

Navigating Language Barriers under Difficult Circumstances

Yael Schenker, MD; Bernard Lo, MD; Katharine M. Ettinger, JD; and Alicia Fernandez, MD

The proportion of the U.S. population with limited English proficiency is growing. Physicians often find themselves caring for patients with limited English proficiency in settings with limited language services. There has been little exploration of the decisions physicians face when providing care across language barriers. The authors offer a conceptual framework to aid physicians in thinking through difficult choices about language services and provide responses to common questions encountered in the care of patients with limited English proficiency. Specifically, they describe 4 factors that should inform the decision to call an interpreter (the clinical

situation, degree of language gap, available resources, and patient preference), discuss who may be an appropriate interpreter, and offer strategies for when a professional interpreter is not available. The authors use a hypothetical case to illustrate how decisions about language services may evolve over the course of an interaction. This conceptual and practical approach can help clinicians to improve the quality of care provided to patients with limited English proficiency.

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For author affiliations, see end of text.

Mrs. A., a 60-year-old diabetic woman who speaks Spanish, arrives in the emergency department with a chief symptom of burning with urination. Dr. B. examines her vital signs and finds that Mrs. A. has a fever. Dr. B. speaks very limited Spanish. A hospital interpreter is available, but not for 1 hour. Dr. B. wonders whether he should wait for a professional interpreter or proceed with the care of Mrs. A. using his own limited Spanish-speaking skills.

This scenario is increasingly common. The proportion of the U.S. population with limited English proficiency nearly doubled from 1980 to 2000 and is projected to increase further (1). More than 20 million people in the United States speak little or no English. Federal laws mandate access to language assistance (2, 3), and hospital guidelines recommend routine use of professional interpreters (4–6). Interpreter services, however, are often limited and poorly integrated into clinical practice (6, 7). Clinician second-language skills and responses to language barriers vary widely (8–11). Many physicians feel uncertain about how best to care for patients with limited English proficiency and uneasy about the quality of care they provide (12–16).

Although suggestions have been made about the appropriate use of interpreters (17, 18), there has been little exploration of how to approach decisions about language services, particularly when such services are limited. We analyze common questions and provide a conceptual framework. Specifically, we describe factors that should inform the decision to call an interpreter, discuss who may be an appropriate interpreter, and offer strategies for when a professional interpreter is not available. Although we rec-

ognize that cultural barriers accompany language barriers (19), we focus on language services. We use the hypothetical case of Mrs. A. to illustrate how decisions about language services may evolve over time.

WHAT FACTORS SHOULD INFORM THE DECISION TO CALL AN INTERPRETER?

In this case, Dr. B. must decide whether to wait for a hospital interpreter, seek some other form of language assistance, or proceed using his own limited Spanish-speaking skills. Four factors must be considered when deciding whether to involve an interpreter: the clinical situation, degree of language gap, available resources, and patient preference. We consider each factor separately, then illustrate how they influence each other and may change during a clinical encounter.

Clinical Situation

Physicians commonly decide whether to use an interpreter on the basis of what information they need to make a diagnosis and provide treatment. In emergent clinical situations, physicians must provide care, even if language assistance is unavailable. In complex clinical scenarios, physicians are more likely to request an interpreter than for seemingly straightforward encounters (15). Although this approach is often reasonable, physicians also must understand the patient's perspective to accurately assess the severity and complexity of the clinical situation and address the patient's concerns (20, 21). For example, in our hypothetical case, Mrs. A. may also be experiencing severe abdominal pain and nausea. Without language assistance, Dr. B. might have missed this key information. Alternatively, Mrs. A. might have feared that her urinary symptoms were a sign of a sexually transmitted disease.

Degree of Language Gap

The need for an interpreter is easily recognized if the patient and physician do not share a common language. However, the degree of language gap is more difficult to assess when the patient or physician is partially fluent in the other's language. In such situations, physicians fre-

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quently attempt to get by using limited second-language skills (14, 15). Language skills are often directional, meaning that spoken ability may exceed understanding, or vice versa. For example, Dr. B. may be able to ask simple screening questions (such as “Do you have abdominal pain?”) in Spanish, but not understand complex responses. In addition, vocabulary and fluency may be adequate for certain clinical scenarios but not for others. For example, Dr. B.’s vocabulary may be limited to symptoms commonly encountered in the emergency department, such as abdominal pain. Accurate assessment of one’s own language skills is difficult. At a minimum, physicians providing care in a second language should be able to follow-up on a patient’s responses and assess patient comprehension to avoid underestimating the language gap.

Available Resources

Availability, accessibility, and quality of interpreter services vary widely among institutions (6). Most hospitals have some mechanism to address language barriers for the most common languages, partly in response to laws that forbid discrimination based on primary language (2). However, institutional constraints may affect the type of interpreter available (that is, on-site professional interpreter vs. telephone interpreter vs. bilingual staff member), the wait time for an interpreter, and the quality of the interpreter. In the hypothetical case, Dr. B. has access to an on-site professional interpreter, but the wait time is 1 hour. Decisions to wait for an interpreter must balance the availability of language assistance with the urgency of the clinical situation.

Patient Preference

Physicians frequently make decisions about interpreter use without taking patient preferences into account. Many patients are not aware that they have a legal right to a professional interpreter at no cost (22). It can be challenging to assess patient preference in the setting of language barriers. Even when a physician has some skills in the patient’s language, the power differential between physicians and patients may make it difficult for a patient to express a preference for formal language assistance over a physician’s partial language skills. However, failure to elicit patient preference about use of an interpreter is associated with decreased patient satisfaction and may lead to poor adherence to treatment plans and overuse of medical services (23–26). Patients should be offered a professional interpreter and be informed that interpreters are free and trained in confidentiality.

Pulling the Factors Together

How might Dr. B. take into account all 4 factors when deciding about language assistance for the patient?

In assessing the language gap, Dr. B. discovered that Mrs. A. spoke very little English, but his Spanish was adequate to ask a few key questions and understand Mrs. A.’s “yes” and “no” responses. After the pertinent review of systems yielded negative results, Dr. B. decided that obtaining laboratory data

Key Summary Points

Four factors must be considered when making decisions about language services: the clinical situation, the degree of language gap, available resources, and patient preference.

As the clinical situation evolves, patient preferences and needs may shift, requiring ongoing assessment of the need for professional language assistance.

Patients should be included in the decision about whether to call an interpreter. As a standard approach, patients should be informed that professional interpreters are available free of cost.

Physicians using their own second-language skills must continuously assess for patient understanding.

When an institution’s interpreter services are inadequate, physicians should advocate for improvement.

Minimum communication standards are needed for hospitalized patients with limited English proficiency.

Physicians have a professional responsibility to ensure that patients with limited English proficiency receive similar care to that of patients who speak English.

was the appropriate next step in Mrs. A.’s care. With the help of a nurse who spoke somewhat more Spanish, he explained to Mrs. A., “I’m concerned you may have an infection. The hospital will provide a professional interpreter free of charge, but with a wait of 1 hour. I think it is important to proceed with blood and urine tests in the meantime.” Mrs. A. expressed her understanding and agreement with this plan, a hospital interpreter was called, and a nurse was sent in immediately to draw Mrs. A.’s blood. The patient’s blood and urine test results reveal that she has a high blood glucose level and a kidney infection.

Under these circumstances, the initial decision to proceed without a professional interpreter was appropriate. However, the 4 factors informing the decision to request an interpreter will change over the course of an encounter. Because the data suggest that Mrs. A. has pyelonephritis, Dr. B. must now ensure that he has not missed anything in his initial limited history and examination, gather information about drug allergies and recent antibiotic use, explain the diagnosis and treatment to Mrs. A., and address Mrs. A.’s questions and concerns. In reassessing his own language skills, Dr. B. will probably find that they are no longer adequate. In reassessing Mrs. A.’s preference, he may discover that she would now prefer to speak through a professional interpreter. At this stage, Dr. B. should use the

Table 1. Types of Interpreters*

Type of Interpreter	Advantages	Disadvantages
Physician using his or her own foreign-language skills	Fast and convenient Protects patient confidentiality, as no third party is involved in the interaction Improves rapport and results in more patient-centered interactions	Physicians may not accurately assess their own language skills Risk for miscommunication if language skills are not sufficient May overlook patient preferences about language assistance
Ad hoc interpreter (e.g., adult family member, friend, or another patient)	Convenient Bilingual family members may serve as patient advocates May be congruent with cultural expectations	Inadequate bilingual language and interpreting skills are common and may result in high rates of errors and omissions Communication may be modified to suit the interpreter's agenda May compromise patient privacy and confidentiality Patients may withhold sensitive information Demands of interpreting may conflict with family role
Bilingual staff (e.g., physicians, nurses, medical assistants, clerks, and janitors)	Convenient No added salary costs Staff may be familiar to patients	Language skills are not assessed and may be inadequate Staff cannot perform other duties
Professional interpreter	Less likely to make errors Trained to protect patient privacy and confidentiality Patients may be more likely to share sensitive information	May have to wait for interpreter to be available Telephone interpreter services may be awkward to use Patients may prefer not to involve a stranger in their care May disrupt family relationships

*Adapted from reference 17.

hospital interpreter he requested earlier, assuming that the interpreter is now available.

Mrs. A. is given intravenous fluids and antibiotics, and preparations are made for admission. Mrs. A.'s daughter arrives and offers to serve as an interpreter. The admitting physician, Dr. C., speaks no Spanish. Dr. C. wonders whether she should accept the daughter's offer or call for a professional interpreter.

WHO IS AN APPROPRIATE INTERPRETER, AND WHO DECIDES?

There are several different kinds of interpreters, each with advantages and disadvantages (Table 1). Again, the clinical situation, degree of language gap, available resources, and patient preference must be considered. Professional interpreters are the most skilled in medical interpre-

Table 2. When a Patient's Choice of an Interpreter Is Not Appropriate*

The ad hoc interpreter is not competent in English or the patient's language.
The medical situation is too complex for the ad hoc interpreter to understand or translate.
The patient does not feel comfortable discussing sensitive information with the ad hoc interpreter.
The ad hoc interpreter experiences substantial role conflict (e.g., an adult son interpreting for an end-of-life discussion).
The interpreter is a child.
Use of an ad hoc interpreter places the patient at risk for harm (e.g., the interpreter is suspected of elder abuse or domestic violence).

* Including ad hoc interpreters, such as family members and friends.

tation, the least likely to make errors, and the only type of interpreter associated with overall improvement of care for patients with limited English proficiency (27, 28). However, professional on-site interpreters may not be immediately available, and professional telephone interpreters may feel impersonal or be difficult to use for patients with hearing or speech impairments (29). Although bilingual staff may be convenient and available, their language skills are usually not tested and may be inadequate (30, 31). Having family members serve as interpreters may be congruent with cultural expectations (32). Relatives may also serve as patient advocates and participate in decisions about a patient's care. However, family members often have inadequate language skills, resulting in higher rates of clinically significant errors (28). Family members may also interpret selectively to fit their own beliefs.

Physicians should inform patients with limited English proficiency of the available resources for language assistance and offer a professional interpreter at each major stage of an encounter. Bilingual staff and family members can help convey this information to patients. Physicians should ensure that patients understand the advantages of professional interpreters and not assume that patients prefer to have family members interpret. Once informed, patients may decide what type of interpreter they prefer.

In some clinical situations, however, the patient's choice of an ad hoc interpreter (that is, a family member or acquaintance) may not be appropriate (Table 2). The chosen interpreter might not be competent in either English or the patient's primary language, or the medical situation may be too complex for the interpreter to understand (28).

Alternatively, the patient may not feel comfortable discussing a sensitive topic in the presence of a relative or friend.

For example, Dr. C. may have initially respected Mrs. A.'s preference to have her adult daughter interpret, but then discovered that Mrs. A.'s daughter spoke very little English. It is then Dr. C.'s responsibility to interrupt the interaction, explain why a professional interpreter would be preferable, and offer to request one. She might say to Mrs. A.'s daughter, "I really appreciate your help with interpretation, but I fear I am not doing a good job of understanding your mother. I would like to ask a hospital interpreter to assist us, in *addition* to you, so that I may provide better care for her. Could you please ask your mother if this would be okay?" By recognizing the ad hoc interpreter's efforts and framing the need for a professional interpreter in clinical terms, physicians may continue to respect the patient's preferences while strongly recommending a professional interpreter.

In rare cases, use of an ad hoc interpreter may place the patient at risk for harm, for example, if the ad hoc interpreter is suspected of abusing elderly persons or domestic violence. In such cases, the physician should request a professional interpreter and conduct the interaction without the suspected person present.

The use of young children as interpreters is common but problematic. Asking children to interpret distorts the child–parent relationship and places a substantial emotional strain on the child (33–35). Some states, including Massachusetts and Rhode Island, have passed laws barring minors from serving as interpreters for family members (36). Except in emergency situations, when no alternatives are available, the use of children as interpreters should be avoided.

Mrs. A. is hospitalized. The next morning, the medical team caring for the patient comes to rounds at her bedside at 8 a.m. No one on the team speaks Spanish. No one is available to translate: The Spanish interpreter arrives at 11 a.m., a bilingual nurse went off shift at 7 a.m., and Mrs. A.'s daughter has gone home. The team therefore checks Mrs. A.'s vital signs, does a perfunctory examination, and leaves without speaking to the patient. Mrs. A. cannot tell them that she has developed an itchy rash on her back.

WHAT IS THE APPROPRIATE RESPONSE IF AN INTERPRETER IS NOT AVAILABLE?

Inpatients commonly have severe illnesses or need invasive procedures, and thus must make important treatment decisions. Failure to communicate with a patient throughout hospitalization and at discharge may compromise the patient's care. A daily conversation between an inpatient and the treating physician should be the standard of care. In this case, the language gap is nearly complete and the clinical situation requires language assistance. Yet, Mrs. A. has no opportunity to voice a preference for an

interpreter, and consequently the team cannot address her concerns, explain the treatment plan, or evaluate her rash.

When a professional interpreter is not immediately available, clinicians must investigate all possible options for language assistance (Table 1). Limits on duty hours may make it difficult for resident physicians to wait for a professional interpreter to become available. Creativity and advance planning may be required to obtain language assistance. In this scenario, the team could have arranged for interpreter services in advance, used a remote interpreter over the telephone, enlisted the services of a staff member or ad hoc interpreter (for example, by calling a bilingual family member from Mrs. A.'s bedside phone), or changed the time of rounds to coincide with the hospital interpreter's schedule (while ensuring that Mrs. A. received timely attention). Physicians must be willing to accept some personal inconvenience during such cases in order to act in a patient's best interests.

WHAT CAN BE DONE WHEN INTERPRETER SERVICES ARE INADEQUATE?

Availability of interpreter services is not always adequate. Recent national surveys indicate that between 38% and 68% of hospitals use professional interpreters (6, 37). More than half of hospitals surveyed reported frequent use of untrained bilingual staff and family members or friends as interpreters. Professional interpreter services may be less available at small or rural institutions, at night or on the weekends, and for less common languages.

A systems approach is necessary to improve language services. Hospitals need minimum communication standards for the care of patients with limited English proficiency, accurate collection of language data, and language services integrated into the flow of patient care. To avoid depending on the initiative of individual physicians, the hospital admissions office could identify patients with limited English proficiency and automatically schedule interpreters for a time that is convenient for the daily rounds (12, 38). Insurers should provide financial incentives for hospitals to meet benchmarks for interpreter services.

Until such changes occur, physicians must also advocate for improved language services. The chief of service or quality improvement department should be informed when access to interpreters is consistently unacceptable. Physicians should notify the risk management department when inadequate access to interpreters compromises patient care. If such attempts to improve language services fail, physicians and patients should be aware that the federal Office for Civil Rights is charged with ensuring that access to health services does not reflect discrimination on the basis of language or national origin. Discrimination complaints filed with the Office for Civil Rights have led to systemic changes in language services at medical centers around the United States (2, 39).

CONCLUSION

Physicians are increasingly treating patients across language barriers and in settings with limited availability of language services. Clinicians and patients often find themselves navigating language barriers under difficult circumstances. Although improved quality and availability of interpreter services are needed, clinicians are ultimately responsible for ensuring safe and effective communication with patients. A conceptual and practical approach to navigating language barriers can help to improve the quality of care for patients with limited English proficiency.

From the University of California, San Francisco, and California Pacific Medical Center, San Francisco, California.

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Requests for Single Reprints: Alicia Fernandez, MD, University of California, San Francisco, Box 1364, San Francisco, CA 94143; e-mail, afernandez@medsfgh.ucsf.edu.

Current author addresses are available at www.annals.org.

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Current Author Addresses: Drs. Schenker, Lo, and Fernandez: University of California, San Francisco, Box 1364, San Francisco, CA 94143.
Dr. Ettinger: California Pacific Medical Center, 2395 Sacramento Street, San Francisco, CA 94115.