QUICK LESSON

Legal Issues...Communication Barriers: Language

Issue Description

All services, especially professional services, depend on the ability to communicate, whether orally or in writing. Healthcare services are no exception. Efficient and safe healthcare depends heavily on the ability of the provider to communicate orally with the patient. Patient satisfaction increases as the quality of communication with nurses improves.(1) Lack of English speaking skills in a patient generally results in inferior care.(2) However, a lower socioeconomic status may also contribute to inferior care. It has been established that a lack of English skills reduces access to care regardless of socioeconomic status. Much information about health care services and disease symptoms is in English thus limiting its availability to non-English speakers.(3) Most of the research in this area focuses on Spanish-speaking people.(4) This is apparently due to the large and rapidly growing number of Spanish-speakingimmigrants from Mexico and Central and South America in the US.(5) It has been suggested that research also suffers when it involves Spanish speakers.(6) In the year 2000, 47 million US residents did not speak English at home. A little less than half of those had limited English capability. There is reason to believe that these numbers have grown since 2000.(7) These immigrants use less screening, preventive, and primary health care services than English speakers.(8) Other countries with many immigrants experience similar problems with access to health care, for example, Sweden,(9) Canada, Australia, and the UK.(10) In the UK communication barriers exist between nurses and South Asian patients leading to dissatisfaction of both patients and nurses. Some South Asian patients felt “alone in a crowd” while the nurses expressed disquiet at not being able to get to know their patients.(11) This occurred despite government and National Health Service policy that staff be properly trained in overcoming communication barriers with minority patients.(12)

An ambulatory care clinic in California established that it was cheaper to hire two professional interpreters than to use existing staff members as interpreters. Also, one must take into account the adverse effects of making do without a professional interpreter. Contrary to one’s expectations, research has shown that no extra time is taken in attending to non-English-speaking patients either with or without an interpreter. However, this does not seem to apply to the emergency department where stays are significantly longer and charges for diagnostic tests are higher. In regard to the higher test costs, it was suggested that physicians ordered more tests to compensate for not being able to take an adequate history.(13)

Many Latino cancer patients suffer pain rather than seek treatment for it. This is due to a lack of cultural competency and Spanish language skills in many healthcare providers, even those in areas of heavy Latino population such as Southern California.(14)

Where there is no common language between healthcare provider and patient, the problem can be especially acute and is usually solved by the use of interpreters. However, skillful interpreting is a difficult art and depends on knowledge of the different cultures involved as well as an expert knowledge of both languages and the idioms employed. Interpreters of this quality can be difficult to find especially when required at short notice as often happens in the healthcare field. Added to this mix is a requirement that the interpreter needs

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a basic knowledge of medical terms in English and an ability to convey their meaning in the patient's language.[15] A solution commonly used is telephone interpreter services where the caregiver calls a number and has a three-way conversation with patient and interpreter. One of these services, Language Line Services, employs over 6,000 interpreters used by hospitals, banks, police departments and others. Charge is by the minute. Other services are ProTranslating, a Florida company[16]and AT&T which seems to be commonly used. Interpreters should be certified by the National Board of Certification for Medical Interpreters.[59]

In Australia a translation service free to physicians charging Medicare-rebatableservices (Doctors Priority Line) was used for only 1% of their LEP patients.[17] The common practice of using a family member, a friend or even a young child, to interpret, is unsatisfactory and may lead to legal liability.[18] Some nurses in the UK were reluctant to ask non-English speaking patients if they wanted an interpreter because they feared this would detract from their relationship with the patients.[19] For the same reason one nurse was reluctant to arrange a regular day when an interpreter would be present.[20]

There are disadvantages to using interpreters. The consultation takes longer (although this is disputed – see above), doctor-patient rapport is affected and the doctor's words may be mistranslated. For these reasons it is preferable for the clinician to be able to speak the patient's language fluently.[21] Some pharmacists in Australia rarely used interpreters to explain medications to patients, presumably due to a fear that their words would be misinterpreted.[22] Having a bilingual doctor reduced the likelihood that a patient would misunderstand the prescription label.[23] A study in Australia of interpreters for non-English speaking oncology patients found that about one-thirdof interpretations were nonequivalent, although some nonequivalent interpretations had no negative consequences.[24] This article will be based on the assumption that healthcare providers use English as their first language and cannot communicate effectively in the language of the patient.

US federal law set forth in Title VI of the Civil Rights Act of 1964 prohibits anyone, on the basis of race, color or national origin, from being deprived of the benefits of any program or activity that receives federal financial assistance. This Act has been construed as requiring healthcare providers to employ interpreters in connection with federally assisted health services.[25] The federal Department of Health and Human Services Office for Civil Rights published a memorandum in 2000 clarifying its requirements for interpretative services. This memorandum was replaced on August 4, 2003 by a new policy guidance document.[26] This document explained the government's rules applicable to federally funded health programs for avoiding discrimination against patients with limited English skills. An analysis of this policy document appears below.

Cultural competency (see *Definitions*, below) is a required skill when treating patients who do not speak English. It is also required when a foreign born patient is able to communicate fluently in English but still retains her foreign culture to a greater or lesser extent.[27] In Australia, health professionals found difficulty in developing a rapport with foreigners who communicated in ways that were strange to caregivers, for example, patients were too direct and abrupt and were unfamiliar with customary meeting routines. These caregivers used stereotypes to justify their criticism. Miscommunication also occurred because a literal translation of what the patient said sounds strange in English: "a chill entered my body"; "I have bad blood". Obviously a high degree of cultural competency is required to translate these words into English that the caregiver can relate to.[28]

"Culturally deaf" adults communicate primarily in sign language and view themselves as members of a unique culture in society. Communication with culturally deaf adults is a serious problem for caregivers, especially when patients suffer from depression and caregivers cannot see the signs of depression they would normally detect in a hearing patient.[29]

Definitions

- **Limited English Proficient** (LEP) individuals do not speak English as their primary language and have a limited ability to read, write, speak, or understand English.[30]
- ***Interpreter*:** A person skilled both in the language of the caregiver (e.g., English) and the patient (e.g., Spanish) who interprets conversations (oral communications) between them. Note that a *translator* only renders written documents from one language to another and does not interpret oral communications.[31] A person skilled in two languages may act at various times both as an interpreter and a translator. In the writer's view interpreting is by far the more difficult art mainly because of the immediacy required in interpreting, whereas translators can take time in rendering documents from one language to another.

› ***Cultural competency*:** A caregiver's willingness and ability to recognize and learn cultural differences between him/herself and the patient and to accommodate those differences when interacting with, and caring for, the patient.[32] Impatience is the enemy of cultural competency.

Risks

The risks of using untrained and uncertified interpreters include the following.[33]

› Omission: The interpreter omits all or part of what the caregiver says
› Addition: Includes information not stated by the caregiver
› Condensation: Editing, simplifying, and summarizing what the caregiver says instead of merely translating her words into the patient's language
› Role exchange: The interpreter takes over the conversation, ignores the caregiver, and conducts her own interview while pretending to interpret the caregiver's words. This is the ultimate nightmare for a caregiver who usually does not know what is happening
› Confidential medical information may land in the wrong hands in violation of HIPAA

The adverse results of these interpretation errors can include inaccurate diagnosis, delayed or incorrect treatment, and lack of informed consent. Using the patient's child as an interpreter is illegal and can cause unnecessary distress and a distortion of the parent-child relationship in addition to violating confidentiality.

The journal, *ED Nursing*,[34] advises that risks of mistranslation are ever-present for emergency department nurses who usually have to act quickly when patients arrive. Signs in all applicable languages should already be posted indicating that interpretation services are available at no cost. The nurse must find an interpreter for non-English speaking patients to avoid a lack of informed consent if invasive procedures, such as a central line, are performed. Avoid using family members for this purpose. LEP patients must be informed in their home language of their privacy rights under federal law, and this should be documented. Nurses should ensure that LEP patients signing discharge instructions understand them fully.

Units Potentially Involved

A primary care setting such as a small private practice will not provide a limited English speaker with optimal health care due to inability to afford interpreters. Where professional interpreters were used in a primary care setting in French-speaking Montreal, Canada, it was found that patients were more likely to convey psychological and emotional issues than if family members were used as interpreters.[35] In a large organization such as the British National Health Service, primary care settings experienced their own problems. Caregivers did not understand that they should use basic communication skills to develop the ability to communicate. Ethnic stereotyping was a problem as where a doctor ascribed a delay in diagnosing myocardial infarction in a female patient to her lack of English skills.[36] Acute care settings such as hospital emergency departments tend not to use interpretative services, including those required to do so because they receive public funding.[37] Medication errors during transfer of care were partly caused by poor communication.[38] Encouraging LEP adults to bring their own medications to the emergency room assisted in documenting medical histories.[39] In certain fields, such as pediatrics, where oral communication may assume a secondary role, nurses and doctors have developed various techniques to overcome the communication problem. Hispanic postpartum LEP women suffer health service disparities and resultant higher rates of urinary tract infections, inferior family planning advice and unintended pregnancy, and less assistance for depression and domestic violence.[40] In occupational therapy settings verbal evaluation of LEP patients for purposes of rehabilitation treatment took longer and was less effective.[41]

In the pediatric intensive care unit communication barriers are a serious safety issue – adults serve as the communication medium with caregivers and sometimes caregivers communicate poorly. Improving communication skills requires effort by caregivers.[42] In the pediatric emergency department having LEP parents resulted in longer stays for the children.[43] In a Canadian teaching hospital the traumatic experiences of Non-English speaking mothers of very low birth weight infants admitted to the neonatal ICU were exacerbated by their inability to communicate with caregivers. One mother thought that her baby was dying because she could not understand the medical terminology her doctor used. When a nurse arrived that could speak her language, she realized that her baby only had a minor infection.[44]

In the home: In Australia about 140,000 people are hospitalized each year due to adverse medicine-related events and some of these mishaps are made by non English speaking older adults. Infants that are discharged from the neonatal intensive care unit

whose parents have LEP are subject to greater risk than those with parents who are proficient English speakers. They are more likely to require follow up emergency care.[45]

Primary care: Foreign family practitioners were recruited to the Wheatbelt area of Western Australia (the area near Perth) due to a serious shortage of doctors in this rural area. The foreign doctors were non-English speaking and had learned to speak formal English fluently albeit with an accent. They struck a serious communication barrier in conversing with rural patients who used what is called "grunt language" –Wheatbelt rural vernacular and jargon spoken quickly.[56] Their patients also had difficulty understanding formal English spoken with an accent. Cultural differences posed an additional problem, especially with female obstetric patients. As a result their patients often had to make repeat visits to clarify what their doctor told them. Suggestions for improvement: 1) More networking with, and supervision by, local Australian doctors; 2) Provide patients with a physical copy of their results or a written explanation to review together; 3) Community involvement, interacting in the local vernacular.[56]

Australian nursing schools:[57] Immigrant nursing students in Australia need assistance with communication in English, not only to learn, but also to enable them to work effectively as nurses after they graduate. Online learning resources were used to prepare these students for their clinical placements so that they could communicate effectively. The same resources were used to enable them also to communicate with patients, families, and staff once they graduated. Most students felt that the tuition helped them to communicate better during placements.

US nursing schools:[58] The Joint Commission requires staff of healthcare facilities in the US to be able to communicate effectively with each other and with patients and their families. This involves not only linguistic abilities but also familiarity with other cultures, known as "cultural competence". For example, a nurse stated that an immigrant patient's accent was so thick that the nurse had to pay careful attention to non-verbal communication. An immigrant nurse observed that medical terms were no problem in class because she could look them up. The problem was others' use of English colloquialisms such as "ruling out" which she could not translate into her native language. Education to acquire a semblance of cultural competency is available at https://www.thinkculturalhealth.hhs.gov/ (accessed Jul. 22, 2016).

Regulations and Court Cases

In *Lau v Nichols*, 414 US 56, decided on January 21, 1974, the US Supreme Court dealt with discrimination against 1,800 non-English-speaking San Francisco school students of Chinese ancestry who were denied English language instruction. They were also denied other adequate instructional procedures and, therefore, could not adequately benefit from the public educational program in San Francisco. The students had filed a lawsuit against the school district which was denied on the basis that the Equal Protection Clause of the Fourteenth Amendment of the US Constitution was not violated and neither was §601 of the Civil Rights Act of 1964. This denial was affirmed on appeal to the Ninth Circuit Court of Appeals. On further appeal, the Supreme Court held that denying English instruction to the San Francisco students was a violation of §601 of the Civil Rights Act. This prohibits discrimination against any person on the basis of their race, color or national origin, even if the discrimination is unintentional. The school district received large amounts of federal financial assistance and, therefore, the Civil Rights Act applied. The Supreme Court gave great deference to the federal Department of Health, Education and Welfare's regulations prohibiting discrimination in federally assisted school systems, holding that the regulations were within the authority granted by the provisions of §601. One guideline, issued in 1968, stated that students of a particular race, color, or national origin are entitled to the education received by other students in the same system. In 1970 the Department went further, saying that federally funded school districts had to rectify the language deficiency in order to open instruction to students who had linguistic deficiencies. The Supreme Court held that it was obvious that the Chinese-speaking minority received fewer benefits than the English-speaking majority from the school system, which denies them a meaningful opportunity to participate in the educational program. This was clearly a situation prohibited by the regulations. The case was remanded down to the trial court to fashion suitable relief for the students. This paved the way for the issuance of analogous regulations governing the treatment of limited English proficient patients in federally assisted clinics and hospitals. Although the subsequent US Supreme Court case of *Alexander v Sandoval*, 532 US 275 (2001) ruled that §601 only covers intentional discrimination and does not give private individuals the right to file a lawsuit, the US Department of Health & Human Services continued with its policy which was not affected.

The US Department of Health & Human Services published a revised policy guidance document on August 4, 2003.[46] This document explained the government's rules applicable to federally funded health programs designed to avoid discrimination against patients with limited English skills. Again, the legal basis for the rules was §601 of the Civil Rights Act of 1964, 42 US Code 2000d, which prohibits discrimination against anyone under any program or activity receiving federal financial assistance and authorizes federal agencies awarding financial assistance to enforce the provisions of the Act. One exception is those

receiving Medicare Part B payments. Recipients of financial assistance must ensure meaningful access to their programs and activities by LEP persons by taking into account the number of LEP eligible persons and how often they come into contact with the program, the importance of the program to peoples' lives, and the resources available to the program and their cost.[47] Small businesses should not have to bear undue burdens. Emphasis should be placed on the languages most spoken by those not proficient in English and not on languages most spoken by those proficient in English. Language services are especially important if an activity is very important to peoples' lives, for example, an emergency department. Programs that have limited finances may train bilingual staff to act as interpreters or use telephone interpretation services. Sometimes patients feel more comfortable if a trusted relative or friend acts as interpreter but should in any event be informed about the availability of another interpreter. Documents such as patient information sheets should be translated from the English. The availability of interpretation services should be made known to patients by posted notices.

In Rhode Island a nurse and physician in the emergency department failed to obtain an interpreter for a LEP uncle and mother accompanying a one-week old infant to the emergency room, resulting in the infant's death.[48] The uncle could only communicate in broken English and gestures. The uncle tapped on the infant's chest and the nurse asked if the baby had stopped breathing. She documented that the uncle did not know. The physician was also unable to secure a medical history and the infant was discharged. When the child stopped breathing and was rushed back to the same hospital, acute tracheobronchitis and bronchiolitis with respiratory syncytial virus was diagnosed. The child was placed on life support in the intensive care unit but died four days later. The court found that discharging the child without treatment caused its death. This was a direct result of a failure to obtain interpretation services. The court awarded the parents $400,000 in damages for wrongful death.

In New Jersey, a man contracted subacute bacterial endocarditis (SBE) six months after having his teeth cleaned at a dental office. He could speak but not read English and was unable to understand the pre-treatment questionnaire that was placed before him. The receptionist filled it out for him except for his name and address and an affirmative response to a question about hypertension. The man alleged that she had not consulted him about the responses to the questions so he had not told her about his heart murmur. Six months after his teeth cleaning he developed SBE and spent a further six months with severe symptoms, including one month in the hospital. After his recovery there were no lasting after-effects. An expert testified that the dental cleaning must have caused the SBE and that the dentist should have taken a full oral history and not just relied on the form. The defense denied that the receptionist would have completed the form and argued that the SBE could have had another cause. The jury found that he had received substandard care which had damaged his health. He was awarded $60,000 which included $16,000 lost wages from his plumber's job and $25,000 in unpaid medical bills.[49]

A medical malpractice case illustrates the need for cultural competency where a husband acted as interpreter for his wife in the 32nd week of pregnancy, and in labor, with her membranes ruptured. Apparently there was miscommunication regarding the wife's symptoms. The reporter of the case comments that the doctor would not have used the husband as an interpreter if he had been aware that in the wife's culture a wife is reticent about bodily functions even with her husband. Therefore, the wife probably did not give full information about her symptoms to the doctor when her husband interpreted for her. A competent female interpreter was needed. The child was born with cerebral palsy. The wife alleged that she should have been told to go to the hospital a day earlier when her husband had called numerous times. However, the doctors denied receiving the calls. The defense contended that the baby would have been born in the previous 24 hours before the wife arrived at the hospital, if the baby had been ready to be born. The cerebral palsy was caused by the baby's prematurity or a Dandy-Walker genetic abnormality. The jury found for the defense.[50]

Recommendations

The American College of Nurse-Midwives issued a position statement in 1992 recommending education for its members to assist them in developing respect for cultural variations. Six years later the American College of Obstetricians and Gynecologists issued a committee opinion statement advocating cultural competency in maternity care for those who do not speak English and recommending the use of trained interpreters.[51] It also recommended that patient education materials and signs be translated and that caregivers should liaise with members of the community to ensure that the care provided is appropriate to their culture. The American Medical Association provided a guideline in 2007 on communicating with LEP patients.[52] The 2003 policy document published by the US Department of Health and Human Services makes many detailed recommendations on providing interpretation services in the health care setting.[53] In 2001 the Office of Minority Health published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care*,which set forth 14 standards ("CLAS Standards") to eliminate health disparities and increase cultural competency.[54] The International Medical

Interpreters Association in 2007, and the Australian Institute of Interpreters and Translators Inc. in 1996, published standards of practice for their members.[55]

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