

**THE CURRENT STATE OF INTERPRETER SERVICES
IN HEALTHCARE AND WHERE WE GO FROM HERE**

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ABSTRACT

Over 25 million Americans report limited English proficiency (LEP) since 2013, and this number has been steadily increasing over the past few decades as immigration to the United States continues to climb. Due to the expanding heterogeneity of the population, cultural and language barriers became more common in the healthcare field which led to worse patient outcomes, inappropriately ordering too many or too few tests, and decreased use of preventative services. This necessitated further resources and interventions to better accommodate individuals with LEP. In accordance with Title VI of the 1964 Civil Rights Act which was elaborated further in Executive Order 13166, federal agencies were required to provide language services to people with LEP. As a result, more medical institutions began implementing interpreter services. Despite these measures, there is lower-than-expected physician compliance with utilizing these services and considerable variability in services offered depending on the clinical setting. Not only does this perpetuate and potentiate the health disparities that this population already faces, but it can also negatively impact a patient's agency as they do not have the proper resources to fully advocate for their health. Hence, it is integral to examine the potential reasons why the current infrastructure for interpreter services is still lacking and what can be done to optimize accessibility. This thesis will explore some of these limitations and then offer potential solutions that both institutions and medical professionals can implement in order to provide equitable care to patients with LEP.

DEDICATION

I dedicate this thesis to my medical school friends (Amy, Komal, Jess, and Shenyece). This thesis would not have developed into the way it did without their input and insight. Thank you for letting me bounce ideas off of you and for encouraging me throughout this whole process.

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CHAPTER 1

INTRODUCTION

According to the American Community Survey, over 25 million Americans reported limited English proficiency (LEP) in 2013. Since 1980, the number of people who primarily speak another language besides English have almost tripled, with Spanish being the most common language (Dietrich & Hernandez, 2022). As a result, there was an increasing demand for interpreting services in various settings, including the healthcare field, to account for this growing diversity. Institutions across the country began adopting different modalities of language services to try to meet these needs. Despite these measures, the quality of interpreter services may differ across clinical settings depending on resources, accessibility, and execution. Some studies show that physicians do not regularly utilize these resources as they are expected to per hospital guidelines and ethical obligations, even when it is well-known that forgoing interpreters in a patient encounter can lead to worse health outcomes, loss to follow-up, and increase in unnecessary tests (Flores, 2005). This is not isolated to a specific institution, and these studies delineate a need to evaluate what systemic factors are at play and what changes should be made to achieve equitable care. In regards to the current infrastructure of interpreter services, we need to address a few key areas: why we should reconsider using ad hoc interpreters, how interpreters can affect agency of a patient, what it means to promote cultural competency at an institutional level, and how we can improve the training that medical interpreters undergo. Whether it be at the level of a small private practice or the federal government, we should strive to incorporate the core tenets behind these principles in order to establish just care to patients with LEP.

CHAPTER 2

HISTORICAL BACKGROUND

Within the past couple centuries, there has been a steady influx of immigrants due to prospects of financial opportunities in the US. With the increasing heterogeneity of the population, there was naturally a growth in individuals who do not speak English fluently, and they faced language barriers in the public sphere, including healthcare. To circumvent these problems, patients often brought in family members or friends who spoke enough English to communicate their concerns during their doctors' visits. If they did not, it would not be uncommon for physicians to ask nurses, medical assistants, receptionists, or other staff to help interpret. Unfortunately, this language barrier can cause serious clinical consequences.

In 1980, an eighteen-year-old male named Willie Ramirez suddenly experienced a sharp pain at the back of his head while he was out with a friend (Price-Wise, 2008). He experienced vision changes, postural instability, and vertigo. He soon became comatose and was transported to a hospital in South Florida. Upon being evaluated in the emergency department, his mother initially thought his symptoms stemmed from food poisoning and relayed to the doctor in Spanish that he was '*intoxicado*,' which is a Cuban slang for when you ate or drank something wrong. His girlfriend's mother interpreted to the doctor that "a hamburger *intoxicated* him" in a thick accent. On physical exam, the physician noticed Ramirez had labored breathing and pinpoint pupils—both of which are signs of opioid overdose. Due to his rapidly deteriorating condition, he was intubated and admitted to the intensive care unit for "probable intentional drug overdose." This misunderstanding was worsened when the physician erroneously believed that the patient

took drugs because of an argument with his girlfriend; meanwhile, his mom was vehemently denying that her son would ever take drugs. When Ramirez was unable to move his arms a couple days later, the attending consulted the neurology team, who noticed deficits in eye movements on their physical examination. The CT scan demonstrated a left intracerebellar hematoma with associated brainstem compression. He underwent surgery to rectify his brain bleed but unfortunately, the neurological damage was irreversible. Ramirez was now quadriplegic. Had there been someone to properly mediate their conversation, this outcome likely could have been prevented.

Unfortunately, this was not the only case that resulted in long-term health consequences. Ramirez's story further emphasized the need for adequate language services in healthcare settings so that people with LEP can obtain equitable care. Technically, there was already legislation that served as the foundation to promote interpreter services—Title VI of the 1964 Civil Rights Act, which states that federally-funded programs or activities are to provide equal treatment to people with LEP (Chen, Youdelman, & Brooks, 2007). In 1980, when immigration hit another peak with the passing of the Refugee Act, the Department of Health and Human Services (HHS) issued a statement to extend Title VI to a healthcare setting: “No person may be subjected to discrimination on the basis of national origin in health and human services programs because they have a primary language other than English.” This legal framework was further elaborated in August 2000. President Clinton signed Executive Order 13166, *Improving Access to Services for Persons with Limited English Proficiency*, which explicitly required federal agencies to identify needs for services to individuals with LEP and to increase accessibility of these resources (“Executive Order 13166”). The HHS

Office for Civil Rights facilitated this framework for healthcare institutions through its Policy Guidance, which outlined several different factors that federal agencies should consider when implementing these services (e.g., more language assistance services are needed in more heterogeneous populations, smaller agencies with limited budgets do not need to provide the same level of resources as larger agencies; Chen, Youdelman, & Brooks, 2007).

From a legislation perspective, this was a major step forward for those advocating for patients with LEP. However, the implementation of these policies drastically differed on a state level, depending on factors like language, medical condition, and institution. The Department of Health in New Jersey requires brochures on breast cancer to be published in English and Spanish but the policy does not extend this to other medical conditions (NJ Rev Stat § 26:2-168, 2021). Across the country, however, California had passed a policy in 2003 that required “every health care service plan and specialized health care service plan to assess the linguistic needs of the enrollee population, excluding Medi-Cal enrollees, and to provide for translation and interpretation for medical services, as indicated” (CA Health & Safety Code § 1367.04, 2017). Furthermore, there is no universal standardized training for medical interpreters, which consequently affects the quality of services provided to patients depending on where they live.

Despite the variability in services provided, there was undoubtedly a shift towards implementing more language services in hospitals in general. With cases like Willie Ramirez, it was clear how language barriers can negatively impact clinical outcomes. In his case, an error in interpretation resulted in devastating consequences but it is not

limited to solely misdiagnoses—patients with LEP often have less access to care and fewer visits with primary care physicians. Additionally, there is poorer treatment compliance, increased dissatisfaction with their care, and decreased comprehension of their medical diagnoses and medications. More and more medical professionals are utilizing these services but, despite widespread availability, physician compliance is not as high as expected. Interestingly, one study discovered that patients with LEP whose physician used interpreter services were more likely to have a longer length of stay at the hospital (López et al., 2015). The patient group where interpreter services were used had significantly more comorbidities compared to the patient group where language services were not used. This may imply that physicians are more inclined to use it in medically complex cases because they can “get by” with an ad hoc interpreter (or even no interpreter) for patients with simpler medical histories.

CHAPTER 3

IDENTIFYING THE PROBLEM

There are a multitude of studies that demonstrate interpreter services lead to better patient outcomes. And yet, the implementation of these services remains suboptimal as these patients are still subjected to disparate care. This section will expand upon why this may be by addressing: usage of ad hoc interpreters, impact on a patient's agency, benefit of comprehensive culturally sensitive resources, and the lack of standardization of training for medical interpreters.

Ad Hoc Interpreters

An ad hoc interpreter is someone who is not trained to be a medical interpreter; it is usually a family member but other common examples include friends of the family or bilingual staff. Particularly for smaller practices or community/rural practices, they may not have the means to pay for interpreter services which leaves them with no choice but to use ad hoc interpreters. But in the context of institutions who do provide these resources, the use of ad hoc interpreters still remains rather prevalent despite availability of language services. There are multiple reasons for why this might be: convenience to both the physician (e.g., perceived time constraints) and patient (e.g., feeling more comfortable with a family member), lack of interpreter who speaks the patient's language, and technical difficulties with phone/video technology.

However, there is a substantial number of studies that emphasize the importance of utilizing professional medical interpreters instead of relying on ad hoc interpreters or forgoing one entirely. For example, researchers of one study retrospectively reviewed audiotapes of pediatric ED encounters in a large urban US hospital and found that

professional interpreters made as half as many errors as ad hoc interpreters or when there were no interpreters (Flores et al., 2012). Specifically, the latter two groups were more likely to commit errors of omission (i.e., the interpreter did not interpret a specific word) and false fluency (i.e., the interpreter used words that did not accurately reflect the original phrase). While some may be innocuous errors, some of these errors could lead to clinical consequences. During one encounter, an ad hoc interpreter had incorrectly interpreted the dosage of a medicine—from two teaspoons to two tablespoons—and omitted another medication entirely when relaying the information to the rest of the patient’s family.

On the other hand, some may argue that patients might find it more comfortable to have their family members interpret because they are more familiar with their medical histories and current symptoms. Additionally, there may be more trust between family members than with an interpreter they had never met before. However, there are many patients who prefer the use of trained interpreters over ad hoc interpreters. Spanish-speaking patients at an urban community health center reported they would rather ask for language support in order to ensure medical accuracy. They were also concerned about privacy and communication issues; they did not want their family members knowing about certain aspects of their health, and they were occasionally skeptical of whether their family member was interpreting faithfully or purposely omitting certain things the physician said (Garcia-Jimenez et al., 2019). Furthermore, there are instances where a physician assumes the family member who fluently speaks English will help interpret. This places an undue burden on the family member, who is then expected to accurately interpret medical terminology, and also the patient, who may not be comfortable speaking

up and directly asking for an interpreter because of perceived patient-physician hierarchy. Because of these various circumstances, there needs to be a stronger push for utilizing trained interpreters when available to not only provide better care but to avoid this unnecessary pressure on patients and their families.

Infringing on a Patient's Agency

The literature clearly demonstrates that using medically trained interpreters leads to better health outcomes when compared to using ad hoc interpreters. However, a related but more nuanced concept that should be considered is how inadequate interpreter support can affect a patient's agency.

For example, a patient with LEP brings in her daughter to help interpret during her appointment. The patient explains her symptoms to her daughter, who then relays it to the physician. However, she likely saw firsthand the symptoms the patient was experiencing and feels compelled to add details that the patient might have neglected to mention. Some may argue that the daughter is simply advocating for her mother's health, not wanting her to leave out potentially relevant details. Despite her well-intentioned actions, this inadvertently shifts the conversation in a direction that the patient did not intend. To take it a step further, the capacity to carry out a specific decision is theoretically contingent on what is being portrayed to the physician by her daughter.

However, this phenomenon is not necessarily limited to ad hoc interpreters. The National Council on Interpreting in Health Care (NCIHC) is an organization that was established in 1998 by a diverse group of medical interpreters, clinicians, and policymakers who desires to minimize language barriers in healthcare and to promote culturally competent health care. In their national code of ethics, they outline how the

interpreter should strive “to render the message accurately, conveying the content and spirit of the original message, taking into consideration its cultural context” and “to maintain impartiality and refrain from counseling, advising or projecting personal biases or beliefs” (The National Council on Interpreting in Health Care, 2004). Hence, the duty of a medical interpreter is to accurately and objectively relay the patient’s words to the physician and vice versa. Naturally, this is the most ideal situation but trained interpreters are not immune to making mistakes—however, the danger comes when interpreters are not sufficiently trained on how to exercise impartiality. In the aforementioned study that compared types of errors made by professional and ad hoc interpreters, professional interpreters were unexpectedly much more likely to commit errors of addition (i.e., adding words not mentioned by either party), substitution (i.e., substituting a phrase for another phrase), and editorialization (i.e., interpreter imbued the interpretation with their own views; Flores et al., 2012). So while professional interpreters may be less likely to commit medical errors that result in clinical significance, these types of errors are still infringing upon a patient’s agency in dictating what they want to relay to their provider.

While impartiality is indeed crucial, urban bioethics tenets might suggest that there is value in “breaking” that impartiality and enhancing a patient’s ability to better exercise their agency. Beyond the language barrier, there are cultural nuances that may not be readily apparent to the provider but may be something the interpreter is familiar with as the interpreter and patient may share similar cultural identity. For example, there was an instance where the physician noticed the mother of a patient was horrified that her child was losing hair. The interpreter at the time helpfully supplemented that, in the context of the family’s culture, hair was not cut because it symbolized a wedding veil

(Hsieh, 2013). On the other hand, while some people may share the same culture, they may not share the same worldview depending on the environment they grew up in. For instance, many Chinese people utilize Eastern medicine when treating ailments, and this seems to be a common assumption as I continue to navigate the medical field.

Anecdotally though, I have noticed that some of my Chinese peers rely more on Western medicine due to the influence of growing up in the United States so they are more used to these medications as opposed to traditional Chinese medicine.

Recognizing these nuances can be helpful in how the interpreter can best advocate for their patient. One way to practice this is to use open-ended questions that provide the patient a space to voice their concerns if they so desire: “The patient seems confused by your explanation. Can I ask the patient if they have any follow-up questions?” In doing so, the interpreter simultaneously remains impartial in terms of accurate interpretation and bolsters the patient’s ability to advocate for their health.

Incorporating Cultural Competency

As alluded to in the previous section, not only do patients with LEP frequently face language barriers in the healthcare setting, but under a broader context, they encounter other cultural barriers in healthcare settings, particularly if their background does not reflect the normative standards of American society. Language barriers in isolation are associated with poorer health outcomes, but the effect is compounded by other social determinants of health such as socioeconomic status, health literacy, immigration status, and cultural differences. In one study, researchers assessed patient outcomes in a pediatric intensive care unit (PICU) before and after an intervention that included educating health care staff on culturally competent care, efforts to employ more

bilingual staff, providing 24-hour language services, translating health documents in Spanish for patients and their families, and outreach to the Latino community to identify barriers to health care. Prior to the intervention, Latino children experienced 2.6 times higher odds of mortality; when adjusting for age, sex, insurance status, infections, and severity of illness, the odds increased to 3.7 when compared with White and Black children. Following the intervention, there was no significant difference in adjusted odds of mortality among White, Black, and Latino children (Anand, 2015; Espinoza & Derrington, 2021). These findings demonstrate the multifaceted issues that need to be addressed, such as cultural competency.

Cultural competency is a rather nebulous concept, making it difficult to characterize what interventions are most effective in addressing this issue in healthcare. Despite that, there are studies that analyzed how cultural competency are associated with better patient health outcomes. In one study, researchers assessed how perceived cultural competency of physicians can help increase colorectal cancer screening in Black patients. Cultural competency was measured using patient self-report questionnaires (e.g., “Do you feel as though doctors are aware of the views that they may have towards African-Americans?”, “Do you think that doctors possess certain skills that are needed to treat a patient from your cultural or ethnic background?”). Patients who believed their providers were culturally competent were more likely to undergo colorectal cancer screening (Dawadi et al., 2022). In the context of patients with LEP, where there is already a language barrier, it becomes that much more important for physicians to make the effort to learn more about how they can be more culturally aware.

Medical Interpreter Training

In a court setting, misinterpretations can potentially sway the jury's opinions or cause wrongful convictions so to combat these issues, the government standardized the certification process for federal court interpreters. This included both written and oral examinations that were deemed valid by third-party psychometricians and assessed by linguistic experts. In the healthcare field, there is something similar. Two national organizations, the Certification Commission for Healthcare Interpreters and the International Medical Interpreters Association, have developed a certification exam over the years. It applies to nearly 30 languages and consists of both oral and written portions. Specifically, the certification tests the individual on their medical terminology, cultural responsiveness, and accuracy of interpretations (VanderWielen, 2014).

But compared to the legal system, there is a lack of regulation of interpreter training in the healthcare setting. Several states have actually established their own certification programs for medical interpreters—Washington was one of the first to do so in the early 1990s—and was largely fueled by lawsuits regarding incompetent language services (Youdelman, 2013). Additionally, the training to become a medical interpreter vastly varies across states. Medical schools may differ in their curriculum but there is a set list of criteria that they must meet in order to be an accredited institution (e.g., students must rotate through certain specialties before graduation). Education programs for medical interpreters do not possess a consistent set of criteria that shapes their training; education programs can range from a few hours to more than 200 hours (Hasbún Avalos, Pennington, & Osterberg, 2013). Some may argue the quality of training is more important than the quantity of hours but they are equally important aspects. In the Flores

et al. (2012) study, which compared professional to ad hoc interpreters, interpreters who had over 100 hours of formal training were less likely to commit errors of potential clinical consequences compared to interpreters who possessed fewer than 100 hours of formal training. Much like how physicians across the country undergo rigorous training to obtain their license, it should be expected that medical interpreters are held to a similar regard and undergo their own standardized form of training.

CHAPTER 4

EVOLVING OUR CURRENT SYSTEM

Various aspects of how interpreter services are implemented should be addressed when identifying areas for improvement. This section will explore three primary areas: medical interpreter training, physician education, and optimizing accessibility.

Competency-based Training

As mentioned previously, there are a couple prominent certification tests that interpreters can take to be deemed qualified but the actual training these interpreters undergo is highly variable. Moving forward, it goes without saying that there should be more standardization of training programs. In the Flores et al. (2012) study, 100 hours was the minimum number of hours that showed statistically significant outcomes in terms of committing interpreting errors. However, rather than focusing on a certain number of hours that an interpreter should complete, it is more beneficial to target areas of competencies. The curricula of numerous training programs include competencies such as medical terminology, introduction to the healthcare system, intercultural communication, and basic ethics principles. Some areas may be easier than others to teach (e.g., medical terminology) whereas some may be more abstract (e.g., intercultural communication). From an urban bioethics perspective, the latter would be more valuable in bridging the cultural gap between providers and patients.

Traditionally speaking, interpreters are often viewed as a “conduit”—their purpose is to interpret word-for-word. The code of ethics for trained interpreters reinforces this concept, emphasizing the importance of remaining impartial and interpreting the original message as accurately as possible. Although it is important to

promote accuracy in order to minimize errors that can negatively impact patient care, this clause restricts the role of an interpreter to just simply interpreting. Interpreters will often share the same culture as the patient, which puts them in an advantageous position to bridge any cultural misunderstandings should they arise. In fact, studies have shown the positive impact that interpreters can play when facilitating patient-physician interactions, especially when language barriers are compounded by issues of health literacy and cultural sensitivity.

Wu et al. (2006) developed an intervention for residents where a trained in-person interpreter conducted 30-minute group sessions and individual sessions, which were centered on: facilitating communication using interpreters, teaching a few common Spanish phrases to help build rapport, and introducing cultural values and common home remedies that Latino patients might be using. Individual sessions were also held to address specific patient encounters where cultural or language issues appeared. For example, it is customary for babies to wear bracelets that are meant to protect them from the “evil eye” in Latino culture. In this study, one physician was not aware of this tradition and proceeded to take off the bracelet, warning the child’s parents that wearing jewelry was a safety risk as it could lead to strangulation or choking. After being informed of this tradition, the physician amended their approach and instead explained to the parents the potential safety risks of wearing a bracelet and suggested other ways to adorn the jewelry, such as securing it to clothing. Following the intervention, patients reported feeling more satisfied with their treatment. Having an accurate interpretation of the patient’s words is important but understanding the cultural context behind it gives the physician a more comprehensive understanding of their beliefs and the ability to

strengthen their relationship with the patient. Interpreters who are properly trained in this respect would be extremely helpful in reinforcing the physician-patient relationship and minimizing cultural misunderstandings, which can improve their health overall.

Physician Training

Throughout the literature and subsequently in this paper, there have been multiple discussions surrounding the expectations and limitations of medical interpreters.

Conversely, physicians should also be regarded the same because how they interact with interpreters and what expectations they have of them will affect patient care.

During my clinical clerkships, I frequently utilized interpreter services when interacting with my patients. At an outpatient office I rotated at, there was a 50-year-old man who came in for knee pain. His preferred language was Spanish, but he was able to speak English conversationally but it was clear that he was unable to sufficiently communicate medical concerns in English. I called our hospital's language services and had everything prepared prior to entering the room with the physician. Once the interview was underway, the interaction between the physician and doctor went relatively smoothly as we were able to obtain a detailed account of his symptoms—up until we began talking about his treatment plan. The physician relayed to the patient the possible causes of his knee pain, a few different ways to alleviate his pain, and when he should follow-up for his next appointment—all at the same time. When he finished speaking, the interpreter asked him to repeat everything he just said as he was unable to understand everything. Exasperated, the physician repeated the treatment plan albeit abridged for sake of convenience. The patient appeared somewhat confused by the much shorter explanation the second time but proceeded to verbalize his understanding of the treatment plan.

In the middle of his explanation, I had tried to signal to the physician to break up his explanation so that it would not overwhelm the interpreter. He continued at the same pace but later revealed to me that interpreters at this hospital possessed a speech-to-text program on their computers, which facilitated their efforts to accurately interpret longer sentences at a time. Even if that were true, speech-to-text software is not wholly accurate, especially when background noise and speech articulation should be accounted for. Patients have expressed similarly, stating that physicians should speak slower to allow the interpreter to accurately interpret their words (Tam et al., 2022). Not only does this allow a more precise interpretation but it also gives the patient a chance to bring up follow-up questions. In addition, physicians should also avoid using third-person language. When clarifying something with the interpreter, they should not frame it as “Can you ask the patient if they took this medication?” but instead, they should directly ask the patient, “Do you take this medication?” Otherwise, it can feel alienating to the patient and damage their relationship with the physician.

Additionally, some patients report more satisfied care if their provider was bilingual, even when compared to in-person interpreters. This is likely due to feeling a stronger connection with the provider versus having the physician rely on the interpreter and inadvertently making themselves feel distant by using phrases such as “Can you ask the patient...” or “Tell the patient that...”. Mazor et al. (2002) organized a 10-week medical Spanish course for pediatric emergency medicine physicians, and during encounters where no interpreter was used, patients felt they were listened to and overall reported greater satisfaction. From a physician standpoint, they felt more comfortable conducting simpler visits without an interpreter but would still call upon an interpreter for

more complex cases. On a related note, bilingual providers without fluent command of the patient's native language can potentially do more harm than good. Some providers may be overconfident in their abilities to speak in that language which leads to false fluency errors. However, the patient may not feel comfortable requesting for an interpreter in fear of damaging their relationship with the physician. But despite this, learning even basic phrases in the patient's language can develop better rapport with the patient, particularly if a large portion of their patient population does not speak English.

Optimizing Accessibility

Time

Through the years, the practice of establishing language services in clinical settings has certainly become more widespread but despite the availability, some research studies suggest that these services are still underutilized. There are many potential causes but there is one prevailing reason that is frequently mentioned—time constraints.

In order to maximize efficiency and revenue, there are external pressures on physicians to increase the number of patient visits at the cost of shorter visits. This is exacerbated in outpatient settings where office visits are typically set to 15-minute intervals. Interestingly, one study found that there was virtually no significant difference in time spent between English-speaking patients and non-English-speaking patients, differing only by 12 seconds (Tocher & Larson, 1999). This might be due to time constraints in general and the pressure to remain on schedule given the 20-minute appointments, which would force the physician to consciously truncate explanations so that there would be less to interpret. Variables like patient satisfaction with their care or quality of the interview were not examined, which may have provided insight into this

observation. Despite that, this study was consistent with several other studies in that the physicians perceived that they spent much more time with non-English-speaking patients compared to English-speaking patients.

Researchers who conducted a qualitative study delved deeper and were able to extract more specific sentiments of why physicians (specifically residents) underutilize interpreter services despite having access to them (Diamond et al., 2009). Convenience and “getting by” with gestures and limited language skills (e.g., knowing common words like ‘pain’ and ‘take a deep breath’) were common themes but another striking theme from these qualitative interviews was normalizing the underuse of interpreter services despite being fully aware that patients with LEP are not receiving equal care. A few residents shared their thoughts regarding this matter:

“I feel guilty... because I feel like I’m not doing my job, and it also makes me feel very frustrated and upset at how our hospitals and clinics are run – that we allow this to happen... There is a lot of sentiment that ‘well maybe [patients with LEP] shouldn’t be getting healthcare.’ I think the reason that I feel badly is because I know that I am not giving equal care to my patients.”

(Diamond et al., 2009)

Another resident tried to justify their reasoning for doing so but also admitted that it was still unfair to the patient:

“I guess I feel like someone is talking to [the patient] and getting a good history at some point... It’s okay if I kind of come in and do a little bit more of a perfunctory exam and history, knowing that I will at some point talk to them with an interpreter when time is available. But in some ways..., it does not seem all that

fair because English-speaking patients—I talk to them in their own language easily even on-call, even when I am busy.”

(Diamond et al., 2009)

So while in that one study, there may have been no substantial difference in time spent with these patients, it does not change the fact that physicians still perceive a difference—and this perception is sufficient to cause deleterious effects on the relationship with their patient and subsequently the quality of their care. As the one physician in the previous quote alluded to, they already have the perception that, if they were to get an interpreter, the interaction would extend longer than they desired. But if it were an English-speaking patient, this physician would still talk to them even if they were busy. In this situation, the English-speaking patient may bring up an issue that inadvertently spirals into a 20-minute conversation that the physician had not anticipated. Therefore, preemptively assuming that interactions with patients with LEP will take much longer is discriminating.

Implicit biases can be difficult to change but there are other more tangible measures that can be taken to alleviate time constraints, which by proxy can improve physician perceptions. The simplest theoretical answer would be to lengthen appointment times but systematic factors such as business aspects of healthcare make this difficult. However, there are other ways to help circumvent this issue. In an outpatient setting, staff should take a note of what patients will require interpreter services and begin setting these services up as it can take a while, especially if the language is less common. This is also helpful in the event that in-person interpreters are utilized because it can take nearly 20 minutes between calling for an interpreter and until they arrive (Burkle et al., 2017).

Different Modalities of Services

With the advent of technology, there are now more modalities that can be utilized for interpreter services. Currently, the most common modalities are in-person, telephone, and video (via tablet/iPad). There are several advantages and disadvantages to each of these modalities. For in-person interpreters, it offers direct face-to-face contact that is beneficial for both patients and providers but it is also the most expensive of the three. Telephonic services became more widespread because they could be provided remotely and were most cost-effective compared to in-person interpreters. However, interpreters are unable to perceive nonverbal communication as there is no face-to-face contact.

Videoconferencing has emerged as a hybrid modality as it incorporates advantages of in-person services (e.g., visual communication) and telephonic services (e.g., remote accessibility). In balancing availability and face-to-face contact, videoconferencing seems to be the most optimal of the different modalities. One downside is that there are more upfront costs; in a large hospital, multiple tablets would need to be purchased in order to cover at least each floor. However, like with any patient encounter, body language is extremely important to consider. With tablets, the interpreter would be able to monitor the patient's body language and offer input accordingly to the provider. Not only does this improve patient satisfaction, but it is also correlated with better health outcomes overall which would then lead to lower healthcare costs in the long-term.

Cost

In addition to time constraints, the financial aspect associated with language services is another barrier that is commonly brought up (Ku & Flores, 2005). While there

are federal policies in place that require institutions to provide language services, not all insurance companies will bear these costs. Medicare does not reimburse providers for these services while Medicaid programs in approximately 13 states have limited federal funds for reimbursement. The data on private insurers are more limited but it is likely they do not regularly reimburse for these services as well. Overall, only about 3% of hospitals in the US receive reimbursement for language services (US Department of Health and Human Services: Office of the Inspector General, 2010). This is especially concerning when a large portion of individuals with LEP have Medicaid or Medicare as their insurance. It should be emphasized that the federal government enforces policies that bars discrimination against individuals on the basis of language via Title VI of the Civil Rights Act but does not provide the funds to do so with its own federal agencies.

But how much do these services actually cost? A survey was conducted regarding physicians' opinions on costs surrounding language access services (Gadon, Balch, & Jacobs, 2007). Many cited they were reluctant to employ these services due to the burden of cost but only a few could actually elaborate on estimated costs and state what portion of their patients required these services. The exact amount is determined by several factors such as the type of institution, location, modality, and need for a specific language in an area. Generally speaking, the cost of telephonic services ranges around \$1.25-\$3.00 per minute while in-person services are naturally more expensive at an average range from \$45-\$150 per hour (Jacobs et al., 2018). For larger establishments with enough funding, supplying interpreter services may not be an issue. Unfortunately, community health centers or private practices that are much smaller in scale likely face more financial difficulties with providing adequate language services. From the perspective of

a cost-benefit analysis, some physicians were more open to providing these services if a substantial portion of their patients would utilize them. While cost is an important factor to consider, it is unjust to deprive these patients of services they have a right to simply due to costs. Particularly for community health centers in urban communities, they care for vulnerable populations, many of which are patients with LEP and hence disproportionately affected by lack of funding to provide comprehensive language resources. Additionally, long-term clinical consequences stemming from misinterpretation can lead to even higher costs for the patient and overall healthcare system so it is also necessary to view overall costs on a long-term basis.

Whether in the short-term or long-term, the burden of cost should not fall on physicians. The federal government should take measures to help provide the financial means for federal, state, and local agencies to offer language services. This could be in the form of directly subsidizing services or reimbursing providers through their respective insurance companies. For example, Arizona's Medicaid program organizes free interpretation services to their contracted managed care organizations at no additional cost to both the provider and the patient (Jacobs et al., 2018). Another option could be to form a partnership with an organization that contracts employees trained in medical interpretation. This provides dual benefit in terms of cost and standardization of training. Alternatively, community organizations could take part as well. There is already an established level of trust between these organizations and the community so not only would they be able to provide language assistance services, but they can also serve as a liaison between the physician and patient as they are more attuned to the needs and barriers of the community.

CHAPTER 5

CONCLUSION

This thesis investigated how interpreter services have evolved through the decades and the remaining unresolved issues that perpetuate health disparities in patients with LEP because of inadequate interpreter services. Specifically, this is due to: persistent usage of ad hoc interpreters despite overwhelming evidence that trained interpreters lead to better health outcomes, potential negative impact on agency of a patient, coexistent cultural barriers, and the absence of standardized training for medical interpreters. Both the government and institutions should take responsibility in tackling these issues and offering solutions to better optimize care for this patient population. This includes regulating training for medical interpreters, enhancing physician education on cross-cultural communication and how to better engage with interpreters, and increasing accessibility by subsidizing these services to institutions. Great strides have been made to advocate for these patients' rights but I hope this thesis illuminates the work that must still be done in continuing to provide ethical care to our patients with LEP.

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