay attention to nonverbal cues that may indicate a need for further clarification or discussion. |
DISCUSSION QUESTIONS

1. How does communication, or miscommunication, affect quality of care? (Try to elicit and synthesize both research evidence and personal experiences.)
2. Do you speak a language other than English? If yes, what do you think about your ability to adequately communicate with patients in that language after reading this chapter?
3. Have you ever used an ad hoc interpreter? What did it feel like? What could you have done to improve the patient encounter?
4. Does your institution provide professional interpreters (in-person or by telephone)? If yes, how are interactions with professional interpreters different from those with ad hoc interpreters?

RESOURCES


REFERENCES


