Foundations of Emergency Medicine
Foundations III: Guided Small Group Experience

Session 30: "Caring for Limited English Proficiency Patients"
Unit: Special Populations

- **Agenda and Learning Objectives**
  - Case Part I – Appropriate Use of Language Assistance (20 min)
    - Identify the difference between interpretation and translation and understand the different types of interpreters
    - Understand the legal basis supporting the right to language assistance
    - Identify best practices for successful interpreter-mediated patient interactions.
  - Case Part II – "Medical Spanish" (20 min)
    - Understand the limits of provider use of non-English language skills in the clinical setting
    - Discuss the limitations of using bilingual staff in a clinical setting
    - Identify an approach for written discharge instructions for patients with Limited English Proficiency
  - Case Concludes (10 min)
    - Review Session Teaching Points

- **Case Begins –** Appropriate Use of Language Assistance (20 min)

  - *M.G. is a 25 year old Spanish-speaking male presenting to the Emergency Department with chest pain. As you enter the room and greet him, a young woman sitting in the room says "He only speaks Spanish. I can translate." On further questioning he describes the pain as pressure-like and is associated with palpitations. He feels short of breath during the interview. Several times when you ask a question, a lengthy discussion ensues between the patient and the family member. After they seem to resolve the question between themselves, the woman turns to you and replies only, "No". When you ask if he'd like pain medication, the woman answers "Yes" without interpreting the question.*

- **Discussion Questions with Teaching Points**
  - **What is the difference between interpretation and translation? Describe the different types of interpreters.**
    - Interpretation is assistance with spoken language, whereas translation is assistance with written language
    - There are different types of interpreters
      - An "ad hoc" interpreter refers to using anyone around that speaks the language (as in the case above) → the use of ad hoc interpreters (like family members and friends of the patients) is discouraged unless it is a true emergency (i.e. no

official interpreter in the area, no interpretation services accessible via video/phone and the situation is life or death for the patient)
    - Children under 18 years old should never be used to interpret → the use of minors as interpreters is expressly forbidden by legislation and most institutional policies
    - The case above illustrates some of the many reasons why ad hoc interpreters should not be used
- A certified healthcare interpreter is someone who has specific skills and training to interpret in the healthcare setting → this includes special instruction in the ethics and standards of the practice of interpreting
- Remote interpretation refers to interpretation provided over the phone or via video connection
- In simultaneous interpretation the speaker speaks continuously as the interpreter conveys the message in the target language at about 2-3 words behind the speaker → there are no pauses
- Consecutive interpretation occurs when the speaker stops at the end of each complete thought to allow the interpreter to render what was said in the target language → the interpreter receives the response and interprets it to originator of conversation

- **What is the legal requirement that medical providers must meet for Limited English Proficiency (LEP) patients?**
    - Title VI of the 1964 Civil Rights Act states that, "No person shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program of activity receiving federal assistance."
    - The Supreme Court has interpreted discrimination based on language as equivalent to discrimination based on national origin
    - LEP patients are entitled to language assistance when utilizing any programs or services that receive federal funding → the vast majority of hospitals fall under this category
    - Section 1557 of the The Patient Protection and Affordable Care Act requires the provision of a qualified interpreter, clarifies permissibility of ad hoc interpreters, and mandates quality in tele-interpreting and requires notice of language service availability in the 15 most common languages spoken in the state
    - Further, some states have additional legislation
        - For instance, in California Senate Bill 223 delineates the requirement for all CA health plans to offer language assistance
    - Most hospitals and health systems have their own local policies on language assistance to guide providers in understanding how the requirements for language assistance can be fulfilled in that particular setting → it is important for you to be familiar with the local policies for each institution where you work clinically

- Many patients are unaware that interpreter services are free of charge in hospitals → in addition to this being posted clearly in the ED, it may be helpful to mention this to the patient if they seem hesitant when an interpreter is offered
- LEP patients may also shy away from asking for interpreter because they do not want to be a "bother" to the physicians

- **What can we do to optimize interpreter-mediated patient interactions?**
  - An interpreter should be used during all parts of the ED visit, from initial evaluation to disposition, when explaining diagnosis and providing discharge and medication instructions
  - If using an in-person interpreter, if possible, meet the interpreter outside the room before the interaction and explain expectations and give a summary of the case
    - Obviously, if you are about to deliver bad news like a new cancer diagnosis, giving the interpreter advanced warning about what to expect will help the interpreter to support you better
  - Always speak to and make eye contact with the patient, not the interpreter
  - When using consecutive interpretation (most cases), be conscious to stop at appropriate intervals to allow the interpreter to render the interpretation
  - Certified healthcare interpreters can also be very helpful as cultural brokers → if something about the conversation is not making sense or if it still seems there is a communication barrier despite the presence of an interpreter, consider asking the interpreter whether there may be a cultural issue that you are not understanding, especially in psychiatric cases
  - The patient's request for an interpreter should be respected even if the provider thinks that the patient's English is sufficient → from the patient's perspective, expressing oneself in a foreign language in a stressful situation like an Emergency Department visit can be very difficult and it is important for providers to recognize this
  - It is a good idea to offer interpreter services to all patients who do not speak English as a primary language
    - Many LEP patients may not know that medical interpretation is legally required and may not feel comfortable making this request to authority figures within the medical system

- **Why is the use of interpreters important?**
  - In addition to the legal aspects mentioned above, the use of professional interpreters improves outcomes for LEP patients
    - Use of interpreters is associated with higher adherence to discharge instructions and fewer hospital revisits, and improved patient safety measures
    - Certified Healthcare interpreters improve patient satisfaction and understanding and safety measures also improve with the use of certified healthcare interpreters

- Certified healthcare interpreters are as valuable as any diagnostic studies or consultations you obtain

- The use of professional interpreters is critical for patient confidentiality and autonomy
  - In the case above, the relationship of the woman at the bedside to the patient is unclear
  - The patient may or may not be comfortable revealing certain aspects of his history to the provider with her present
  - Consider the case of a patient who is the victim of human trafficking → if the trafficker volunteers to act as the ad hoc interpreter and the provider allows this to happen, the trafficker is in complete control of the exchange and the patient loses the opportunity to reveal the situation (see Session 19: Sex Based Crimes)
  - It must be recognized that ad hoc interpreters, by having a relationship with the patient, are limited in their ability to provide objective interpretation

❖ **Case Continues –** "Medical Spanish" (20 min)

- *The initial provider orders labs and a chest x-ray and then signs the patient out to the resident on the on-coming night shift pending results. The night-shift resident goes to re-assess the patient and realizes that the patient speaks Spanish. The night shift resident took medical Spanish classes in medical school and uses his Spanish to communicate. He tells the patient that the x-ray and bloodwork were negative and that he will be discharged. The resident returns to the workroom, completes the discharge paperwork and writes the order for discharge. The nurse then discharges the patient. Four hours later the patient checks back into the ED stating that he cannot breathe and has a heart rate of 130 and a respiratory rate of 30 on triage vital signs. The night resident wonders what could have happened to cause MG to deteriorate and return so quickly after discharge.*

❖ **Discussion Questions with Teaching Points**

- **When is it appropriate to use your own non-English language skills with patients?**
  - There is good evidence that participants in short-term training programs in foreign languages such as "medical Spanish" classes do not achieve levels of proficiency adequate to achieve clear bi-directional communication with patients → this, in turn, diminishes the quality of care provided
  - Further, the implementation of medical Spanish training programs has the potential negative effect of making providers overly-confident in their language skills and decreasing rates of professional interpreter use
  - In many health systems, a formal language examination is offered through which a provider can become "certified" as bilingual, meaning that they have demonstrated adequate skills to communicate with patients → residents and attendings alike should investigate pathways toward certification if their language skills are sufficient

- Certified bilingual providers should still access professional interpreters for important conversations such as all procedural consent, family conferences, hospice and end of life discussions
- Even heritage speakers of a language may not have sufficient skills to be a bilingual healthcare provider without further training → despite growing up speaking a language at home with family, heritage speakers may not have sufficient medical and technical vocabulary to achieve unhindered communication

- **What additional factors may have contributed to miscommunication in this case?**
  - Limited health literacy levels often compound communication difficulties with LEP patients
  - Carefully selected wording is important when providing information to patients that are LEP and/or limited health literacy
    - Ie telling a patient that test results are "negative" is frequently understood by the patient as something bad, i.e. that there is something wrong with them
    - "Doctor speak" is confusing enough, but doctor speak interpreted directly into another language is a set up for miscommunication
  - When communicating with LEP patients, providers should remember that education levels vary widely throughout the world and the patient may have limited health literacy as well as little or no formal education in some cases
  - Access to healthcare is equally variable → the patient may be completely unfamiliar with healthcare in the U.S. or healthcare systems in general
  - Many patients will not tell providers when they do not understand what is being said → the physician, especially, may be seen as an authority figure and the patient may think it disrespectful to ask for repetition of information
  - In the same vein, patients may not state outright if they disagree with or cannot adhere to the treatment plan as outlined by the provider and the provider must take time to ensure that understanding is achieved → this is true of all patients, but particularly applicable to those with LEP and limited health literacy
  - One method to confirm understanding is to ask the patient to use a "teach back" asking the patient to explain the important points back to the provider

- **How can the written discharge process be improved for LEP patients?**
  - This is dependent on resources available at your institution
  - Many electronic medical records have pre-written patient education on common discharge diagnoses available in other languages → these can be very helpful and only require that the provider remember to choose the appropriate language
  - In some instances, it is important to give written instructions specific to the patient's case, such as "Go to the ophthalmology clinic on Thursday at 8am." → for LEP patients, it may pose a challenge to write "free text" instructions like this in their language
  - Automated internet-based translation, such as from "Google Translate" are error-prone and not sufficient to ensure that the message will be conveyed correctly

- The best option for written communication is to have a translator from your hospital's language department translate the instructions and any hands outs used in your practice → in most hospitals, this is not available
- Secondary options include asking the interpreter to assist you in writing the instructions in the target language, or writing the instructions in English and having them verbally given to the patient by the interpreter
- If you do obtain written instructions in the target language, they should also be in the record in English so that other providers reading the chart are able to understand what the patient was told
- Finally, remember also to choose the correct language for the prescription if that is an option in your institution.

- **What are some of the risks to the patient when formal language assistance is not utilized?**
  - As in this case, LEP patients are more likely to have unplanned revisits to the Emergency Department when compared to their English-speaking counterparts
  - Further, when communication is compromised, patients are less likely to adhere to treatments prescribed and to obtain needed follow up care
  - Risks to the provider and institution when formal language assistance is not utilized include increased risk of misdiagnosis and poor outcomes and the legal risks of being found in violation of Title VI or the PPACA in addition to citation by the Joint Commission

❖ **Case Concludes (10 min)**

- *Seeing the vital signs, the attending and resident head straight to MG's room to find out what happened in the four hours since his discharge. They find MG distraught, crying and yelling in Spanish. The attending asks the family member to step out to the waiting room and calls an interpreter. The patient states that he didn't understand what happened on his first visit, but knows there must be something wrong with him because he was told to call his doctor in the morning for an appointment. He doesn't have a doctor and can't read the English language instructions he was given at discharge. The attending repeats the history and physical from the beginning with the assistance of the interpreter. The patient reveals that his chest pain and palpitations occur every time he has intrusive thoughts about witnessing his brother's murder at the hands of a gang in El Salvador two months ago. The attending delves further into his symptoms and finds out that he startles easily, is very irritable and cannot sleep at night. MG meets the diagnostic criteria for PTSD, is referred to appropriate resources for psychologic support, and given Spanish language education materials to learn about PTSD.*

- **Case Teaching Points Summary**
  - **Appropriate Use of Language Assistance**
    - Interpretation is assistance with verbal communication whereas translation is assistance with written communication
    - The term "ad hoc interpreter" refers to anyone available that identify themselves as a person that may speak the target language such as family or friends of the patient
    - Ad hoc interpreters should not be used except in specific emergency circumstances as they have no training in interpretation and have high rates of error → their use raises ethical concerns which can be avoided by using a trained interpreter
    - A patient's right to language assistance is based in federal and state law
    - The patient's request for an interpreter always trumps the provider's estimation of the patient's English language ability
    - When using an interpreter, be sure to speak to the patient, not to the interpreter
    - Interpreters can also function as cultural brokers in cases when a cultural barrier may be hindering communication
    - Patient outcomes improve with the use of formal language assistance

  - **Medical Spanish**
    - Short term training programs in foreign languages such as "medical Spanish" can negatively impact patient-provider communication via overconfidence in limited language ability
    - Providers must be aware of local hospital policy regarding the use of non-English languages for patient care and obtain certification via available pathways before using their non-English language skills
    - Written discharge instructions must be either in the correct and proper language or verbally interpreted
    - Many LEP patients are also impacted by limited health literacy → care should be taken to choose simple wording and provide extra time for explanations and to verify understanding
    - Choose pre-printed education sheets and prescription options in the patient's native language when available
    - Attempting to "get by" without using formal language assistance puts the patient at risk of worse outcomes and the provider and institution at legal risk of not meeting federal and state requirements for the appropriate use of language assistance

❖ **Facilitator Background Information**

Over 60 million people speak a language other than English at home, 42% of which report that they speak English less than very well. Communicating with LEP patients is important to healthcare providers across the United States. Throughout the medical literature, it is clearly demonstrated that underuse of language services is pervasive. Skipping the interpreter is viewed as a time-saver by clinicians but results in worse outcomes for patients. Legislation mandates the use of formal language assistance for LEP patients, however, many clinicians remain unaware of these laws. Given the large and increasing numbers of LEP patients and the persistent health disparities they experience, including care of LEP patients in training curricula is an important step toward advancing health equity in the United States. Connecting bedside decision making to the larger issue of health disparities and spelling out the legal ramifications both have the potential to improve rates of appropriate use of language assistance.

Many policies and procedures related to accessing language services, availability of interpreters and written translation and processes for becoming certified as a bilingual provider are specific to the hospital and health system. It is important for the faculty facilitator to be familiar with the local landscape regarding language services before this session. An easy way to do this is to call your hospital interpreter or language service office and ask them for clarification and a copy of your institution's policies prior to the teaching session.

Even if no policy is in place at your institution regarding the use of Non-English language skills, care should be taken in discussing this topic with trainees. Evaluating one's own language fluency can be subjective. One tool that is available for self-assessment of language fluency of clinicians is the Interagency Language Roundtable (ILR) Scale of the federal government. (Below is a summary, see http://www.govtilr.org/Publications/speakingsa.html for the full scale.)

0. No Communicative Ability - isolated words and phrases
1. Can ask and answer uncomplicated questions but may need repetition to understand
2. Can give straight forward instructions but may use awkward or inadequate phrasing
3. Communicates in most social and professional situations but has difficulty with abstract topics
4. Near fluent, sensitive to cultural references but may have difficulty with unusual dialects or slang
5. Communicates like a native

If the trainee self-reports a level 4 or 5 it would be appropriate to refer them to your hospital's formal bilingual certification process. Those reporting 2 and 3 are potentially the most dangerous because they have some conversational capacity but are at high risk for misunderstanding and should use an interpreter.

Finally, use of this module for teaching purposes can also be helpful to obtain feedback from residents as to how processes can be improved. Ideally, language assistance is readily available and easy to access with minimal barriers to use. We know, however, that this is not always the case. Feedback from this

discussion can be brought to ED or hospital administrators to help streamline processes, making it easier for residents and students to access language assistance when appropriate.

- **References**
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  - **References:**

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Please direct any feedback on this case to the Foundations III Course Directors Natasha Wheaton (wheaton.natasha@gmail.com), George Leach (gleach@emory.edu) or via the Foundations of Emergency Medicine website.