Use of Interpreter Services in the Emergency Department

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INTRODUCTION

People with limited English proficiency cannot speak, read, or write English well enough to communicate effectively in the language.[1] Approximately 8% of the US population older than 5 years have limited English proficiency; this number is increasing overall.[2] This group includes not only those whose primary language was not English but also those who have sensory impairments: diminished hearing or deafness, partial sight or blindness, or physical inability to speak. Limited English proficiency is associated with disparities in access to health care, lower health literacy, and poorer health care outcomes.[3] As of October 2015, 21% of the US population did not speak English as a first language at home. Rather, they spoke one of approximately 380 other languages or language groups. Half of them spoke English less than "very well."[4,5]

Federal law addresses this in Title VI of the Civil Rights Law of 1964 that requires recipients of federal financial assistance, including virtually all US hospitals and their emergency departments (EDs), to provide meaningful linguistic access to health care for patients with limited English proficiency. Because patients with limited English proficiency who require interpreter services use ED services significantly more often than those of similar ages not needing an interpreter,[6] emergency medical providers must be educated in the importance of interpreter services, how to use these services, and current laws and guidelines in regard to these services.[7] Emergency providers must strike a balance between the most feasible, ethical, and legal modalities of communicating with patients with limited English proficiency and advancing health equity and improving their emergency health care outcomes.

INTERPRETER USE

Interpreters facilitate communication between 2 individuals who do not speak each other's language, as opposed to translators who convert written text. Interpretation often involves not only reexpressing a spoken (or signed) message in the target language but also framing the message in an appropriate cultural and social context. In an ED setting, interpreters may both translate documents and explain conversations between providers and patients.

Clinicians often use any available person as an interpreter, even though it has been shown that using trained interpreters or interpreter services increases patient and provider satisfaction, improves informed consent, and decreases readmission rates.[8,9] Additionally, using ad hoc or untrained interpreters doubles interpretation errors compared with discussions with trained interpreters.[10] In time-sensitive ED situations, providers may need to use, at least initially, ad hoc interpreters to communicate with patients and families. However, they must do this with the understanding that using untrained interpreters often yields significantly degraded information and may result in misdiagnoses and unnecessary testing and procedures.[11] Just as an emergency physician would not, when there is time, cut short a patient relating his or her history because his or her speech is slow and halting, so also providers should use markedly inferior techniques to communicate with patients with limited English proficiency only when it is absolutely necessary.

Nevertheless, providers continue to underuse professional interpreter services even when they recognize their benefit and have the services readily available.[12] This underuse of interpreter services may exist because of insufficient training in how to work with interpreters and because no specific guidelines seem to exist for emergency health care providers to implement this requirement.[7] This article offers an ethical framework for the use of interpreter services in the ED.

LEGAL AND REGULATORY ISSUES

Case 1: Feasibility

A 55-year-old Mayan woman presents alone to the ED, demonstrating that she has anterior chest pain, but is found

to have normal vital signs and physical findings. Recently arrived from southern Mexico, she speaks only Cakchiquel and Kekchi, but not Spanish. You obtain the only available Kekchi interpreter through a local, very expensive, service. The interpreter arrives to help with the initial evaluation and explanation of what the diagnostic process will be. However, you anticipate that even if all test results are normal, the patient will be in the ED for at least 6 hours. Having recently been reminded of the federal law applying to providing ED patients with interpreters, you would like the interpreter to stay with the patient the entire time in the ED. You believe the chest pain is probably not due to a serious cause, and, as the nurse manager reminds you, the interpreter's bill is steadily increasing. *Main point: Although it is important for emergency physicians to be stewards of resources in our country's overburdened health care system, in this case, the patient's welfare remains paramount and trumps any cost considerations. If the physician encounters resistance because of cost concerns by the institution, he or she can explain that the decision to maximize patient care is supported by federal law.*

The duty for health care facilities to provide "competent" interpreter services to patients with limited English proficiency was first based on Title VI of the Civil Rights Act.[13] Many states then added a patchwork of legal obligations for health care organizations to provide language access. For instance, Massachusetts requires EDs to have interpreter services available, whereas states such as New Jersey and Rhode Island tie hospital licensure to the provision of language services. Other states have laws focusing on language access around specific medical issues or conditions (eg, reproductive health, cancers, HIV testing, mental health).[14-16]

Previous federal regulations were generally superseded in 2016 by changes to section 1557 of the Patient Protection and Affordable Care Act. This regulation establishes the standards required of language services, clarifies permissibility of ad hoc interpreters, mandates technical quality in tele-interpreting services, and requires notice of language service availability in the 15 most common languages spoken by individuals with limited English proficiency in a given state.[17-20] Health care facilities must now hire interpreters[17] who are not merely competent but also "qualified," meaning those who adhere to interpreter ethics principles, have demonstrated proficiency in speaking and understanding both English and another language, and are able to interpret effectively and impartially to and from English and another language.

Case 2: Ad Hoc Interpreters

When a Spanish-speaking middle-aged man presents with chest pain, you ask one of the Hispanic unit assistants to help interpret. She speaks Spanish at home and says that she is comfortable interpreting. As you are taking the history through the interpreter, a visiting Mexican medical student comes into the room to watch and listen. When you are done, he quietly mentions that most of the "interpretation" was incorrect. *Main point: Speaking limited conversational Spanish at home or with friends does not qualify an individual to be a medical interpreter. Being able to work in that capacity may increase status or pay, so the individual may be reluctant to admit that he or she does not know what is being said either because of a patient's unusual accent or vocabulary.*

This legislation also generally forbids the use of ad hoc interpreters, such as family members or friends accompanying the patient, or unqualified multilingual staff, with 2 exceptions. The first exception is if an individual with limited English proficiency specifically requests that an accompanying adult serve as an interpreter, as long as the accompanying adult agrees, and reliance on his or her interpreting is appropriate to the situation. The second exception allows ad hoc interpreters (including accompanying children) in "an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter…immediately available."[19] One poignant example of this was experienced by one of the authors of this article: a deaf Nepalese patient who communicated with the physician through a professional Nepalese interpreter speaking by telephone to her 7-year-old daughter, who was then using Nepalese sign language with her mother.

Case 3: Making Excuses (No Time): American Sign Language as a Special Case

A 28-year-old profoundly deaf woman arrives alone in the ED with abdominal pain. In the interest of expedience, you communicate with her by writing on a notepad. She demonstrates "pain" and points to her umbilicus. By using the notepad, you ask about symptoms of nausea, vomiting, diarrhea, and constipation. She indicates no, but then gestures that she has been vomiting. Other written questions about her condition generate somewhat contradictory answers. You decide to order a CBC count, comprehensive metabolic panel, lipase test, a pregnancy test, urinalysis, and a computed tomography (CT) scan of the abdomen. During her stay, you determine that she is pregnant and cancel the CT scan. Several hours later, you give her a diagnosis of a viable intrauterine pregnancy at 9 weeks' gestation. You provide referral to an obstetrician and medications to control her nausea. *Main point: Deaf patients use American Sign Language as their first language and English as a second language.*[14] *Many are not proficient in*

English. The syntax of American Sign Language differs from that of English. Patients are unlikely to understand common medical terms, such as "diarrhea" and "constipation." Overordering when a language barrier exists may lead to increased costs and longer ED stays. The physician errs in using written communication and not offering an American Sign Language interpreter.

Section 1557 of the Patient Protection and Affordable Care Act also reinforces the legal requirement of health care facilities to have interpreting services available for deaf or hard-of-hearing patients that was originally established by the Americans With Disabilities Act of 1990. The core obligation of health care providers in the Americans With Disabilities Act is to provide "effective communication with individuals with disabilities" and patient companions who are themselves disabled.[21,22] The provisions thus depend on what is required to provide effective communication in a specific context. In the ED, real-time interpretation is required, although this may range from written notes to more resource-intensive solutions such as video remote interpreting services or in-person interpreters. Ad hoc interpreting is not an acceptable substitute except in cases of true time-sensitive emergencies or patient preference.[23]

DECISIONMAKING GUIDELINES (WHO SHOULD OFFER OR REQUEST AN INTERPRETER—AND WHEN?)

Decisionmaking in regard to who can ask for an interpreter and when it should be done varies with state laws and the specific circumstances. However, there is significant legal jeopardy attached to not providing appropriate services for a patient with limited English proficiency. Therefore, once a patient or a family member either expresses or demonstrates discomfort with his or her ability to communicate with the staff in an out-of-hospital, clinic, or hospital setting, anyone should be able to activate the interpreter service process. This includes the patient, a family member, and any employee who needs to communicate with the patient or family for any reason.[24]

Case 4: Provider Overconfidence

You are caring for a 56-year-old Spanish-speaking man who complains of an ear problem. You have recently completed a medical Spanish course and believe that it has improved your ability to communicate in Spanish with your patients. You conduct the history of present illness and review of symptoms in Spanish. Your examination reveals no evidence of otitis media or externa, but you decide to treat the patient with decongestants, given his symptoms. When the patient's English-speaking daughter arrives, she asks you about the patient's dizziness and headache that he has had for 2 days. *Main point: Overconfidence in one's command of a second language may lead to misunderstandings, mistranslations, and treatment errors.*

A problem with communication is when any party to the communication cannot express or understand ideas clearly (language or cultural issues) or when the patient or family is more comfortable with a native speaker. For example:

- Is a patient having difficulties understanding the health care providers because of differing languages or deafness?
- Is a health care provider having difficulty understanding the patient because of differing languages, speech defects, or patient deafness?
- Are health care providers having difficulty understanding one another because of differing languages?

The nature of the interpreter service will depend on the complexity and seriousness of the communication, the length of time that interpretation will be needed, and what is available within the required time frame.

All parties in the communication must have the option of changing interpreters if the interpretation does not seem to be going smoothly; if the patient, family, or health care provider is not reacting as expected; if the parties are not receiving the information they need; or if one of the participants understands enough of the language to know that the interpretation is not adequate or correct.

MODALITIES

Multiple modalities are used for health care interpreting, including the face-to-face interpreter hired explicitly for his or her language services. There are various degrees of training, certification, and qualifications, which can be state or institution dependent. A permutation of this is the dual-role employee, who is a member of the health care staff in a noninterpreting capacity but also identified (and tested for proficiency) and willing to serve as an interpreter when needed. Additionally, many providers rely on teleconference or video-conference service lines. These are fee-based services that provide a library of languages available on demand. Patients with hearing impairment are unique in that they are restricted to either face-to-face or video interpreting. Finally, and only when permitted by law, ad hoc interpreters are used when untrained individuals (such as family, friends, or bilingual staff) provide the interpreting service.[25-27]

Working with interpreters is a skill that requires specific knowledge. For example, the interpreter should sit slightly

to the side and behind the patient, so the conversation or eye contact is between the patient and clinician, as depicted in the Figure.

SPECIAL SITUATIONS (3-WAY INTERPRETING, DIALECTS, AND AMERICAN SIGN LANGUAGE)

Case 5: Emergency Situations

A middle-aged Vietnamese man is brought to the ED trauma bay after a motor vehicle crash. He has trauma to the chest, as well as a left lower extremity deformity. He does not seem to speak English. His vital signs are deteriorating rapidly. You recognize the seriousness of his presentation and attempt to explain the need for treatment. Because there is a large Vietnamese population in your area, you use what limited language skills you have in Vietnamese to explain "emergency" and "operation." The patient is sedated, intubated, and taken to the operating room. While the patient is recovering in the ICU, the staff makes use of a video interpretation device to explain the patient's condition to him and his family. *Main point: In time-sensitive emergencies, you must do the best you can in the patient's best interest. This may include using clinical staff with limited language abilities, computer-based applications, or telephone-accessed interpreters.*

Although ideally professional interpretation services should be offered to all patients with limited English proficiency, special circumstances may arise in which physicians simply must do their best in the patient's best interest. The use of ad hoc interpreters should be discouraged, yet may be necessary at times. For example, one of the authors worked in an area serving many Guatemalan immigrants who spoke a Mayan dialect, rather than Spanish. Professional interpretive services could not offer an interpreter in this circumstance. It was necessary to use an ad hoc interpreter who could translate from the Mayan dialect to Spanish, and then another interpreter for Spanish to English. Although not ideal, this proved to be the best scenario, given the circumstances.

Another problem is that many different dialects and accents exist for all languages used across large areas (including English). For example, Crossman et al[28] showed that their in-person Spanish interpreter patient cohort scored worse on quality and satisfaction than both the bilingual and telephonic cohorts. However, they used a Peruvian medical interpreter, whereas 92% of the in-person cohort was Mexican.

Interactions with deaf and hard-of-hearing patients present unique issues with which physicians may be unfamiliar. Profoundly deaf people compose a minority population within the deaf community. The deaf use American Sign Language as their primary language, which differs from English in its syntax, idioms, and grammar.[29] Although physicians may be tempted to use written communication with their deaf patients, they should remember that English is their second language. Furthermore, deaf patients often have low reading levels

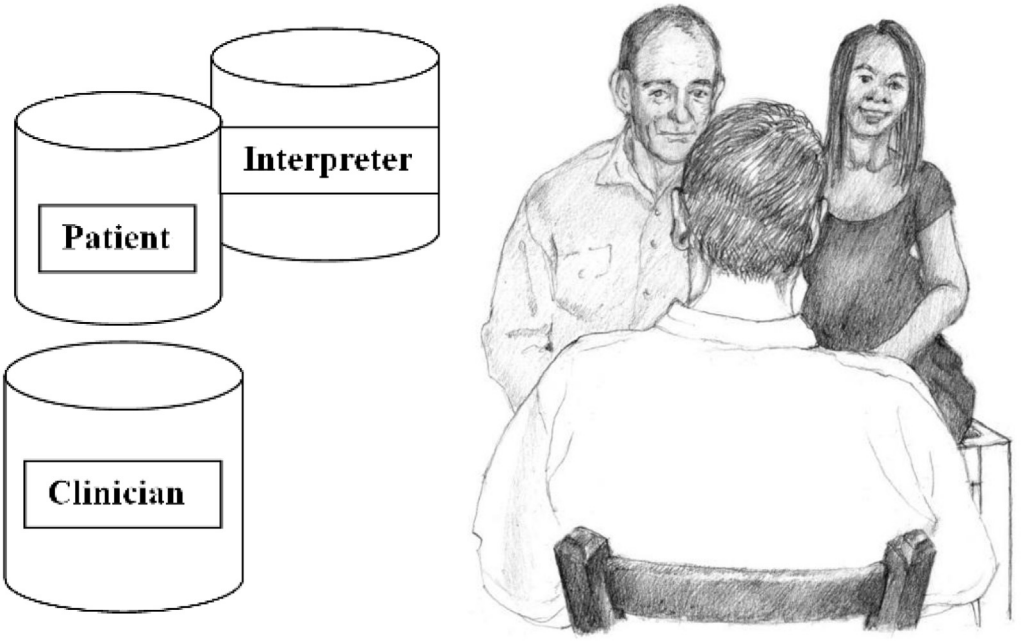

Figure. Proper positioning of the clinician, patient, and interpreter. Used with permission: Iserson K. *The Global Healthcare Volunteer's Handbook: What You Need to Know Before You Go*. Tucson, AZ: Galen Press; 2014.

and write in nonstandard English.[30] They may be unfamiliar with common medical terms, such as "nausea" or "allergic."[31]

An example provided by Meador and Zazove[30] illustrates miscommunication with written English. A physician wrote, "You may need surgery," but the patient understood this to mean "you need surgery in May." The English "you may need surgery" would be signed "you maybe need surgery," whereas "you need surgery in May" would be signed "you (in) May need surgery."[32] It is better to offer the services of an American Sign Language interpreter to avoid miscommunication, whenever possible.

INDUSTRY INFLUENCE

Many companies have offered tele-interpreter services for decades. Rapid advances now provide the opportunity to use handheld devices for interpretation, although for now they may be inadequate for most ED interpretation. When one works with interpretation companies, ethical concerns include, but are not limited to, conflicts of interest. The Council of Medical Specialties has a Code for Interactions with Companies, which 14 medical specialty societies, including the American College of Emergency Physicians, have endorsed.[33] Its preamble includes a commitment to "transparency and integrity" that should guide members of these individual societies well. Of course, this does not necessarily extend to the American Hospital Association members who make contracts with companies on the American College of Emergency Physicians' members' behalf. It could, though, at least guide the interaction of individuals and groups engaged in research on this topic.

CONCLUSIONS

Effective communication is the cornerstone of the patient-provider therapeutic relationship; language barriers have the potential to compromise all aspects of medical care. Throughout the world, language barriers adversely affect public health, including access to care, quality of care, health information comprehension, and health outcomes.[1,2] In the United States, as of 2013, more than 25 million persons had limited English proficiency, making quality medical interpreter services an important public health issue that affects a large proportion of our diverse population.[34]

From a public health perspective, improvements in medical interpreter services involve educating physicians on the importance, use, and policies that guide the use of interpreter services; working through their communities to give persons with limited English proficiency knowledge of their rights; partnering with communities and services to determine and support local needs; and developing policies on all levels to support education, development, and funding of medical interpreter services. The engagement of all stakeholders is crucial as policies are developed and subsequently implemented.

In summary, we offer the following recommendations:

- Offer a professional interpreter if practical and available when a patient has either limited English proficiency or hearing impairment.
- Choose a modality of interpretation among in-person, video, or telephone that best suits the clinical situation.
- Allow use of an ad hoc interpreter only if the patient prefers or the emergency is so extreme that a professional interpreter is impractical.

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