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COMMENTARY

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Meeting the needs of the patient with non-English language preference in the hospital setting

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1 | INTRODUCTION

Language barriers, cultural differences, and low health literacy are the triple threat to healthcare communication.[1] In the United States, over 67 million individuals speak a language other than English at home, and over 25 million individuals speak English less than very well.[2] Language-concordant care in which the clinician and patient speak the same language is not always possible as patient diversity frequently is not mirrored by the clinician workforce. Patients who identify as having a non-English language preference (NELP) then are entitled to a qualified professional interpreter during healthcare encounters. Because Spanish is the second most common language in the United States,[3] Spanish interpretation is available in many healthcare institutions, but interpreter availability for other languages often varies based on the local population needs.

High-quality care for hospitalized patients with NELP depends on the availability and engagement of professional healthcare interpreters. Access to professional healthcare interpreters improves outcomes for patients with NELP,[4,5] supports equitable care for historically under-resourced populations, and reduces healthcare costs through increased preventive care, adherence to care plans, and reduced readmissions.[6,7] This commentary provides the legal underpinnings for professional healthcare interpreter use, the ethical rationale for professional healthcare interpreters as part of the care team, and the standards for professional healthcare interpreters. Next, we identify pragmatic realities in the hospital setting that challenge healthcare teams and systems to meet the legal and ethical standards for interpreter use. Finally, we describe an approach to address interpreter access, call out the educational needs of care team members, and identify research opportunities for language services in the hospital setting to advance toward health equity.

2 | PATIENT RIGHT TO LANGUAGE SERVICES: LEGAL UNDERPINNINGS

Patients with NELP, and in the case of pediatric patients, parents or guardians with NELP, are entitled to a qualified professional interpreter during healthcare interactions. The Civil Rights Act of 1964, specifically Title VI, provides the legal underpinnings for the provision of language services for patients with NELP in environments that receive federal funding.[8] The Department of Health and Human Services outlines the National Standards for Culturally and Linguistically Appropriate Services, or the CLAS Standards, which are intended to progress toward health equity and eliminate disparities by respecting the right to timely, quality care, regardless of preferred language.[9,10] These standards include offering language assistance at no cost, informing individuals of language assistance availability, and ensuring the competence of individuals providing oral interpretation or written translation. Interpretation may occur in person, by video, or by phone. In-person interpretation is preferred for moderate and high-acuity scenarios, which commonly occur in the hospital setting, while video and telephone interpretation serve as alternatives for low-acuity scenarios and situations when in-person interpretation is not available.

3 | PATIENT RIGHT TO LANGUAGE SERVICES: ETHICAL PRINCIPLES

In addition to the legal rationale for language-concordant care or engagement of interpreter services for patients with NELP, the ethical principles of justice, beneficence, non-maleficence, and autonomy inform the role of the professional healthcare interpreter in the care of patients with NELP in the United States. Use of a qualified healthcare interpreter promotes justice in information shared and protected.

Inequities in pain management,[11] adverse events,[12] hospitalization duration,[13,14] and return visits to the emergency department[15] have affected patients with NELP. With respect to beneficence, professional healthcare interpreter use is associated with improved clinical outcomes, discharge education processes, patient comprehension, and patient satisfaction for those with NELP.[4,5,16] The principle of non-maleficence, or do no harm, is also relevant to language-concordant care and interpreter-facilitated care. Medical errors are more common when no interpreter is used for patients with NELP as well as when ad hoc interpreters lacking formal healthcare interpretation training are used compared to when professional healthcare interpreters are engaged in the care of patients with NELP.[17] Reducing medical errors through the use of professional healthcare interpreters exemplifies non-maleficence. Finally, autonomy in decision-making and the informed consent process must be respected regardless of preferred language. Autonomy in decision-making hinges on effective bidirectional communication, which is more likely with professional healthcare interpreter use for patients with NELP. Autonomy also underscores the need to respect the patient's use or nonuse of a professional healthcare interpreter. Many individuals who identify a preferred language other than English also speak English. It is critical that assumptions are not made surrounding proficiency that disrespect the patient's autonomy.

4 | PATIENT RIGHT TO LANGUAGE SERVICES: ROLE OF THE PROFESSIONAL HEALTHCARE INTERPRETER

High-quality care and communication for the patient with NELP depend on professional healthcare interpreter availability and use in the hospital setting. Yet it is common for bilingual family members or healthcare team members who are not trained in healthcare interpretation to interpret during clinical encounters.[18,19] Patients and care team members may not recognize how care and communication break down with ad hoc interpretation by untrained individuals. The educational background and standards of professional healthcare interpreters inform how their skillset differs from a bilingual family member or care team member. The educational standards for healthcare interpreters include a high school degree, fluency in two or more languages, and completion of a minimum 40-hour healthcare interpreter training course.[20] In some states, certification is required through the Certification Commission for Healthcare Interpreters or the National Board of Certification for Medical Interpreters.[21] Many interpreters exceed these standards, hold advanced degrees, and are certified to the highest level for the language(s) they interpret. Practice standards and the code of ethics for professional healthcare interpreters highlight accuracy, confidentiality, impartiality, and respect for persons as central to quality interpretation.[22,23]

Along with providing interpretation, a healthcare interpreter may serve as a cultural broker, a patient advocate, as well as a clarifying agent or health literacy guardian.[24,25] Safety risks for patients with NELP include underreporting of adverse events[26] and a lower likelihood of patients or families asking questions, particularly if perceived as challenging healthcare professionals.[27] These inequities have the potential to be reduced with the routine use of professional healthcare interpreters whose profession informs their role as cultural brokers and patient advocates. Recognizing the interpreter as a core healthcare team member for patients with NELP respects their role and responsibility to facilitate high-quality care for patients with NELP.[28]

5 | SYSTEM-BASED BARRIERS TO LANGUAGE SERVICES ACCESS

Despite the legal and ethical obligations for clinical care facilitated by professional healthcare interpreters, a key barrier for hospital care teams and health systems remains adequate access to interpreters. Even major medical centers are not spared the access challenge.[28] Data from the American Hospital Association database and the Census Bureau's American Community Survey for 2009–2013 revealed that approximately one-fourth of hospitals with moderate or high language services needs did not offer language services, and approximately one-third of hospitals with low language services needs (i.e., <5% of the population identified as NELP) did not offer language services.[29] While we speculate that progress has been made since these analyses were conducted, a gap remains. More recently, in the National Standards for Cultural and Linguistically Appropriate Services Physician Survey, only 30% of outpatient physician respondents reported regularly using a professional interpreter for patients with NELP, while 40% reported never using a professional interpreter.[30] In many care models, time constraints may disincentivize team members from using a professional healthcare interpreter even when one is available.[31] There also may be questions surrounding how to access an interpreter in real time. Failure to address barriers to professional healthcare interpreter use can be a costly oversight in the form of medical malpractice.[32]

Access issues are magnified when the patient's preferred language is a language of lesser diffusion. Languages of lesser diffusion are contextually determined by location, making efforts to quantify the number of individuals whose preferred language is a language of lesser diffusion challenging. For example, with over 80,000 Minnesota residents identifying as Somali, Somali–English interpretation is available in many urban healthcare settings in Minnesota, whereas Somali may be a language of lesser diffusion in communities with a smaller Somali population.[33] Indigenous languages are frequently classified as languages of lesser diffusion, particularly if spoken by small communities who are marginalized politically, socially, or economically. Professional interpretation may not be a readily available resource for populations who speak languages of lesser diffusion. For some languages, there a handful of professional healthcare interpreters serving hospitals and healthcare systems across the country remotely by video or phone. This does not reliably meet the needs of the patient or the care team; an interpreter may not be available in real time, and prescheduling an interpreter is not feasible in medical emergencies.

Meeting the needs of individuals who identify a language of lesser diffusion as their preferred language magnifies the challenge healthcare teams and systems face to provide appropriate language services.[34]

6 | PATIENT-RELATED BARRIERS TO LANGUAGE SERVICES ACCESS

In addition to addressing the issue of access to professional healthcare interpreters, healthcare team members and administrators need to be aware of additional patient-related barriers to interpreter use. When interpreters are available, patients with NELP may decline to use an interpreter for many reasons. There may be perceived stigma associated with being flagged for an interpreter. Patients may have concerns about potential decreased frequency of communication with the care team if flagged for needing an interpreter.[35,36] They also may worry unnecessarily about incurring costs related to interpreter use. Finally, there may be a perceived threat to confidentiality in a community in which the patient or family knows the interpreter outside of the healthcare setting.[37]

7 | CALL TO ACTION: EMPLOYEE INVESTMENT, EDUCATION, AND RESEARCH FOR LANGUAGE SERVICES

Hospitals and healthcare systems can facilitate language-concordant care by investing in their employees, which include community members from diverse backgrounds who are fluent in more than one language, and some of whom identify as having a NELP. Pathways for professional advancement for bilingual and multilingual healthcare team members who can provide language-concordant care directly or who may train to serve as interpreters are an often overlooked potential human resource. For example, a housekeeping team member who speaks English and Pohnpeian, a language of lesser diffusion, could receive training and become a professional healthcare interpreter for patients who identify Pohnpeian as their preferred language.

When language-concordant care is not possible, healthcare systems must recognize that engaging professional healthcare interpreters may incur upfront costs associated with longer consultations and perceived lower physician productivity. Clinicians and healthcare systems should not be penalized financially for meeting a need protected by the Civil Rights Act. Funding is needed to ensure that clinicians and healthcare systems are compensated for serving patients with NELP in such a manner that recognizes the impact on productivity. Provision of high-quality, safe care facilitated by professional healthcare interpreters for patients with NELP is cost-effective care.[38–40]

The responsibility to ensure that current healthcare team members are equipped to care for all patients, regardless of language preference, falls not only on clinicians but also on licensing boards and healthcare systems. Language services departments and external language services vendors may be resources for educational opportunities and content expertise to meet the needs of the existing healthcare workforce. While interpersonal and communication skills are integrated throughout undergraduate and graduate medical education, there may not be specific guidance on the appropriate use of interpreters and how to approach language-discordant care.[41] Health professional schools are responsible for educating future care team members to care for patients with NELP. Learners need to be exposed to best practices for interpreter use. Education on interpreter use in healthcare often occurs passively by modeling, which may not align with best practices.

Finally, research is needed to understand how the interpreter modality (in-person, video, or phone) impacts the patient experience and clinical outcomes. With a shortage of professional healthcare interpreters, technology is filling the gap with audio and video virtual remote interpretation.[42,43] Infrastructure costs for efficient, secure virtual interpretation systems highlight the need for data on the patient experience and outcomes with virtual interpretation. Artificial intelligence likely will further revolutionize virtual interpretation, and this needs to be studied prior to implementation in clinical practice.

8 | CONCLUSION

As the US population becomes more linguistically diverse, healthcare teams increasingly care for patients whose preferred language is not English. Legal obligations based on Title VI of the Civil Rights Act as well as the ethical principles of justice, beneficence, non-maleficence, and autonomy should incentivize healthcare systems to provide high-quality language services for patients with NELP. Therefore, insufficient access to professional healthcare interpretation must be addressed. There is an opportunity to invest in healthcare team members who can provide language-concordant care directly or who may expand the pool of professional interpreters. Additionally, educational curricula on interpreter-facilitated communication for patients with NELP should be a focus for future and current clinicians. Lastly, research has the potential to characterize how virtual interpretation affects the patient experience and outcomes for those with NELP.

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