

PROTECTING THE RIGHTS OF LIMITED ENGLISH PROFICIENCY
PATIENTS DURING HOSPITAL DISCHARGE

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ABSTRACT

Discharge instructions were originally created to alleviate the burden of transitioning from inpatient hospitalization to outpatient care. The US healthcare model's evolution throughout the 20th and 21st centuries has firmly distinguished inpatient providers from outpatient providers, with little continuity between them. As a patient leaves inpatient care there is an increasing need for clear discharge instructions to help navigate complex diseases and care regimens. However, comprehension of discharge instructions, both oral and written, is a major obstacle for many populations, with certain demographics especially affected. Populations with limited English proficiency (LEP), for example, are commonly provided discharge instructions in English, preventing them from fully engaging in their care and from understanding information that is paramount to a smooth transition to outpatient settings. Many factors contribute to the failure to provide this and other care in LEP patients' primary languages. Factors include but are not limited to: misinformation regarding price of interpreter services and time necessary to use these services, biases against LEP populations, and ignorance regarding the effect this has on the LEP population. This paper discusses the background of discharge instructions, reasons for development, the price LEP patients pay when we fail to provide care in their primary language, and possible reasons why we fail to provide that care.

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CHAPTER 1: INTRODUCTION

Discharge Instruction Use and Relevance

The transition from inpatient to outpatient medical management is becoming an increasingly important target for the improvement of patient outcomes. The evolution of US healthcare from a model in which patients were allowed extended hospital stays in the care of their outpatient providers to rapid turnover and care by exclusively inpatient providers has left considerable gaps in patient care. Hospitals are increasingly being pressured to care for critically ill inpatient populations while also managing growing outpatient populations. While this model change may be beneficial for addressing the financial burdens faced by large public hospitals and the high demand of an aging and chronically ill population, gaps created by this paradigm shift need to be addressed to ensure proper patient beneficence and safety. As often is the case in healthcare, systemic shifts towards efficiency and cost reduction can come at the expense of patient well-being.

Discharge from an inpatient setting is “increasingly recognized as a time of heightened vulnerabilities for lapses in safety and quality” (Coleman et al., 2013, p. 383). Patients being discharged from the hospital face major obstacles to adherence of certain therapeutic plans, including: discontinuity of care providers, substantial changes in medications, new self-care responsibilities, and often overly-complex discharge instructions. A major area for improvement within the transition from inpatient to outpatient care is in the realm of discharge instructions. Patient discharge instructions are

a combination of oral and written information provided at the time of discharge. They are integral to a smooth transition out of the hospital. Effective discharge instructions should contain three major components: a hospital stay summary, future appointments made, and a comprehensive medication list including any changes made during a patient's hospital stay and current dosages. Details may include home self-care instructions, lab and imaging results, follow-up care, and symptoms that necessitate emergent care. Frequently, some combination of the registered nurse, attending physician or medical resident is responsible for delivering these instructions (Ashbrook et al., 2013). In previous healthcare models, lack of high quality patient discharge instructions may have had less of an impact when the same physician provided both inpatient and outpatient care and the patient knew who to call for clarification. With the separation of outpatient and Hospital medicine, however, this is no longer the case.

The value of discharge instructions has increased as patient turnover has increased – patients are leaving the hospital “quicker and sicker” (Kosecoff et al., 1990), which necessitates some tool to help guide the patient, outpatient practitioner, and patient support system in disease management. Discharge instructions are thought of as a tool to help address heightened vulnerabilities following hospitalization but often fall short of accomplishing these goals. One study looking at adverse events following discharge showed that one in five patients experienced some adverse event following hospitalization (Forster, A, 2003). Adverse drug events were the most common type of adverse event (66% [CI, 55% to 76%]), and 33% of all events were considered preventable (Forster et al., 2003). The authors of this study found that of all the ameliorable and preventable adverse events seen, each one was in some part contributed

to by “system problems.” The most common “system problem” was lack of communication between inpatient providers and either the patient or the outpatient provider. Other “system problems” noted were: “assessment and communication of unresolved problems at the time of discharge, patient education regarding medications and other therapies, monitoring of drug therapies after discharge, and monitoring of overall condition after discharge” (Forster et al., 2003, p.165). Notably, all of these “system problems” could be addressed by focusing on the original design and purpose of discharge instructions while addressing a system that has rendered discharge instructions relatively ineffective.

Barriers to Discharge Instruction Comprehension and Implementation

Comprehension of discharge instructions is necessary for adherence to any plans or changes made during a hospitalization, yet there are many barriers to achieving this. A number of non-medical factors affect a patient’s comprehension and utilization of these instructions, including proper explanation by the health care team, age, primary language, sex, social support, and health literacy (Albrecht et al., 2014).

Despite medicine’s growing interest in social determinants of health, providers continue to struggle with accurately determining the unique needs and circumstances of their patients. While physicians may understand the impact social determinants have on health, many refrain from inquiring about these circumstances, preventing them from being considered during treatment design. This oversight is not necessarily due to physician negligence; with the decreasing amount of time allotted for each patient visit

physicians are forced to focus on questions that guide medical treatment but do not necessarily take into account the various obstacles patients have to treatment adherence. Additionally, a 2011 Robert Wood Johnson Foundation study on social determinants of health found that while nearly all physicians surveyed agreed on the importance of discussing unmet social needs of patients, 80% of respondents were not confident they were able to address such problems successfully (Robert Wood Johnson Foundation, 2011). Other programs looking at physicians' perceptions on social determinants of health showed similar results; physicians were at times reluctant to address unmet social needs of patients if they felt they did not have the appropriate tools to address them.

Failing to appreciate these barriers can have serious effects on patient outcomes. In regard to discharge instructions, barriers to comprehension or compliance can translate to misunderstanding of disease, failure to attend important appointments, and medication nonadherence. Considering the extensive burden of modern medication regimens, explanation of inpatient medication changes is one of the most valuable potential contributions of discharge instructions. One study of hospitalized elderly patients showed that 40% of home medications were discontinued by the time of discharge, and that 45% of all medications the patients were discharged home on were newly started during that hospitalization (Kripalani et al., 2007). Despite the complicated nature of inpatient medication changes, discharge instructions often fall short of properly conveying a patient's new outpatient regimen. In one cohort of discharged patients studied, 49% of the adults experienced a medical error after hospital discharge, with 19-23% experiencing an actual adverse event – most commonly related to medication issues (Kripalani et al., 2007). It is not uncommon to see patients discharged from the hospital

with little understanding of their medication changes, only to return to the hospital as a consequence of sub- or supra-therapeutic drug doses. Medication burden is often overlooked by providers who in large part enjoy better health than their patient population – making it difficult to empathize with the obstacles patients face not only in baseline adherence but to frequent and confusing changes made during hospitalizations. These obstacles increase as medication lists grow longer. Researchers examining 308 patients admitted to two urban hospitals between 2005-2008 showed that the number of drugs prescribed to each patient was inversely related with likelihood of understanding, and that with each additional medication prescribed there was a 10-15% decrease in a patient's understanding of that medication (Karliner et al., 2012).

An additional factor complicating discharge instruction comprehension is the setting in which they are provided. Discharge instructions, as the name suggests, are presented at time of patient discharge. This is a time when patients and their families may be focused on basic logistical needs such as transportation and placement, and are less receptive to listening to detailed instructions, taking time to participate in “teach-back” methods for comprehension, or discussing personal obstacles to adherence (Weiss et al., 2011). Delivering discharge instructions is a pivotal point in a patient's healthcare trajectory and should be respected as such. Taking the time to fully communicate with a patient and to gauge a patient's understanding before discharge is a valuable component of successful patient care. This is especially true since both general and disease-specific communication have been shown to increase patient satisfaction with care providers, increase medication adherence, and help in long term disease outcomes (Piette et al, 2003). In regard to medical regimens, it is especially valuable to make sure there is two-

way communication with the patient being asked to utilize the “teach-back” method of explaining their medication regimens to their care providers. One study showed the value of this reciprocated communication dynamic by looking at patients with self-reported adherence to a medical regimen and the concordance/discordance with their health provider’s understanding of the regimen (Schillinger et al., 2006). Ultimately, the authors found no correlation between a patient’s stated adherence to a regimen and concordance with the set regimen by the provider, leading the authors of the study to emphasize the need to have the patient utilize the “teach-back” method of communication with providers. The study also illuminates how patients are often unaware of the gaps of knowledge they have regarding their health care regimens, emphasizing the key role practitioners play in the management of both medical decisions and a patient’s understanding of such decisions. This depth of communication cannot realistically occur during the expedited time of patient discharge and may warrant an extended period of education before the hours immediately prior to patient discharge.

CHAPTER 2: PATIENTS AT RISK FOR DISCHARGE INSTRUCTION MISCOMPREHENSION

Low English Proficiency Patients

As the US healthcare model continues to evolve towards separation of inpatient and outpatient care, the population it serves continues to evolve as well. Providers are struggling to keep up with the demands put on them by administrators looking at the bottom line and patients whose unique needs make it difficult to implement a uniform healthcare-related intervention. So, while the value of discharge instructions has increased exponentially in the past three decades, there has been little attention paid to adapting these instructions to the needs of vulnerable populations in the ever-evolving US demographic.

One demographic for whom discharge instructions have failed to evolve with their needs is the limited English proficiency population (LEP), a growing demographic in the United States. Data from the last US census shows that 61.8 million people speak a language other than English at home, and 25.1 million of them report speaking English “less than well.” After English, the most common language is Spanish (38.4 million), followed by Chinese (three million), Tagalog (1.6 million), Vietnamese (1.4 million), French (1.3 million), and Korean and Arabic (Camarota, Steven A. & Zeigler, K. 2014). This amounts to over twenty-five million patients being cared for by providers who largely do not speak their primary language, and this demographic is increasing.

As discussed above, regardless of primary language, patients universally struggle in adhering to complex therapeutic regimens. Studies referenced earlier show how

integral communication is to an effective treatment regimen, and how providers in the US struggle to successfully communicate with patients even when they speak their same language. Clearly this depth of communication cannot occur between providers and LEP patients unless interpreter services are used in *every* aspect of their care, which often is not the case. This need for effective communication is emphasized even more so during the transition from inpatient to outpatient care because patients go from having licensed professionals administering their therapies to being their own care providers (or having other laypersons administering care).

There has been a large effort to address LEP patient needs while in and out of the hospital – mainly in regard to using certified interpreters when speaking with the patient. Under Title VI of the Civil Rights act of 1964, any hospital receiving federal funding through Medicaid or Medicare reimbursements is legally required to provide translator services to LEP patients. However, no specific protections exist for providing those services during the *transition* from inpatient to outpatient care. LEP patients are rarely provided discharge instructions in their primary language and are often left to their own devices to interpret and comply with this detailed information. The window of time during which a patient is being discharged from the hospital is a pivotal moment in their care but guidelines regarding translator services often fail to specify the importance of providing discharge instructions in patients’ primary languages. Although, as is the case with inpatient interpreter use, having specific laws/guidelines does not necessarily translate to successful implementation. For example, despite the push to provide medical interpreters for every LEP patient interaction with a care provider, there is still an inexplicable lack of interpreter use by providers in US hospitals. One study looking at

the University of California San Francisco Hospital interpreter service database showed only 14% of LEP patients were recorded as having interacted in any way with a professional medical interpreter during their inpatient hospitalization (Karlner et al., 2010). Similarly, another study of “heavily resourced” academic hospitals showed that 66% of LEP patients reported having no interpreter during their inpatient clinical encounter (Lopez et al., 2015).

Many studies have exposed the under-utilization of interpreter services for LEP patients - despite the laws requiring access to these services and the proven benefits they provide LEP patients. Limited English proficiency patients with access to interpreters have been shown to receive better quality of care, better outcomes, and increased patient satisfaction (Flores et al., 2005). Professional interpreter use has been recognized as so important for LEP patient well-being that the Institute of Medicine stated that using an interpreter for LEP patients is a “patient safety imperative” (Institute of Medicine, 2001). If health care providers are not utilizing interpreter services during periods of time in which they are legally required to do so, such as inpatient interactions, it would be naive to expect that they are providing these services during periods in which they have not been specifically told they need to, such as during hospital discharge.

Health Policy Response to Low English Proficiency Patient Needs in Healthcare

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, or national origin in any program or activity that receives Federal funds or financial assistance - which encapsulates most hospitals that receive Medicare or

Medicaid reimbursements. It gives specific protections for LEP patients, stating that LEP people “must be afforded a meaningful opportunity to participate in programs that receive Federal funds” (Title VI of Civil Rights Act of 1964, HHS.gov). Furthermore, the Supreme Court ruling in *Lau v. Nicols* (1974) set a precedent of language being used as a proxy for national origin, further protecting LEP patients from discrimination. In concordance with Title VI, the Joint Commission, the national accreditor of health care programs and organizations, published Standard RI.2.40 which requires that patients “receive information in a manner that he or she understands,” specifying both written information (although not explicitly discharge instructions) and spoken communication. Despite these guidelines and legal protections, no funding was allocated to protect these rights, and many have questioned whose responsibility it is to pay for language services in hospitals.

While the above laws and standards exist to protect LEP patients in more general rhetoric, there has been less attention paid to specific rights of this population, especially within the realm of hospital discharge. With the ever-evolving data on gaps in patient care from inpatient to outpatient management, health policy makers have focused on ways to improve hospital discharge yet fail to focus on the unique needs of the substantial number of LEP patients in the United States. In response to the above studies and others showing barriers to inpatient discharges, a Transitions of Care Consensus Statement was released by the American College of Physicians, the Society of General Internal Medicine, the Society of Hospital Medicine, the American Geriatrics Society, the American College of Emergency Physicians and the Society of Academic Emergency Medicine (Snow et al., 2009). In this consensus statement a Communication

Infrastructure section listed ten guidelines to follow to ensure proper communication between providers and patients. However, out of the ten guidelines, not one mentioned language accessibility or concordance for LEP patients. This is not the first time interpreter services has failed to be acknowledged in major health policy publications regarding hospital care. In 2000, the groundbreaking report “To Err is Human” (Institute of Medicine, 2000) shed light on gaps in patient safety resulting from physician errors. Despite thousands of reports filed annually to the Department of Health and Human services regarding language accessibility, the report failed to include language barriers as a major threat to patient safety.

Ultimately, the question as to where the specific protections are for LEP patients gets lost in the already chaotic world of inpatient medicine. Providers are quick to endorse a variety of objections and obstacles to providing interpreter services to LEP patients, some more valid than others. It is relevant to this conversation to break down these obstacles to understand how to address them further.

Objections and Perceived Obstacles to Interpreter Services

Healthcare providers cite a variety of obstacles to providing translation services. For a period of time a lack of resources prevented hospitals from providing language services to LEP patients, but increasingly this is not the case. In 2007 the Joint Commission released a report on hospital services showing that 98 percent of hospitals surveyed had access to phone interpreters. It is no longer a reality in major US hospitals that access to interpreters is an obstacle to providing these services. Practitioners working

at large urban hospitals have access to both in-person and telephone interpreter services, often able to reach phone interpreters without delay. However, as mentioned above, multiple studies have shown that even in the most resource-rich hospitals fewer than two thirds of LEP patients receive language services. While these services are often accessible, it is possible there may be subtle messaging from the hospital administration to avoid overutilization of services that cost additional dollars for inpatient stays (Bell et al., 2017).

Another perceived obstacle to providing language services to LEP patients is the concern for time. Every year providers are asked to see more patients, faster, and as a consequence are often averse to anything perceived as adding onto their already full schedules. Additionally, physicians who may be seeing patients on different floors of the hospital may be disinclined to wait for an interpreter to arrive to see a patient (Green & Nze, 2017). While almost all providers believe that phone or in-person interpreters require more time with a patient, several high-quality studies have shown this not to be the case. One “time motion” study in a primary care clinic found no difference in time spent with a patient with or without interpreters. (Tocher et al., 2003). Other studies on inpatient doctor-patient encounter times showed no statistically significant difference in time spent with a patient with or without an interpreter present (Jacobs, 2007; Fagan, 2003).

For providers, it can be difficult to know when an interpreter is necessary. Many patients are able to have basic exchanges in English (yes, no, hello, etc.) which allows providers a false sense of security regarding the patient’s understanding of their care. Alternatively, some LEP patients falsely assert their understanding of English. Several

studies looking at LEP patient interactions with providers showed that patients oftentimes nodded and verbalized their understanding, regardless of comprehension (Sevilla et al., 2013). It is possible that patients truly did think they understood the provider, which is why it is important to elicit the “teach-back” model when talking to patients for whom comprehension is a possible concern.

Another obstacle to successful language service utilization is the lack of standardization regarding whose responsibility it is to provide these services. Patients interact with many levels of care providers during hospitalization. Without standardized guidelines, it is easy to delegate use of interpreter services to the subsequent provider seeing the patient, which can translate to under-utilization of translational services. Before a patient is admitted they will see a variety of care providers ranging from patient care assistants to nurses to medical residents and attending physicians. Without clear and direct guidelines stating otherwise, providers will continue to be able to relegate the job of calling an interpreter to someone else.

The topics discussed above are some of the most prominent objections and perceived obstacles to using interpreter services but do not begin to fully encapsulate the issue of interpreter access. Regardless of which obstacle providers perceive to be the largest, it would be naive to think that patients are unable to perceive the sense of burden providers clearly endorse regarding using these services. This burden is emphasized more upon discharge, when practitioners are pressured to move patients quickly and are often busy with new admissions before discharged patients have left the hospital. Additionally, the complexities of LEP patients’ lives usually far surpass language barriers. Immigration concerns, cultural differences, tenuous living situations, and more

can contribute to LEP patients' barriers to self-advocacy without even considering the role provider burden perception may play. The dynamic of feeling uncomfortable advocating for interpreter services forces an already marginalized population further into a second-class citizen status – it robs LEP patients of the comfort and benefit of being communicated with in their primary language at a critical moment of transition between acute care and community-based care.

CHAPTER 3: LONG TERM CONSEQUENCES

Effects of Withholding Language Services from LEP Patients at Discharge

LEP patient vulnerabilities should not be overlooked when considering “at risk” populations in the US healthcare system – even when they have access to care LEP patients are shown to have “poorer adherence, decreased comprehension of their diagnoses, decreased satisfaction with care, and increased medication complications” (Karliner et al., 2010, p. 276). These barriers are certainly present during inpatient and outpatient care, but this population is at an even more heightened risk during discharge because of lack of targeted communication for LEP patients augmented by the reality that successful discharge *depends* on effective communication. An important question regarding miscommunications at time of discharge is – what are the costs? Financial, physical, and social costs are all impacts of poor transition from inpatient to outpatient care. Financial cost of readmissions is only a small example of the way restricting language services costs our healthcare system and LEP patients. The more figurative costs are just as concerning when considering the overall beneficence of LEP patients in healthcare models that do not focus on just language concordance for all patients.

The Doctor-Patient Relationship and Patient Autonomy

Withholding language services from LEP patients at discharge prevents them from being full and able participants in their own care. Communication is an integral part

of a successful patient-doctor relationship and LEP patients without this opportunity are stripped of their ability to act autonomously. This patient-doctor relationship mimics antiquated models of paternalistic medicine; the physician acts as the central decision maker while the patient is forced to be a passive actor in his/her own care. For most of medical history, physicians chose treatment regimens with little input or engagement by the patient, occasionally resulting in devastating risks not understood by the patient and ultimately seeding significant distrust in physicians by the larger population that we continue to struggle with in the modern era. Patients were figuratively silenced by not being included in their own health management, a dynamic ultimately understood to be unethical. In the example of failure to use interpreter services, LEP patients are literally silenced and excluded from fully engaging in their care, thus reinstating the paternalistic model we have tried so hard to evolve away from. This model not only hurts the patient, it also undermines the balanced doctor-patient relationship we know to be so important in the long-term management of chronic diseases. It is unjust to withhold the tools necessary for our patients to fully engage in their healthcare. Doing so sends the message that the partnership emphasized by so many providers is either less important than we claim it to be, or not valued for the LEP population. With language discordance we also miss out on the valuable insights patients often have into their illnesses. Not only can they not understand the provider and her medical decisions, the provider cannot understand the patient and their unique perspective on why they are sick and what would contribute to their wellness. Patients who report satisfactory communication with their physician are more likely to “share pertinent information that leads to accurate diagnoses, follow advice, adhere to prescribed treatment, and feel more satisfied with their care” (Ha

& Longnecker, 2010, p. 39). This reciprocity is beneficial to both parties and its absence is mutually detrimental.

That being said, it is important to note that the US healthcare evolution away from a paternalistic model is a reflection of our culture's increasing value (although not necessarily protection) of patient autonomy. This value is in holding with the deeper creed of individualism that has defined America since its inception over two centuries ago. While this paper is a reflection of those core tenets, and was written within the context of these values, there are many (perhaps a majority of) cultures that do not value individualism to the extent that America does, especially in regard to the doctor-patient relationship. Many LEP patients come from cultures at odds with the dominant United States culture of patient receptivity to detail on diagnosis and prognosis. There are a number of cultures, specifically within Central America and Asia, in which it is acceptable and even desirable for medical information, oftentimes poor prognoses, to be withheld from patients. There continues to be an interesting ethical discussion surrounding the management of patients whose cultural norms differ from those of their healthcare provider. So, while LEP patients deserve the opportunity to engage in communication to the fullest extent as their English proficient counterparts, they may not choose to do so. In one health services study looking at the cultural differences in patient communication during colorectal cancer screening, some Latino patients preferred "high power distance relationships...these patients looked up to their physicians for their authoritative voice, knowledge, and expertise." The Latina women in the study "depended on physicians and were comforted in having the doctor give a recommendation rather than being given autonomy to make their own decisions" (Sevilla

et al., 2013, p. 7). Some patients, especially those whose culture may differ from the hyper-individualized American norm, prefer “high power distance,” in which reliant relationships of dependents on superiors dominate. So long as we are practicing in a country in which patient autonomy is valued, however, all patients must be afforded the same opportunity to achieve as much or as little autonomy as they deem beneficial to their health.

Patient Health and Beneficence

Barriers to effective communication with LEP patients limit understanding of future appointments and medication changes, and limit caregivers’ ability to provide proper home care (Karliner et al., 2010). One study looking at language needs during hospital discharge showed that LEP patients without interpreted discharge instructions had higher readmission rates as compared to English proficient speakers, but similar care efficiency and mortality rates (Karliner et al., 2010). This demonstration of a possible correlation between language and readmission rates suggest there may be a “communication-critical” step being missed in the LEP population (Divi et al. 2007). Specifically, some lapse in communication would cause LEP patients to be readmitted at a higher rate than English proficient patients. It is reasonable to infer that interpreted discharge instructions could begin to address these communication barriers.

A study done by faculty at the University of California at San Francisco looking at Spanish, Chinese and English-speaking patients discharged from two urban hospitals between 2005-2008 showed that baseline understanding of discharge instructions was low for all demographics (Karliner et al., 2010). However, LEP patients

had significantly lower odds of understanding medication category (OR 0.63) and combined medication category and purpose (OR 0.59) as compared to English Proficient (EP) patients (Karliner et al., 2010). The authors showed that LEP patients were less likely to know appointment type following discharge as compared to EP patients (50% vs 66%, $p = .01$). Of importance, this study also showed that when a certified medical interpreter was present these discrepancies were erased, with LEP patients having equivalent rates of understanding as EP patients. An important point made by this study was to distinguish between certified and ad hoc interpreters (this could be family/friends or ad-hoc hospital employee interpretation). While LEP patients with certified interpreters were shown to have the same understanding of discharge instructions as their EP counterparts, the group with the poorest understanding of discharge instructions were LEP patients with ad-hoc interpreters. This illuminates a key concept that most hospital employees do not understand in regard to LEP patient populations – ad hoc interpretation can actually harm patient care and outcomes. While healthcare providers may believe that their grasp on a language is sufficient enough to interpret for a patient, there is no evidence to support that belief and plenty that refutes it.

Financial Consequences

LEP patients have been shown to have poorer medication adherence and higher readmission rates when language services are withheld during discharge. In regard to confusion surrounding medication regimens, one study showed 14% of patients had one or more medication discrepancies on discharge, and those with medication discrepancies

were twice as likely to be readmitted at 30 days than those who did not (Snow et al., 2009).

There is a clear connection between poor transitional care and preventable readmissions, and as is being discovered with the increased focus on health care expenditures in the US, readmissions carry a significant financial burden for hospitals and insurance companies. The Medicare Payment Advisory Committee's (MedPac) 2007 report to congress found that 17.6 percent of Medicare patients were readmitted to the hospital within thirty days of being discharged, accounting for \$15 billion dollars in spending in 2005 (MedPac Report to Congress, Promoting Greater Efficiency in Medicare, June 2007). Another study completed by the Agency for Healthcare Research and Quality showed that of patients admitted to the hospital with a preventable admission, almost twenty percent had at least one preventable readmission within six months following discharge (Friedman et al., 2004). The authors calculated that the cost of those readmissions averaged out to \$7,400 per readmission. Readmission costs were so concerning to policy makers that the Affordable Care Act included a penalty for hospitals if certain patients were readmitted within 30 days of being discharged. The initial penalties were for patients readmitted after being diagnosed with heart attacks, lung infections, or heart failure. Research conducted on these penalties show significant reductions in readmission rates following ACA implementation. Prominent authors of one such study concluded, "We and others believe that better educating patients about their conditions before leaving the hospital, better coordinating their care, and providing access to office visits after leaving the hospital have helped improve patient safety and reduce readmissions" (Wafsy et al., 2016). While LEP patient readmissions are not yet

one of the targets for hospital penalization, it is possible that including this demographic could incentivize hospitals to consider the unique needs of this population during discharge. It would also be valuable to compare the costs of preventable readmissions of LEP patients to the cost of employing additional certified interpreters if the concern regarding language services was, as it often is, related to resource allocation. In one of the few studies looking at direct cost, the use of on-site, trained interpreters added about \$235 to a hospitalization, while significantly decreasing visits to the emergency department post-hospitalization (Jacobs et al., 2007).

Patient Labeling

As mentioned above, withholding interpreter services at discharge can lead to tangible adverse effects on care. LEP patients for whom interpreter services are withheld are less likely to adhere to medical regimens and understand appointment types and dates following discharge. Lack of interpreted discharge communication can also lead to more intangible long-term consequences in how patients are perceived and engaged by future providers. When patients are unable to adhere to their provider's treatment regimen, they are often labeled as "non-compliant." It is impossible to quantify the fall-out from having this descriptor in one's medical records. Non-compliance is a value-laden title given to patients when they are unable, for reasons in but usually out of their control, to adhere to medical regimens. The implication of this descriptor is that the patient is lazy, disinterested, and unwilling to take responsibility in the management of their health. "Non-compliant" is a pseudo-medicine, pseudo-jargon term used between health care

providers that is difficult to un-learn once a patient is described as such. Physicians often use this title offhand, with little recognition or interest in the multitude of factors that contribute to “non-compliance.” We force patients into “non-compliant” identities when we strip them of their ability to *understand* how to comply. It is another way physicians are able to disenfranchise their patients, especially those who are already in marginalized demographics in the US. Failure to recognize obstacles that can cause “non-compliance” is poor medical care, but withholding tools that would aid in compliance, as in the case of withholding interpreter services, is unethical.

CHAPTER 4: DISCUSSION

Bias and the Politics of Translation

It is difficult to talk about LEP patient treatment without acknowledging the fraught political environment informing our care. Rampant nationalism has become pervasive in both local and national elections, with politicians exploiting fear and uncertainty and blaming globalism and immigration for all that ails the United States. Donald Trump, the president of the United States, has fueled this movement, continuously seeding fear of the “other” and encouraging doubt about the motives and backgrounds of anyone who deviates from the Christian, Anglo Saxon image so many falsely associate with being an American citizen. During his presidential campaign Trump said regarding immigrants in the US, “When Mexico sends its people, they’re not sending their best...They’re sending people that have lots of problems, and they’re bringing those problems with us. They’re bringing drugs. They’re bringing crime. They’re rapists. And some, I assume, are good people” (Washington Post, 2015, “Donald Trump Announces Presidential Bid”).

Since the majority of LEP patients in the US are Spanish speakers, the general sentiment against Spanish speaking immigrants, specifically those of Mexican descent, is paramount to the discussion regarding access to translator services. What role does bias, whether implicit or explicit, play in our failure to provide language services for LEP patients? When the president of the country sows seeds of doubt regarding immigrants, how does that inform the treatment of these individuals? As discussed above, large

academic hospitals provide access to interpreter services, and studies show there is not a significant time cost of using these services. Are biases fueled by our country's leaders allowing providers to justify inequitable care for LEP patient populations? Or are biases against these populations so ingrained in this country's history that the unjust treatment is considered an acceptable reality? After all, anti-immigrant sentiment, and specifically anti-Mexicanism, is in no way a recent phenomenon. As the historian Dr. Juan Gómez-Quiñones writes about anti-Mexicanism: "U.S. anti-Mexicanism is a race-premised set of historical and contemporary ascriptions, convictions and discriminatory practices inflicted on persons of Mexican descent, longstanding and pervasive in the United States... Anti-Mexicanism is a form of nativism practiced by colonialists and their inheritors..." (Gómez-Quiñones, January, 2017, *La Realidad: The Realities of Anti-Mexicanism - A Paradigm*) Withholding language services from LEP patients, the majority of whom are of Mexican descent, is an extension of the historic, more explicit discriminatory practices seen throughout US history. Now, however, they are masked behind the obstacles discussed above, with unjust care being defended as shortcomings of our healthcare system. The categorization of LEP patients as "other" allows providers to defend, consciously or subconsciously, the marginalization of this population, a common phenomenon of justification through dissociation. In reality, seemingly benign actions such as failing to call an interpreter are the subtle ways in which we perpetuate the marginalization of immigrant populations, even if it is not as overt or ugly as the xenophobic rhetoric utilized by certain politicians.

As our tools to measure more qualitative measures, such as bias, advance, we are increasingly able to quantify the role both explicit and implicit bias have on patient care.

Although providers are generally held to a higher standard regarding acceptance of diverse populations, studies suggest this should not be the case. Researchers looking at provider bias against Latino patients found substantial implicit bias by physicians, especially in comparison to sentiment towards non-Latino white patients (Blair et al., 2013). In fact, the doctors studied were shown to have the same implicit bias against Latino patients as the control group of community members. However, providers in this study showed no *explicit* bias towards Latino patients, suggesting an unawareness of their deeper sentiments towards this population. This knowledge reshapes the discussion regarding perceived (by physicians) obstacles to language services for LEP patients. Physicians would not be able to name implicit bias as a barrier to equitable care, since “implicit” suggests they are not aware of the issue. Provider bias should be considered on par with other more tangible obstacles to language services such as financial and temporal concerns. Standardized and specific guidelines regarding language services would help to circumnavigate provider bias, as physician judgment would play a smaller role in determining the appropriate level of language services for LEP patients. Regardless of its manifestation, provider bias is a direct threat to LEP patient beneficence and should be appreciated for the public health threat that it is.

Suggestions for the Future

There are multiple variables that need to be addressed to ensure the provision of translated and interpreted discharge instructions for LEP patients. Putting aside the larger goal of instilling a respect for LEP patient rights, it is important to propose realistic and

achievable suggestions for addressing unethical practices. One such suggestion would be to utilize electronic medical records (EMR) to create a standardized system of communicating with LEP patients. When patients are admitted to a hospital using EMR, their preferred language is recorded in their chart. EMR can be adapted to alert providers to a variety of descriptors. For example, alerting a physician about required vaccines if a patient's age is over a certain limit, or alerting a physician of a necessary screening test if there are no records of it in the patient's chart. One specific example is that of Rheumatologists creating an alert system for DEXA bone density scans to screen for osteoporosis. During a patient visit, if a woman is over a certain age and has no record of a DEXA bone density scan in her chart, the EMR alerts the doctor that one is needed. There is no reason why this same technology could not be used to benefit LEP patients. On admission a patient's preferred language would be recorded in the EMR, and when the physician attempts to select "discharge" in the patient's chart, the doctor would be alerted of the need for an interpreter. To close the window and successfully discharge the patient, the provider would need to certify that discharge instructions were translated into the patient's primary language and also interpreted. This feature could work differently depending on the provider. For example, registered nurses often print the discharge instructions. EMR could again be utilized so that if a nurse attempts to print the instructions, an alert message would remind them of the need for interpreter services to see the patient before they leave the hospital. The technology exists to provide these services to LEP patients, what is lacking is recognition of the extent of the problem and how it affects this patient population.

Conclusion

Hospital discharge is a time of heightened vulnerability for all patients, especially those with predisposing obstacles to care. Discharge instructions were created to help alleviate some of the burden of the transition from inpatient to outpatient care, but regularly fall short of accomplishing these goals. It is often the populations that already face substantial barriers to health that suffer the most. Limited English proficiency patients are at particular risk not only because of the multitude of factors that cause providers to fail at providing appropriate language services, but because these patients' lives are often complicated by concerns that far exceed, yet directly affect, their health. Although we have succeeded in protecting LEP patient rights in general rhetoric through laws and national guidelines, these efforts have been largely symbolic and failed to ensure just language accessibility. LEP patients are rarely provided patient-specific discharge instructions in their primary language and are therefore forced to face the already convoluted time of hospital discharge with information they do not understand. There are significant consequences that result from withholding language services to LEP patients, ranging from financial costs of therapeutic non-adherence to the jeopardization of core ethical values of beneficence, autonomy, justice, and nonmaleficence. To begin to address these issues providers need to be educated about the problem and prompted to reflect on personal biases that may be affecting their care of this population. Most urgently, hospitals must adopt standardized and specific guidelines regarding language service access, including who is responsible for attaining these services, which documents need to be translated, and technological advances that can help ensure the

provision of these services. Failing to provide discharge instructions in a patient's primary language discriminates against LEP patients and perpetuates the mistreatment of an already marginalized population in the US. It is our duty as healthcare providers to continuously reevaluate our practices and focus our attention on populations we have sworn, yet repeatedly fail, to protect.

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