

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Clinicians Respond to Language Barriers That Exacerbate Health Inequity?

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Abstract

Patients and families with limited English proficiency (LEP) face barriers to health care service access, experience lower quality care, and suffer worse health outcomes. LEP is an independent driver of health disparities and exacerbates other social determinants of health. Disparities due to language are particularly unjust because LEP is morally irrelevant and a source of unfair, unnecessary disadvantage. Clinicians and health care organizations have duties to intervene, which this article describes.

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Case

Dr J is a second-year emergency department (ED) resident physician who, during an unusually busy shift, sees MM, a 13-year-old girl, accompanied by her father; this is their third visit to the ED this week. MM, rubbing her belly, appears somewhat uncomfortable but in no apparent distress. After 15 minutes of fumbling with an interpreter via phone, Dr J realizes that MM and her father speak a language or dialect not available via the interpreter phone service. The 3 navigate a broken English dialogue that seems to reveal that, for 5 days, MM has had decreased appetite and abdominal pain, which was most severe yesterday and since then has improved. Dr J's physical examination of MM reveals mild, diffuse, nonspecific abdominal tenderness that seems most consistent with acute gastroenteritis. Dr J leaves MM's room and confers with Dr C about a treatment plan. Dr J returns to MM, suggesting she take acetaminophen for pain, and arranges for MM's discharge from the ED before moving on to another patient.

Two days later, MM returns to the ED with an abdominal abscess from a ruptured appendix, in septic shock, and requiring urgent surgical intervention. Dr J wonders what she might have done differently.

Commentary

MM's story is one example of the many ways in which 25 million patients in this country with limited English proficiency (LEP) experience inequitable health care,¹ sometimes with devastating outcomes. LEP makes it more difficult for patients to navigate an English-dominant health care system. In one study, Hispanics with LEP reported worse access to care and health care status and received fewer preventive services than English-speaking Hispanics.² Professional medical interpretation is effective in improving care for patients with LEP,³ but it is not always provided, despite its proven efficacy and inclusion in professional guidelines and federal and state regulations.^{2,3,4} This article examines barriers to **interpreter availability** and utilization, reviews the health impact of language barriers, and describes ethical obligations for clinicians, institutions, and health care systems related to improving care for patients and families with LEP, as well as possible policy implications.

Health Disparities for Patients With LEP

Use of professional medical interpreters is associated with decreased health disparities for patients with LEP, improved patient comprehension, fewer medical errors, and greater patient and clinician satisfaction compared to use of ad hoc interpreters, such as family members or bilingual staff.³ Federal and state regulations require health care organizations to provide trained interpreters for patients with LEP,^{4,5,6} but inadequate interpreter staffing, functional limitations of video or telephone conferencing, and interpretative inaccuracy cause persistent barriers to communication.^{7,8,9,10} As in MM's case, a professional interpreter might not be available for less common languages, dangerously limiting communication. Even when interpreters are available, some clinicians choose not to use them^{11,12} or fail to use them effectively; one recent study showed that only 23% of trainees received instruction on working with interpreters.¹⁰ When communication barriers persist, patients with LEP are less satisfied with clinical encounters,⁷ have decreased comprehension of medication instructions,^{7,9} and are less comfortable with postdischarge care regimens.^{9,10,13} Poor communication also affects clinicians' understanding of patients' complaints,^{7,13,14} which complicates diagnoses and interventions, prompts inadequate or excessive testing,⁷ and, when compared to English-proficient patients, results in differences in length of stay^{15,16} and increased morbidity and mortality.^{4,17,18}

Although LEP is an independent determinant of health outcomes among adults and children, it can overlap with other disadvantageous social determinants of health, exacerbating disparities in health care access and health outcomes. Children of parents with LEP are more likely to be uninsured, lack a medical home and specialty referrals, and experience serious errors compared to children of parents who are English proficient.¹⁷ These disparities are further exacerbated in racial and ethnic minority children¹⁸ and in children with special needs.¹⁹

Linguistic Inequity

Health disparities related to LEP are profoundly unjust because LEP is morally irrelevant. Language skills have no bearing on one's personhood, value, or rights. Clinicians and organizations have **ethical and legal obligations** to care for patients regardless of language proficiency, ethnicity, or country of origin. Additionally, LEP is an unchosen disadvantage. Immigrants to the United States are increasingly learning English,²⁰ but individuals' ability to do so varies, is complicated by numerous other factors,²¹ and has nothing to do with their need for or desert of health services. Justice requires that

patients with LEP be able to access and receive the same quality of care as English-proficient patients.

Patients with LEP experience both *distributive injustice*—poor health outcomes as a result of decreased access to care—and *relational injustice*, which involves devaluation of identities. Patients who do not speak English might be seen by some as outsiders or as “other,” which makes it dangerously easy to devalue and depersonalize them and to make damaging assumptions about unrelated attributes such as their intelligence, religion, culture, or attitudes towards health and illness. “Othering” may be encouraged by the frustrating challenges of accommodating language differences, such as the additional time required to use a professional interpreter.^{14,22} Correcting distributive injustice requires ameliorating resource maldistribution, but correcting relational injustice requires changing the structure and character of interpersonal relationships, which in turn requires changes to social and institutional norms and practices.^{23,24}

Linguistic Redress

Although data show the importance of medical interpreters’ roles in care quality, positive health outcomes, and cost savings,^{3,25} many organizations still don’t provide adequate interpreter services; only 13% of hospitals are compliant with all 4 National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health care.²⁶ Costs of interpreter services tend to be inflated and their cost effectiveness underappreciated,^{4,7,27} which might lead payers to limit reimbursement and organizations to limit services. Inconsistent, inadequate reimbursement remains a major systems-level barrier to meeting CLAS standards.⁴ Telephone and video interpreter services offer a more affordable alternative²⁸ but might not be adequate for all languages and dialects, as in MM’s case. Additional limitations to remote interpreter services include reliance on stable internet connectivity and an impersonal quality that can hamper clear communication of complex health information, especially during emotionally distressing encounters. A qualitative study found that clinicians’ choice of whether to use professional interpreting services depends on **time constraints**, subjective preferences, and therapeutic objectives.¹² Even when professional interpreting is utilized appropriately for informed consent discussions, care conferences, and daily updates, patients and families with LEP still receive a fraction of the communication that English-speaking families receive from their health care team,^{27,29} which affects the therapeutic relationship between health care team members and the patient and family, complicating shared decision making.^{22,29,30}

If distributive injustice can be redressed by increasing access to professional interpreting services, correcting relational injustice requires restructuring health care systems to develop bilingual competence and to recruit and hire more bilingual clinicians. Patient-physician non-English language concordance has been shown to improve a range of patient outcomes, including glycemic control, pain management, and cancer screening adherence.¹ Few studies compare use of trained interpreters with use of language-concordant clinicians, but those that do indicate that language concordance promotes question asking and patient empowerment and is generally preferred by patients with LEP.^{31,32} Fostering systemic changes in the health care workforce is a long-term strategy with many peripheral benefits that could ultimately prove more economically favorable than focusing on technology solutions.

Intersectionality

Patients with LEP often have other disadvantages, including limited financial resources, and their communication difficulties may be compounded by lack of formal education, vulnerability due to insecure immigration status, and mental health issues, such as anxiety and stress.^{14,18,33} Language barriers make it even more difficult for patients in English-dominant environments to advocate for themselves, ask questions, and navigate the nuances of health care systems that lead to better care.³⁴ Individual clinicians should be attuned to these overlapping vulnerabilities and can make a difference by listening to and advocating for patients.³⁵ However, meeting the complex needs of patients and families with LEP is a shared responsibility across medical teams and organizations.³⁶

Efforts to address health inequities related to language barriers should be situated in and integrated with comprehensive efforts to improve health equity.³⁷ As one example, researchers demonstrated that Latinx children in their hospital's pediatric intensive care unit (PICU) had a 3.7-fold higher risk of mortality than White and African-American children after controlling for covariates, including illness severity, age, sex, insurance status, and diagnosis.³⁸ In response, the hospital implemented a multilevel intervention, including cultural sensitivity training for clinicians, hiring additional bilingual staff, expanding the availability of trained interpreters in its emergency department and PICU, making consent forms and educational materials available in multiple languages, and expanding outreach to Latinx communities.³⁸ In the 3-year postintervention period, PICU mortality for Latinx children dropped to a level comparable to the levels of White and African-American children.³⁸ The striking improvement in outcomes achieved by this multilevel system-wide intervention suggests a moral imperative for health care organizations: first, to assess outcomes data by race, ethnicity, and language, and then to act to address those disparities.

Why are these types of assessments and interventions not more widely employed? Collection of data on race, ethnicity, and primary language is inconsistent and error prone, and perhaps this is why organizations infrequently analyze their outcomes by sociodemographic factors.³⁹ Organizational leaders may doubt the existence of racial, ethnic, or LEP inequity in their organizations, just as individual clinicians may deny the roles of implicit racial, ethnic, or LEP biases in their practices, but health care inequities and implicit bias are widespread.^{40,41} System-wide change will likely require legislation that creates financial incentives and that implements accountability for outcomes for patients with LEP.

What's Your Language Behind the Veil?

John Rawls, best known for his foundational work in justice theory, suggested that a just society could best be designed behind a "veil of ignorance," such that no stakeholders would know what place in that society they might have.⁴² Rawls' thought experiment reminds us that the circumstances in which we are born have nothing to do with our worth or whether we deserve to flourish. So, with a veil of ignorance in mind, imagine what it would be like to need health care for yourself or your spouse, child, or parent in a country where you didn't speak the language and where few health care clinicians spoke yours. Imagine how vulnerable you would feel, struggling to navigate the untranslated signage and unintelligible forms. Imagine having to wait for interpreting services to connect via video or phone—or, if you're lucky, in person—every time you wanted to communicate concerns or ask questions.

Health care organizations and clinicians have a moral imperative to reduce and ultimately eliminate the injustice experienced by patients with LEP in this country. Health care organizations should do so by responsibly staffing and clinicians by using available interpreting services and advocating for systems-level changes that make language skills an aspect of diversity rather than a barrier to quality health care. Finally, at the national and societal level, we should address the intersectional social determinants of health that add to the injustices experienced by patients with LEP, many of whom are recent immigrants.^{43,44} There will be prejudices and assumptions to overcome and financial and logistical barriers to cross. However, in this globally connected world, there is no place for linguistic isolationism. We can change the system and we should.

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