

INTERPRETER SERVICES FOR PATIENTS WITH LIMITED
ENGLISH PROFICIENCY IN PRIMARY CARE:
A PREREQUISITE FOR PROVIDING
ETHICAL HEALTHCARE

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ABSTRACT

This paper highlights the importance of the provision of interpreter services for patients of limited English proficiency (LEP) in primary care settings in the United States. In the United States today, over 8% of the population is of LEP, and yet no formal funding structure exists to ensure that these patients have access to interpreter services when they see their primary care provider. Research shows that without appropriate interpreter services, LEP patients not only endorse poorer subjective experiences of healthcare, but that these patients also experience objectively worse healthcare, such as less frequent visits to primary care providers, poorer management of chronic illness such as diabetes and hypertension, and higher rates of expensive testing in emergency departments, to list a few examples. This paper was inspired by firsthand experiences of a medical student learner at an urban health center witnessing frequent improper utilization of interpreter services by physicians in primary care settings. The paper traces the federal legal history addressing communication services in healthcare in the United States, reviews papers that juxtapose patient and provider opinions of interpreter services, and concludes with a discussion of potential steps forward for improving interpreter services offered to the large percentage of the US population that is currently receiving subpar care due to unsurmounted barriers to communication.

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CHAPTER 1 INTRODUCTION

This research was inspired by personal observations of providers in primary care and specialty clinics affiliated with an urban academic medical center utilizing interpreter services during interactions with patients of limited English proficiency (LEP). Even in situations where providers have access to robust telephonic and in-person professional interpreter services, physicians often continue to utilize personal limited language skills to quickly get through what they perceive as a routine clinic encounter. As an observer, questions arose as to what influences this decision, how the patient feels about the efforts of the provider to communicate brokenly in her spoken language, and what the legal requirements are regarding interpreter services providers must offer to LEP patients. In this paper, I will discuss the importance of interpreter services in primary care settings, the United States laws that address and enforce the necessity for interpreter services in medical care, and the perspectives and opinions of patients and providers regarding interpreter services in primary care settings. I will conclude by identifying some changes that patients and clinicians are identifying as necessary to better serve the growing LEP population of the United States in primary care settings.

CHAPTER 2 WHY INTERPRETATION MATTERS

The United States is home to citizens from diverse countries of origin that speak a wide array of languages. In 2013, 25.1 million individuals, or 8 percent of the total U.S. population ages 5 and up, were considered to be of LEP.¹ LEP is defined as anyone above the age of 5 who reports speaking English less than “very well” to the U.S. Census Bureau. The LEP population has rapidly grown throughout the 20th and 21st century; between 1990 and 2013, the LEP population expanded from nearly 14 million to 25.1 million individuals (a growth of 80 percent). Of the total immigrant population of 41.3 million in 2013, about half was of LEP.¹ These statistics demonstrate that the LEP population in the United States is rapidly becoming a substantial percentage of the overall population. Such changing demographics will place new demands on healthcare organizations to provide services to meet the needs of the diversifying population.

It is well established that language barriers contribute to health disparities for patients with LEP. Many studies have demonstrated the profound adverse impact of language barriers across many dimensions of access to and quality of care.^{2,3,4,5,6,7,8,9,10,11}

¹Zong, J., Batalova, J. (2015) The Limited English Proficient Population in the United States.

² Stein, J.A, Fox, S.A. Language preference as an indicator of mammography use among Hispanic women. *J Natl Cancer Inst.* 199;80(suppl): 11-19.

³ Weech-Maldonado R, Morales LS, Spritzer K, Elliot, M., Hays R.D. Racial and ethnic differences in parents’ assessments of pediatric care in Medicaid managed care. *Health Serv Res.* 2001;36(3)575-94.

⁴ Carrasquillo, O., Orav, E.J., Brennan, T.A., Burstin, H.R. Impact of language barriers on patient satisfaction in an emergency department. *J Gen Intern Med.* 1999;13(2):82-7.

⁵ Weech-Maldonado, R., Morales, L.S., Elliott, M., Spritzer, K., Marshall, G., Hays, R.D. Race/ethnicity, language, and patients’ assessments of care in Medicaid managed care. *Health Serv Res.* 2003;38(3):789-808.

Overall, LEP patients are more likely than non-LEP counterparts to report being in fair or poor health, to defer necessary medical care, and to leave the hospital against medical advice,¹⁰ presumably due to language barriers to understanding care. These patients have less access to a usual source of health care, lower rates of physician visits and utilization of preventive services, poorer adherence to treatment and follow-up for chronic illness, decreased comprehension of their diagnoses, higher utilization of emergency department services with less follow-up care, decreased satisfaction with care, increased medication complications, and higher rates of costly medical and lab testing due to the inability of the medical provider to obtain an accurate history of present illness.¹¹ Surveys of Latino parents have revealed that language issues are cited as the single greatest barrier to health care access for their children.³ LEP patients who need but do not get an interpreter report the lowest satisfaction with interpersonal aspects of care of any patient group,^{10a} and it is frequently these interpersonal aspects of care that contribute to long-standing and

⁶ John-Baptiste, A., Naglie, G., Tomlinson, G. The effect of English language proficiency on length of stay and in-hospital mortality. *J Gen Intern Med.* 2004;19(3):221-8.

⁷ Perez-Stable, E.J., Napoles-Springer, A., Miramontes, J.M. The effects of ethnicity and language on medical outcomes of patients with hypertension or diabetes. *Med Care.* 1997;35(12):121-19.

⁸ Sarver, J., Baker, D.W. Effects of language barriers on follow-up appointments after an emergency department visit. *J Gen Intern Med.* 2000;15(4):256-64.

⁹ Wilson, E., Chen, A.H., Grumbach, K., Wang, F., Fernandez, A. Effects of limited English proficiency and physician language on health care comprehension. *J Gen Intern Med.* 2005;20(9):800-6.

¹⁰ Ku, L., Flores, G. (2005). Pay Now or Pay Later: Providing Interpreters Services in Health Care. *Health Affairs*, 24(2), 435-444, doi: 10.1377/hlthaff24.2.435.

¹¹ Karliner, L.S., Jacobs, E.A., Hm Chen, A., Mutha, S. (2007). Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature. *HSR: Health Services Research*, 42(2), 727-754, doi:10.1111/j.145-6773.2006.00629.x.

^{10a} Ku et al., 436.

successful therapeutic alliances between patients and their physicians in the management of chronic and debilitating illness.

Conversely, many studies document the positive impact of trained professional interpreters and bilingual providers.^{7,12,13} LEP patients with access to interpreter services attend more outpatient visits, receive and fill more prescriptions, have better control of chronic illness such as diabetes, ask more questions and engage in more dialogue with their providers, report less pain and better physical functioning, and report high satisfaction with care.⁷ Despite the numerous negative factors associated with inadequate language services and the numerous positives associated with provision of trained professional interpreters, as of 2005, only 10 states paid for interpreter services under Medicaid or SCHIP and notably, Medicare did not pay for interpretation services at all.^{10b} These low rates of federal funding for interpreter services conflict with required provisions for language access services outlined in United States law and as will be discussed subsequently, demonstrate the shortcomings of U.S. law in ensuring the provision of language services when the legal language does not explicitly establish funding for interpreter services.

¹² Tocher, T.M., Larson, E. Quality of diabetes care for non-English-speaking patients: a comparative study. *Western Journal of Medicine*. 1998;168(6):504-11.

¹³ Kuo, D., Fagan, M.J., Satisfaction with methods of Spanish interpretation in an ambulatory care clinic. *Journal of General Internal Medicine*. 1999;14(9):547-50.

^{10b} Ku et al., 438.

CHAPTER 3
THE AMERICAN LEGAL BASES FOR LANGUAGE ACCESS SERVICES IN
HEALTHCARE: FROM THE 1964 CIVIL RIGHTS ACT TO THE AFFORDABLE
CARE ACT

In the United States, the requirement for provision of language access services in healthcare settings has evolved from two distinct bodies of law: civil rights law and the law of informed consent.¹⁴ In the realm of civil rights law, the legal basis for a patient’s right to language services was established with Title VI of the 1964 Civil Rights Act, which states:

No person in the United States shall, on the ground of race, color, or **national origin** (*emphasis mine*), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.¹⁵

“National origin” has been interpreted by all three branches of the federal government to include persons with limited English proficiency (LEP), and thus healthcare organizations receiving federal funding may be found liable for discrimination if they fail to provide access to language services. Within the legislative branch of the government, lawmakers expanded on the prevention of discrimination set out in the Civil Rights Act with multiple pieces of legislation. Two examples of such legislation include Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA). Together, these acts prohibit discrimination against qualified persons with disabilities in public programs and by public accommodations, and thus further establish the principle

¹⁴ Teitelbaum, J., Cartwright-Smith, L., & Rosenbaum, S. (2012). Translating Rights into Access: Language Access and the Affordable Care Act. *American Journal of Law & Medicine*, 38(2-3), 348-373. doi:10.1177/009885881203800205.

¹⁵ Civil Rights Act of 1964, Pub.L. 88-352, 78 Stat. 241 (1964).

of language access in healthcare via the concept of “communication-related rights”^{14a}. The Supreme Court has interpreted the language of these acts and “communication-related rights” to encompass and protect against discrimination toward non-English speakers in healthcare settings, in cases such as *Canterbury vs. Spence*,¹⁶ which will be discussed in further later in this section. Within the Executive branch, the right to language access was again reinforced in 2000 by President Clinton’s Executive Order 13,166, which required all federal agencies to review their own policies and procedures to ensure appropriate access for LEP persons.¹⁷ In response to this Executive Order, the DHHS released guidelines for health care providers receiving federal funding (e.g., providers who accept Medicare or Medicaid patients) on how to ensure language access, including provision of competent (i.e. trained) interpreters at no cost to LEP patients.¹⁸ This executive order represents one of the few pieces of American law to explicitly mention interpreter services as a critical component of language services.

Informed consent law has also heavily influenced the evolution toward a healthcare system that recognizes the importance of communication and partnership between patient and provider in medical decision-making. A definitive shift in informed

^{14a} Teitelbaum et al., 348-373.

¹⁶ *Spence v. Canterbury*, 1972 U.S. LEXIS 348, 409 U.S. 1064, 93 S. Ct. 560, 34 L. Ed. 2d 518 (U.S. Nov. 1, 1972).

¹⁷ William J. Clinton: "Executive Order 13166—Improving Access to Services for Persons With Limited English Proficiency," August 11, 2000.

¹⁸ *In the Right Words: Addressing Language and Culture in Providing Health Care*. Issue Brief No. 18. San Francisco, CA: Grantmakers Health, August 2003.

consent law in the United States occurred with the 1972 *Canterbury vs. Spence* case,¹⁶ in which the Court of Appeals for the District of Columbia Circuit ruled that a physician must not only convey to a patient all the information a reasonable person would need to know to make an informed decision, but that the physician must do so in a way that the patient can understand. “Patient understanding” can be interpreted to mean that if language is a barrier to communication between patient and physician, then this may be considered an impediment to informed consent, and the physician may be held liable for proceeding with treatment or care decisions without the informed consent of the patient if they do not use appropriate language services.^{14b}

These preceding federal legal efforts preventing race-, disability-, and language-based discrimination in healthcare evolved in a fee-for-service context that did not prioritize the wellbeing of the patient, as the fee-for-service model compensates providers based on the number of services billed for, often regardless of the health outcomes of the patient. The Patient Protection and Affordable Care Act (ACA) built upon these scaffolds of race-, disability-, and language-based anti-discrimination laws and introduced a new legal construction for healthcare that attempted to rebuild the system away from fee-for-service payment plans and toward an expectation of healthcare equity for patients. The ACA did so by placing the financial transaction dimensions of the healthcare system within the broader context of patient outcomes. One way the ACA considers patient outcomes is by establishing into legislative law the need to provide services for LEP individuals in the healthcare setting, as well as addressing the need to develop methods

¹⁶ *Spence v. Canterbury*, 1972 U.S. LEXIS 348, 409 U.S. 1064, 93 S. Ct. 560, 34 L. Ed. 2d 518 (U.S. Nov. 1, 1972).

^{14b} Teitelbaum et al., 355.

for better assessing the necessity for communication-based services for LEP individuals. Areas of particular strength in terms of the assurance of resources for LEP persons within the ACA include the requirement of collection of language data from organizations receiving ACA funding, funding patient navigators and community health workers, funding community health centers, and emphasizing the importance of cultural competency training for primary care providers.^{14c} Each of these areas will be described briefly here.

In terms of collecting language data, the ACA establishes a National Strategy for Quality Improvement in Health Care (National Quality Strategy, or NQS) to “address the reduction of disparities through the use of language services, community outreach, and cultural competency trainings”¹⁹. One example of a method employed by the NQS to achieve this reduction in disparities is by requiring the collection of language data by all federally conducted or supported health programs. Such data has not been regularly collected in the past, and the hope was that once collected, this data could be analyzed to determine an organization's’ degree of compliance and provision of meaningful access for LEP patients.^{14d} Unfortunately, it is difficult to find detailed raw data collected after the establishment of the NQS goals. AHRQ.gov documents the “2015 National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy,” which lists the NQS’s six priorities addressing the range of quality concerns that affect most Americans, including, “Person- and Family-Centered Care:

^{14c} Teitelbaum et al., 369-373.

¹⁹ Patient Protection and Affordable Care Act, Pub. L. No. 11-148, 1311(g), 124 Stat. 119 (2010). Retrieved December 15, 2017.

^{14d} Teitelbaum et al., 371.

Ensuring that each person and family is engaged as partners in their care”²⁰. In the document, progress on each priority is assessed and the person-centered care priority is defined as, “care [that] adapts readily to individual and family circumstances, as well as differing cultures, languages, disabilities, health literacy levels, and social backgrounds”²⁰. The data included in the report related to patient communication with providers includes the response to the following survey question: “Adults who reported that their health providers sometimes or never listened carefully, explained things clearly, showed respect for what they had to say, or spent enough time with them are considered to have poor communication.” The results showed that from 2002 to 2013, the percentage of adults who reported poor communication with their healthcare providers significantly decreased overall and among all racial/ethnic and income groups, but that Hispanics were more likely than whites to report poor communication in all years and that this gap did not change overtime.²⁰ The fact that this gap did not change over time indicates that there was no significant impact of ACA legislation on communication barriers for Hispanics.

The ACA also further enables the reduction in healthcare disparities related to language by authorizing funding for patient navigators and the training of community health workers, two groups of patient aids that could enhance the provision of culturally and linguistically competent care. The ACA also expanded funding for community health centers, which serve a large number of LEP persons.^{14d} Of note, however, funding for community health workers, patient navigators, and community health centers is not akin to the provision of trained interpreters in healthcare settings, and funding for ancillary

²⁰ <https://www.ahrq.gov/research/findings/nhqrdr/nhqrdr15/priorities.html>. Accessed March 3, 2018.

^{14d} Teitelbaum et al., 371.

staff, services, and community health centers does not directly translate into improved communication between providers and patients in the setting of the clinic visit. For instance, recipients of grants for patient navigators are required to “provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges,”^{14e} but leaves the interpretation of what is “culturally and linguistically” appropriate to the grant recipient.

The ACA also includes increased funding for training programs in primary care and general dentistry that must include cultural competency training.¹⁹ While cultural competency training of primary care providers intuitively sounds beneficial for LEP persons, literature review demonstrates that there is a lack of research on the effectiveness of cultural competency training. Often, studies assessing the impact of cultural competency have relied on outcome measures such as self-reported patient satisfaction, which as a metric has been proven to be less reliable across language differences. Studies into the effectiveness of cultural competency have been widely criticized for failing to include health outcomes as endpoints as opposed to subjective measures that are not always reliable across different languages.²¹

While the ACA treats language access as a foundational element of high quality healthcare and reemphasizes preceding laws establishing that organizations receiving federal funding must provide language services for LEP persons, it does not directly

^{14e} Teitelbaum et al., 371.

¹⁹ Patient Protection and Affordable Care Act, Pub. L. No. 11-148, 1311(g), 124 Stat. 119 (2010). Retrieved December 15, 2017.

²¹ Ferguson, W. J., & Candib, L. M. (2002). Culture, language, and the doctor-patient relationship. *Family Medicine and Community Health Publications and Presentations*, 34(5), 353-361. Retrieved October 8, 2017.

establish funding sources for interpreter services or for comparing the effectiveness of various translator services (ad hoc vs. professional in-person vs. video vs. telephone). While funding for the collection of language data, community health workers, patient navigators, community health centers, and cultural competency training for primary care providers will undoubtedly lead to improvements in care for LEP individuals, the lack of direct mention of funding for interpreter services is undeniably a limitation of the ACA. Research preceding the ACA has demonstrated that perceived barriers to implementing cost-effective strategies to address language barriers are high among primary care physicians, specialists, and practice managers.²² Without allocating specific funding for interpreter services or research into the most effective method of interpretation, the ACA misses an opportunity to advance national understanding of the significant benefits associated with medical interpreter services. And this is unfortunate, as a significant body of literature exists regarding the most effective methods of interpretation from the patient and provider perspectives, as will be detailed in the following sections.

²² Gadon, M., Balch, G. I., & Jacobs, E. A. (2007). Caring for Patients with Limited English Proficiency: The Perspectives of Small Group Practitioners. *Journal of General Internal Medicine*, 22(S2), 341-346. doi:10.1007/s11606-007-0311-4. Retrieved July 23, 2017.

CHAPTER 4 PATIENT PERSPECTIVES ON INTERPRETER SERVICES

There is a large and varied body of research into patient perspectives on interpreter services in primary care settings. The major foci of this research include patient preferences regarding interpretation method (in-person trained professional vs. telephone vs. ad hoc/family member/friend), differences in patient preference based on country and language of origin of the patient, and how other barriers to communication between primary care providers and patients, such as differing cultural backgrounds, impact perceptions of understanding between language discordant provider-patient pairs.^{3,10,11,12,13,14} In order to delve into these areas of research further, four representative publications have been selected to exemplify patient perspectives on interpretation and communication with language discordant providers in primary care settings.

Effect of Spanish Interpretation Method on Patient Satisfaction in an Urban Walk-in Clinic²³

This study addresses the main question posed in this paper regarding patient satisfaction with interpretation services in the outpatient primary care clinic. While there is a legal obligation for a public and private entities receiving federal financial assistance from the DHHS to provide appropriate interpretation as established in Title VI of the Civil Rights Act, the provision of “accurate and effective communication” at no cost to

²³ Lee, L.J., Batal, H.A., Maselli, J.H., Kutner, J.S. (2002). Effect of Spanish Interpretation Method on Patient Satisfaction in an Urban Walk-in Clinic. *Journal of General Internal Medicine*. 17, 641-646. Retrieved December 5, 2017.

the patient has not been well-regulated or evaluated in terms of patient satisfaction with interpreter services.

The purpose of this study was to examine the effect of Spanish interpretation method on patient satisfaction with medical care. The study compared satisfaction with the use of language concordant providers, telephone interpreters, and ad hoc (untrained) interpreters or family members among Spanish-speaking patients seen at an urban primary care clinic. Satisfaction was assessed via self-administered post-visit questionnaires. In terms of patient characteristics, a total of 233 English-speaking patients and 303 Spanish-speaking patients were seen by language-concordant providers, while the remainder of the Spanish-speaking participants utilized telephone interpretation (n=59), family members (n =69), or ad hoc interpreters (n=47). The main results were that patients seen by “language-concordant” providers and patients using telephone interpreters reported identical overall visit satisfaction, while patients using family or ad hoc interpreters were significantly less satisfied. Of particular note, patients for whom a family member interpreted noted being less satisfied with provider listening, discussion of sensitive issues, and provider manner. Patients who used ad hoc interpreters were less satisfied with provider skills, manner, listening, explanations, and support. The surprising overall conclusion was that Spanish-speaking patients using telephone interpretation were as satisfied with care as patients seeing language-concordant providers. This is surprising as other studies indicate that language-concordant providers are better versed in cultural nuances that enable them to connect and communicate more effectively with their

patients than providers utilizing interpreter services.²⁴ This study supports the idea that clinics serving a large population of Spanish-speaking patients can enhance patient satisfaction by avoiding untrained interpreters and utilizing trained in-person and telephone interpreters.

In situations where language-concordant providers are not available, this study suggests that telephone interpreters may be equally effective for providing satisfactory care. In contrast, untrained interpreters such as family members or ad hoc interpreters (clinic staff, for example) were found to be less acceptable to patients due to limitations in proficiency in both English and Spanish, particularly with respect to medical terminology, as well as issues with confidentiality, particularly when using family members. The fact that telephone interpreters were considered as satisfactory as language-concordant providers is promising for cost-saving interpretation methods that meet the needs of the growing US LEP population.

Providing High-Quality Care for Limited English Proficient Patients: The Importance of Language Concordance and Interpreter Use^{24a}

As the majority of LEP patients in the United States speak Spanish (as of 2013, 64 percent, or 16.2 million, of the total LEP population),^{1a} the majority of research on patient perspectives on interpretation services in primary care involves Spanish-speaking

²⁴ Ngo-Metzger, Q., Sorkin, D.H., Phillips, R.S., Greeinfeld, S., Massagli, M.P., Clarridge, B., Kaplan, S.H. (2007). Providing High-Quality Care for Limited English Proficient Patients: The Importance of Language Concordance and Interpreter Use. *Journal of General Internal Medicine*, 22(Suppl 2), 324-330. doi:10.1007/s11606-007-0340-z. Retrieved December 14, 2017.

^{24a} Ngo-Metzger et al., 324-330.

^{1a} <https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states>.

patients. This study looks at language barriers among LEP Asian-American patients, specifically Chinese and Vietnamese-Americans (who make up 6 percent/1.6 million and 3 percent/847,000 of the LEP population as of 2013, respectively)^{1b} and, “examines the effects of language discordance on the degree of health education and the quality of interpersonal care that patients received, and examined its effect on patient satisfaction”^{24a}.

The specific goals of the study authors were to examine whether LEP patients with language-discordant providers received as much health education and had the same levels of interpersonal care and patient satisfaction as their counterparts with language-concordant providers. Study authors also tried to evaluate how the presence or absence of an interpreter impacted the receipt of health education, the quality of interpersonal care, and ratings of providers. A survey assessing these questions conducted with 2,746 Chinese and Vietnamese patients identified as LEP receiving care at 11 health centers across 8 US cities with high concentrations of Asian-American immigrants demonstrated that patients with language-discordant providers received less health education, but that this effect was mitigated with the use of a clinic interpreter. Those with language-discordant providers also reported worse interpersonal care, and that this effect was not mitigated via use of an interpreter. Study authors do not explicitly define what is meant by interpersonal care, but allude to the fact that interpreter training is not standardized to address ethical issues, role playing, or cultural awareness, so it is most likely that participants found language-discordant providers to be lacking in terms of cultural

^{1b} <https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states>.

^{24a} Ngo-Metzger et al., 324.

awareness and ethical issues unique to their cultural identity. The conclusions of the study were that although having access to a clinic interpreter facilitates the transmission of health information, having an interpreter present does not serve as a substitute for language concordance in terms of perceptions of interpersonal care. This finding that interpersonal care suffers when interpreters are used has also been supported by studies conducted with Spanish-speakers as well.^{25, 26}

The findings of this study demonstrate that while interpreters are important for addressing language barriers in healthcare, interpretation alone may fall short in terms of providing culturally competent interpersonal care. One way to improve interpersonal care may be to provide more cultural competency training not only for providers, but for interpreters as well. As previously mentioned, there are currently no minimum requirements or standards for medical interpreter training, and often, cultural awareness may not be emphasized in training. Providers could also benefit from training on how to best use interpreters when interacting with patients.

Finally, in this study, 140/559 patients seeing language discordant providers reported that they did not have access to a clinic interpreter and instead had to “get by” with their limited English abilities. Although law requires that patients be provided with interpreter services, the lack of an established funding route for such services means that patient care is continually compromised in situations where interpreter services are unavailable due to clinic-perceived cost and resource limitations.* Overall, this study

²⁵ Baker, D.W., Parker, R.M., Williams, M.V., Coats, W.C., Pitkin, K., (1996). Use and effectiveness of interpreters in an emergency department. *JAMA*, 13, 275(10), 783-788.

²⁶ Baker, D.W., Hayes, R., Fortier, J.P., (1998). Interpreter use and satisfaction with interpersonal aspects of care for Spanish-speaking patients. *Med Care*, 36(10), 1461-1470.

highlights the necessity for more robust interpreter services and training of interpreters and physicians to be culturally competent, and of the importance of establishing funding sources for interpreter services so that patients do not go without appropriate care.

***An example of a malpractice suit related to failure to use an interpreter:** “In one well-known case, an 18-year-old was rushed in to the emergency department, accompanied by his mother and girlfriend. The young man was unconscious, and the only clue to his condition was the use of the Spanish word "intoxicado" by his mother and girlfriend [2]. As no one in the ED spoke Spanish, hospital staff interpreted the word to mean that the boy was intoxicated or, more specifically, suffering from a drug overdose. What the women had intended to convey, however, was that the boy was nauseated, not intoxicated. Nearly three days after his admission, all the while being treated for a drug overdose, the doctors ordered a routine neurological test. The test showed two blood clots in his brain, the result of a break in an artery that had been defective since birth. Finally receiving appropriate treatment for his condition, the boy regained consciousness, but was left with quadriplegia. He ultimately sued the hospital, the paramedics, the ED, and attending physicians for medical malpractice, and his settlement topped \$71 million.”
<http://journalofethics.ama-assn.org/2007/08/hlaw1-0708.html>. Accessed March 3, 2018.

Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature.¹¹

This review is notable as it was conducted by Health Services Research and preceded the publication of the ACA, thus highlighting the potential impact of interpreter services in primary care prior to the development of the language access guidelines of the ACA. 28 studies were included in the review: 10 publications compared results for professional vs. ad hoc interpreters (including the study by Lee et al discussed above), 11 studied only professional interpreters, and seven studied the combined effect of professional and ad hoc interpreters. In terms of outcomes measured, seven studies looked at communication and errors, 10 considered utilization of services, four assessed clinical outcomes, and eight looked at patient satisfaction. The studies included in this review were predominantly conducted in outpatient settings (24/28 studies). Taken as a

¹¹ Karliner, L.S., Jacobs, E.A., Hm Chen, A., Mutha, S. (2007). Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature. *HSR: Health Services Research*, 42(2), 727-754, doi:10.1111/j.145-6773.2006.00629.x.

whole, the findings of the review suggested that professional interpreters are associated with an overall improvement of care for LEP patients, as professional interpreters appear to decrease communication errors, increase patient comprehension of care, equalize healthcare utilization between LEP and non-LEP individuals, improve clinical outcomes, and increase satisfaction with communication and clinical services for LEP patients.

A notable shortcoming detailed in the discussion section of the review was that a quarter of the articles did not “separate the effects of different types of interpreters used, and half did not make it clear whether or not the professional interpreters in the study had undergone any training”^{11a}. At the time of publication of this review, medical interpreting was and continues to be a field in evolution, undergoing changes in standards of practice and codes of ethics. As training can range from a few hours to over a year, such variation can lead to a wide range of competencies among those labeled as “professional” interpreters. However, the review demonstrated that overall when studies differentiated between professional and ad hoc interpreters, that the impact of interpretation on health outcomes is more consistent. All studies that definitively looked at the effects of professional interpreters and excluded ad hoc interpreters showed better outcomes with the use of interpreters.

The major takeaways from the review were that the use of professional interpreters is associated with improved quality of health care for LEP patients, and that use of professional interpreters is associated with an improvement in quality of healthcare that is greater than with use of ad hoc interpreters. Overall, the findings of the review suggest that the provision of professional interpreter services reduces disparities in care

^{11a} Karliner et al., 727-754.

for LEP populations, and that health care providers need to recognize that language barriers place LEP patients at a disadvantage that can be overcome by providing better linguistic access. While the conclusions of this HRSA-funded review illuminate the importance of providing professional interpreter services for LEP patients to improve health outcomes, it is interesting that the ACA, which was written after this review, does not directly mention or mandate the provision of professional interpreter services in healthcare settings.

A Systematic Review of Patients' Experiences in Communicating with Primary Care Physicians: Intercultural Encounters and a Balance between Vulnerability and Integrity²⁷

This review aims to synthesize qualitative studies looking at patients' experiences in communicating with primary care physicians. Relevant to the topic of barriers to communication, this review included 57 studies from around the world that highlighted four categories of factors found to exert mainly a negative influence on clinic visits for ethnic minorities: language barriers, discrimination, differing values, and acculturation. It expands the context of communication barriers from simply language discordance with providers to include issues of discrimination and differing values and culture between patients and providers. This is important because as stated in the article,

On top of transmitting objective information, communication also conveys emotions, implicit content, and implicit meanings, all of which are derived from one's cultural systems. In light of this information, communication between ethnic minority patients and physicians may be explained by differences in cultural backgrounds of both interlocutors.^{27a}

²⁷ Roque, R., Leanza, Y., (2015). A Systematic Review of Patients' Experiences in Communicating with Primary Care Physicians: Intercultural Encounters and a Balance between Vulnerability and Integrity. *PLoS ONE*, 10(10): e0139577, 1-31. doi:10.1371/journal.pone.0139577. Retrieved July 25, 2017.

^{27a} Roque et al., 2.

Looking at barriers to communication beyond language ties into the emphasis the ACA places on training providers to be culturally competent and providing funding for community health workers and patient navigators to bridge the cultural and value differences between patients and healthcare systems. Roque et al. highlight the relationship between cultural competency, perceived discrimination, and health disparities in the following quote:

Indeed, the lack of sensitivity to cultural aspects can lead to perceptions of discrimination; a subjective experience that has been demonstrated to engender adverse effects on health in the long term, thus perpetuating health disparities.^{27b}

Overall, the review thoroughly highlights barriers to communication that hinder the care of minority patients in primary care settings related to cultural, value, and language differences between patients and providers.

One interesting cultural barrier discussed in the review was the dominance of biomedical culture. In multiple studies, biomedical culture was identified as serving to orient conversations towards physical symptoms and biological aspects of illness, making it “very difficult for patients to obtain or to discuss psychosocial information regarding their condition (e.g. emotions and impact of illness on their life)”^{27c}. This dominance of biomedical culture was also perceived by patients to prevent physicians from getting to know them in a holistic way, to justify physician use of incomprehensible medical jargon, to downplay patients’ attempts to discuss psychosocial information related to disease, and to influence a lack of prioritization of continuity of care. This is important to note as so

^{27b} Roque et al., 3.

^{27c} Roque et al., 7.

often laws such as the ACA emphasize the importance of cultural competency training for primary care providers to better understand patient culture, when in reality there must be equal emphasis placed on understanding the barrier that biomedical culture places upon communication with minority and LEP individuals.

Besides cultural barriers, another significant factor identified as influencing ethnic minority patients' (EMP) experiences in the included studies were language barriers. Language barriers were noted to impede communication and studies described EMPs experiencing challenges accessing professional interpreters and often needing to utilize informal interpreters (such as children, husbands, or friends). Most patients reported feeling embarrassed, guilty, and/or uncomfortable when utilizing informal interpreters, and that the presence of such interpreters constrained discussions about sensitive topics, mental health topics, and disclosure of intimate information. Due to these communication challenges associated with accessing professional interpreters or relying on informal interpreters, EMPs were noted to be at risk of receiving inadequate care related to language barriers.

This review is important for informing future policy and law as it highlights that language barriers to primary care do not exist in a vacuum; often, patients experiencing language barriers are simultaneously experiencing perceived discrimination and cultural barriers related not only to a lack of understanding of their culture by the healthcare system, but also by providers imposition of biomedical culture on the patient. This review supports the emphasis that the ACA places on cultural competency training and the provision of funding for community health workers and patient navigators to mitigate discrimination and cultural barriers for LEP patients, and also highlights the necessity of

funding for trained interpreters so that LEP and minority patients do not have to rely on informal interpreters that compromise care.

Universally, these studies demonstrate that LEP patients prefer professional interpreter services and bilingual providers to ad hoc interpreters, family members, and friends. Patient preferences and the growing LEP population in the United States reemphasize the need for appropriate funding for interpreter services and highlight the shortcomings of the ACA in terms of providing appropriate allocations and infrastructures to best meet the needs of LEP patients. While studies indicate that there is some variability in terms of patient preferences regarding communication services between different cultural groups, these patient preferences need to be better elucidated with more widespread research. More funding, research, and collaboration between the federal government, healthcare organizations, and patients needs to occur in order to most cost-effectively and efficaciously provide communication services to the growing population of LEP patients across the U.S.

CHAPTER 5 PHYSICIAN PERSPECTIVES ON INTERPRETER SERVICES

From personal observation, provider perspectives on caring for LEP individuals and utilizing interpreter services are varied and frequently negative. As a medical student training in an urban area with a large population of Spanish-speaking patients, I have often witnessed providers utilize interpreters incorrectly by speaking directly to the interpreter as opposed to the patient, thus compromising rapport; by stacking questions and speaking over telephone interpreters before the interpreter has the opportunity to finish translating for the patient, thus leading to gaps in the information conveyed; and by dismissing interpreter services before the clinic visit has been completed, causing the patient to lose out on the opportunity to ask clarifying or follow-up questions. I have also witnessed providers bypass interpreter services all together, even though they were available, and instead rely on broken Spanish to “get by” for a routine clinic visit. While these are just personal observations from a variety of outpatient clinic settings within an urban healthcare institution, they inspired this research into the disconnects between the legal requirements for interpreter services and how these requirements are honored and adhered to in primary care clinic settings, or what should be the main site of preventive and continuous healthcare for LEP and non-LEP patients alike. The following representative studies shed some light on patterns of provider utilization of and opinions on interpreter services, despite legal mandate for all LEP persons to have access to interpretation services.

Caring for Patients with Limited English Proficiency: The Perspectives of Small Group Practitioners²²

In developing this study, the authors acknowledged that most previous research had focused on how language barriers affect patients and that less is known of the physician perspectives on and efforts being made to overcome language barriers. Participants included 67 primary care physicians, specialists, and practice managers based in small private practices in geographic areas across the United States that had experienced recent substantial increases in LEP populations. Data was collected via computer-assisted telephone focus groups with an open-ended discussion guide. Results of the study demonstrated that perceived barriers to implementing cost-effective strategies to communicating with LEP patients were high. In these small private practices, clinicians cited cost, inaccessibility, and inconvenience of using professional interpreters as barriers to employing such services and often used family and friends of patients as interpreters. Few study participants had any actual experience with professional interpreters or were knowledgeable regarding the cost of such services. In the focus groups, both physicians and practice managers voiced concern about how language barriers negatively impact quality and safety of patient care, leading to increased malpractice risk.

The concerns expressed by participants in this study are entirely physician-centered and consider the quality of care received by LEP patients only in terms of how patient-perceived substandard care could lead to legal problems for physicians. Participants acknowledge that language barriers could negatively impact quality and

²² Gadon et al.

safety of patient care, but the ultimate worry was due to the implications of language barriers for increased malpractice risk. Physicians and practice managers in this study had a great deal of seemingly unfounded perceptions regarding the costs of language access services:

In every [focus] group, participants made frequent spontaneous comments about the high cost of interpreter services. Yet, few of the physicians or managers had experience using and paying for professional interpreter services on which to base their perceptions. None knew exactly how many LEP visits their office had over a period of a year and therefore their service need...Most had never investigated the costs of contracting with remote or on-site interpreters...When pressed about how much they would be willing to pay for a language service to ensure good quality of communication, [participants] had difficulty justifying any cost whatsoever.^{22a}

A direct quote from one of the study participants included in the paper states, “The doctors would just rather that the patient go somewhere else and find a solution somewhere else,”^{22b} and these excerpts taken together represent the extent of the issue. Physicians in small private practices are uninformed regarding interpreter services, unaware of the extent to which providing interpreter services has the potential to be cost-effective by minimizing extraneous tests, saving time, and improving patient understanding of and adherence to medical treatment, and most concerning of all, these physicians and practice managers do not seem interested in learning about how to most effectively provide care for this growing population, but would instead rather dish the care of this population off to other, younger practitioners. Passing the responsibility on to other providers and refusing to innovate within a care model is not the way to efficiently and effectively meet the medical needs of the diversifying U.S. population. As study authors summarize, “our findings also suggest that physician concerns about quality of

^{22a} Gadon et al., 344.

^{22b} Gadon et al., 345.

care are outweighed by the perceived cost and inconvenience of using these services,”^{22c} and it is this attitude that is truly prohibitive to the development of established legal funding sources for interpreter services. Without physician advocacy for such services, it will be difficult to see legislation and law for medical interpreter services progress beyond where they are now. This study highlights the need for more effective health policy and advocacy efforts to provide physicians and practice managers with education regarding the resources for the provision of services to address language barriers, and demonstrates that such resources must address liability, inconvenience, and cost concerns.

Clinician Ratings of Interpreter Mediated Visits in Underserved Primary Care Settings with Ad hoc, In-person professional, and Video Conferencing Modes²⁸

The goals of this study were to compare physician ratings as to the quality of: “interpretation and communication, their visit satisfaction, their degree of patient engagement, and their self-rated cultural competence across three methods of interpretation: in-person professional, video conferencing professional, and ad hoc interpretation”^{28a}. Physician participants were recruited from safety net adult primary care centers in California where approximately 60% of all outpatient visits are with LEP patients. Data was collected from self-administered clinician post-visit surveys for 283

^{22c} Gadon et al., 345.

²⁸ Napoles, A.M., Santoyo-Olsson, J., Karliner, L.S., O’Brien, H., Gregorich, S.E., Perez-Stable, E.J., (2010). Clinician Ratings of Interpreter Mediated Visits in Underserved Primary Care Settings with *Ad hoc*, In-person Professional, and Video Conferencing Modes. *J Health Care Poor Underserved*, 21(1), 301-317. doi:10.1353/hpu.0.0269. Retrieved December 6, 2017.

^{28a} Napoles et al., 303.

visits from 2004-2005, when video interpretation services were being implemented at the clinics. Results showed that physicians rated the quality of interpretation with in-person and video conferencing modes similarly, and that in-person and video conferencing interpretation was rated higher than ad hoc interpretation. Self-assessed cultural competence was rated better for in-person versus video conferencing interpretation. Overall conclusions of the study were that video conferencing interpretation increased access for LEP persons without compromising visit quality, but that cultural nuances may be best addressed with in-person interpreters, as summarized in the following quote:

These results suggest that when language-concordant clinicians or in-person professional interpreters are not available, video conferencing increases access to professional interpreters without compromising the quality of the interpretation and communication, and clinician satisfaction with the visit. These findings also support the use of professional over ad hoc interpreters whenever possible.^{28b}

The attitudes of physicians participating in this study were vastly different than those in Gadon et al. These differences in attitude may be due to a variety of factors. For one, this study was conducted in California, the state that has seen the largest influx of LEP individuals,¹ and in clinics receiving federal funding and providing care for a high volume of LEP patients. The practitioners surveyed in this study were familiar with translator services out of longstanding necessity, and thus their attitudes and familiarity with such services differed accordingly from their counterparts in the Gadon et al. study.

In the discussion section of this study, authors alluded to the “largely unfunded mandate for federal fund recipients to provide language services,”^{28c} and the fact that

^{28b} Napoles et al., 308.

¹ <https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states>.

^{28c} Napoles et al., 308.

although legislative intent to address language discrimination appears as far back as Title VI of the Civil Rights Act of 1964, the question still remains regarding who will pay for language services, and study authors conclude that, “significant gaps in the availability of professional interpreter services exist due to inconsistent government mandates and public and private reimbursement policies,”^{28d} that unfortunately the ACA fails to clarify. Overall, study authors conclude, and arguably this finding was also supported in the previous Gadon et al., study, that the lack of comprehensive reimbursement strategies for interpreter services represents a disincentive for clinicians to see LEP patients or for LEP patients to seek care when they need it. Although studies such as this one are able to identify creative solutions to language barriers via new technology such as video conferencing, without established funding sources, there are significant limitations as to how accessible these solutions may be for clinics across the country.

Not Just “Getting by”: Factors Influencing Providers’ Choice of Interpreters²⁹

This study is important to the body of research on provider perspectives on interpreter services as it looks at why providers underutilize professional interpreters in healthcare settings even when the benefits of such services are acknowledged and the services are readily available. The objective of the study was to understand the decision-making process that shapes provider use of interpreter services. Study participants included 39 healthcare professionals from nursing, mental health, emergency medicine,

^{28d} Napoles et al., 310.

²⁹ Hsieh, E., (2014). Not Just “Getting by”: Factors Influencing Providers’ Choice of Interpreters. *Journal of General Internal Medicine*, 30(1), 75-82, doi:10.1007/s11606-014-3066-8. Retrieved November 29, 2017.

oncology, and obstetrics-gynecology from a large academic medical center with “excellent” interpreter services. Data was collected via focus groups and key results included the following:

Four factors influence providers’ choice of interpreters: (a) time constraints, (b) alliances of care, (c) therapeutic objectives, and (d) organizational-level considerations. The findings highlight (a) providers’ calculated use of interpreters and interpreting modalities, (b) the complexity of the functions and impacts of time in providers’ decision-making process, and (c) the importance of organizational structures and support for appropriate and effective interpreter utilization.^{29a}

Of particular note, in terms of time constraints, providers stated that waiting for a professional interpreter may delay care for other scheduled patients and create a “snowball effect of task delays for an entire clinic”^{29b}. Providers also expressed concerns with telephone interpretation, including “poor sound quality, awkward discursive style (e.g., passing the handset back and forth), and lack of interpersonal closeness,”^{29c} and identifying the telephone as a barrier to establishing rapport. These concerns with professional and telephonic interpreting echo concerns I have heard expressed by providers on clinical rotations within a large urban academic center and are thus presumably not limited to provider participants in this study.

Overall, it seems that providers in clinic are often making specific interpreter choices due to time pressure and high patient volume, and that these choices are simultaneously influenced by interpersonal, organizational, therapeutic and ethical considerations that must be balanced to the best of their abilities. In the discussion section of the study, Hsieh suggests that health care organizations not only need to increase

^{29a} Hsieh, 75.

^{29b} Hsieh, 77.

^{29c} Hsieh, 77.

access to professional interpreters through various modalities, but that resources must be modified to address the logistics of using remote interpreters (for example, providing higher quality speaker phones that are accessible from all patient rooms). Hsieh also reaches a conclusion that is in line with much of recent research on bilingual healthcare, that “providing institutional training, certification, and guidelines for bilingual physicians and staff members can promote quality care by maintaining the standards of bilingual healthcare”^{29d}. Essentially, just because a provider or staff member identifies as bilingual, this does not mean that they have the necessary medical vocabulary or cultural competency to conduct clinic visits in a second language. Such bilingual staff members also must receive training and certification to ensure that they can provide high quality care to patients who speak this second language. In conclusion, this study highlights the need for more in-person interpreters, better quality remote telephonic interpreter services, and the need to train and certify bilingual staff so that the quality of care LEP individuals receive does not suffer due to the limitations of interpreter services or communicative abilities.

These three studies highlight some key issues from the provider perspective regarding interpreter services. For one, small group practitioners in areas of the country that have not previously provided care for LEP populations may be naïve to interpreter options or cost effective and necessary strategies for providing such communication services to LEP patients. Second, in areas of the country that are used to caring for LEP patients, providers are working to develop creative strategies to mitigate language barriers, such as utilizing video-conferencing services when the demand for interpreters

^{29d} Hsieh, 81.

exceeds the supply of available in-person interpreters. However, because there is no dedicated federal funding stream to cover such services, clinics and practitioners often do not have the resources necessary to develop innovative and effective strategies to address communication barriers, or to enable the spread of such creative solutions to similar practice settings across the country. Finally, even when a healthcare center is considered to be equipped with “excellent” interpreter services and has identified the need to provide these services to patients, the services often do not meet the needs of providers or patients and providers are forced to make decisions regarding how to utilize interpreter resources while taking into consideration time and the burden that utilization of such services may place on fellow providers, staff, and other patients waiting to be seen. For providers and patients alike, current interpreter services are not robust enough to meet the needs of LEP patients and clearly further research, funding, and collaboration is needed between the government, providers, and patients to make sure that Title VI of the Civil Rights Act is actually upheld and LEP patients do not continue to face discrimination and worse health outcomes due to communication barriers.

CHAPTER 6 CONCLUSIONS

From personal observation, provide Although federal civil rights policy obligates healthcare providers to supply language services, wide gaps in services offered persist because insurers typically do not pay for interpreter services. Without appropriate reimbursement streams, many clinics continue to utilize ad hoc, or untrained, staff to interpret for patients, to rely on family members to interpret, or to utilize friends, despite many studies that indicate that patient care is compromised by these situations. While LEP patients feel more comfortable with professional interpreter services and bilingual providers, many providers identify frustrations when caring for LEP patients due to the perceived higher costs of support/language services required for this patient population, and for the longer period of time that must be dedicated to clinic visits with LEP patients. However, studies show that failing to provide interpreter services may actually lead to more expensive care as without language services, clinicians cannot elicit LEP patients' symptoms, leading to the utilization of more diagnostic resources or invasive procedures.³⁰ These increased costs are in addition to the compromised care that patients receive when interpreter services are not provided. Overall, the ACA missed the mark when it failed to include mandates for insurers such as Medicaid and Medicare to reimburse for translator services. Without explicit funding streams for the provision of these services, physicians continue to bear the costs of interpretation, and this serves as a disincentive for many clinicians to provide care for the growing LEP population.

³⁰ Hampers, L.C., (1999). Language Barriers and Resource Utilization in a Pediatric Emergency Department. *Pediatrics*. 103(6), 1253-1256. Retrieved January 9, 2018.

As language services are not evenly distributed across all providers, a potential equitable solution for reimbursement for such services would be via funding at the federal level. In 2002, an Office of Management and Budget (OMB) report estimated that it would cost the United States \$268 million per year to provide interpretation services for inpatient hospital, outpatient physician, ED, and dental visits. The OMB estimated that interpretation at that time would cost an average of \$4.04 per visit by an LEP patient or a mere 0.5 percent of the total visit cost.^{10d} While undoubtedly these costs will have increased with both inflation and the growing US LEP population since 2002, the OMB report makes clear that it is feasible for the federal government to reimburse for interpreter services. As there is significant variability in LEP population density across cities and states, funding for these services at the federal level would be an efficacious and equitable way to provide these integral services for 8 percent of the population.

However, the body of research on interpreter services and communication in outpatient clinic settings makes clear that merely providing unstandardized interpreter services for LEP patients is not enough to guarantee effective communication. A recent study focusing on medical interpreter utilization within obstetrical and neonatal services demonstrated that providers' use/non-use of interpreter services is merely:

...one piece of a much 'bigger picture' regarding difficulties and challenges in delivering care to a growing culturally diverse patient population, and that these cultural challenges, not just the availability of interpreter services, may affect providers' ability to deliver effective and efficient care. It is argued that simply adding additional communication-based resources may not be sufficient to impact providers' attitudes and behaviors or the overarching organizational culture regarding LEP patients.³¹

^{10d} Ku et al., 439.

³¹ Barret, M., Maiden, K.M., Ortiz, J., Bell, A.V., Ehrental, D.B., (2014). Providers' Perceptions of Medical Interpreter Services and Limited English Proficiency (LEP) Patients: Understanding the "Bigger Picture". *Journal of Applied Social Science*, 9(2), 156-169, doi:10.177/1936724414550247. Retrieved December 15, 2017.

This and other studies included in this paper highlight the importance of providers, healthcare institutions, and patients working together to develop solutions to best overcome communication barriers to care. A study looking at pediatric health care experiences of LEP Latina mothers in 2 urban US cities demonstrated that as recently as 2015, patient mothers experienced frustration with health care and reported suboptimal accommodation for language barriers as well as experiencing stigma and discrimination in the healthcare system.³² Study authors concluded that, “partnering with families to address the management of language barriers is needed to improve health care quality and safety for LEP patients and families”^{32a}. Presumably, healthcare institutions should already be dedicating resources to such partnerships under the language of the ACA, which authorized funding for the National Quality Strategy, patient navigators, and community health workers. The fact that these interventions have not adequately met the needs of the growing LEP population demonstrates that new laws and legal structures need to be implemented to ensure that research, resources, and funding at a national level are appropriately dedicated to these issues. Another potential avenue to help overcome communication barriers is to standardize medical interpreter training and certification. Recent studies demonstrate that research should examine cost-effectiveness and ensure that certified interpreting services are appropriately used by health care practitioners, as it is not only important that the interpreters receive standardized training, but that health care practitioners are using these services in an appropriate manner to best serve their

³² Steinberg, E.M., Valenzuela-Araujo, D., Zickafoose, J.S., Kieffer, E., Ross DeCamp, L., (2016). The “Battle” of Managing Language Barriers in Health Care. *Clinical Pediatrics*, 55(14), 1318-1327, doi:10.1177/0009922816629760. Retrieved December 15, 2017.

^{32a} Steinberg et al., 1318.

patients.³³ The need for further research, funding, and creative strategies for interpretive and communicative services in clinical care demonstrates that while, as a nation, we have come a long way in terms of identifying the need to accommodate patients of different cultural and ethnic backgrounds, that we still have far to go in terms of establishing an actual functional infrastructure to meet the healthcare needs of our LEP citizens.

³³ VanderWielen, L. M., Enurah, A.S., Rho, H.Y., Nagarkatti-Gude, D.R., Michelsen-King, P., Crossman, S.H., Vanderbilt, A.A., (2014). Medical Interpreters: Improvements to Address Access, Equity, and Quality of Care for Limited-English-Proficient Patients. *Academic Medicine*, 89(1), 1324-1327, doi: 10.1097/ACM.000000000000296. Retrieved December 20, 2017.

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