

# How to Appeal to the Evidence When Justifying Language Services

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This document is divided into three sections:

- 1) Part 1 is a list of basic arguments that are often used to undermine the value or importance of language services. Each point is matched with compelling evidence to counter the argument.
- 2) Part 2 suggests other reasons to support language services.
- 3) Part 3 offers a briefly annotated bibliography of relevant research.

## INTRODUCTION

### Medical Research Evidence Grading

Various kinds of evidence, including medical research, are included in this document. As a general guideline that does not purport to scientific accuracy but is offered here as a guide for the reader unfamiliar with medical research, here is one way to approach evaluating the quality of the evidence that you consider presenting to others. The categories A, B, C and D below refer to quality of evidence in descending order, so that a higher grade, such as A, suggests the evidence is more powerful because it is more likely to have scientific validity. Many of the studies quoted in this document are included just below as examples of these four categories:

- A. Evidence from reviews of the literature and meta-analysis.  
(e.g., Timmins, 2002; Flores, 2005; Karliner *et al* 2007).
- B. Evidence from controlled trials, randomized or nonrandomized, with results that consistently support a specific action (e.g., assessment, intervention or treatment).  
(e.g., Cohen *et al*, 2005; Cunningham *et al*, 2008; Garcia *et al*, 2004; Graham *et al*, 2008; Jacobs *et al*, 2004; Jacobs *et al*, 2007; Jacobs *et al*, 2001; Leng *et al*, 2007; Moraliest *et al*, 2006)
- C. Evidence from observational studies (e.g., correlational, descriptive studies) or controlled trials with inconsistent results.  
(e.g., Bernstein *et al*, 2002; Bischoff *et al*, 2008; Burbano O'Leary, 2003; Divi *et al*, 2007; Flores *et al*, 2003; Gany *et al*, 2007; Gerrish *et al*, 2004 Green *et al*, 2005; Kuo *et al*, 2007, McCabe *et al*, 2006; Norris *et al*, 2005; Novak *et al*. 2005; Ramirez *et al*, 2008; Schenker *et al*, 2007; Wilson *et al*, 2005)
- D. Evidence from expert opinion or multiple case reports.  
(e.g., Bethel *et al*, 2006; Flores, 2006; Ginsburg, 2007; Hablamos Juntos, 2007b; Ku, 2006; Ku and Flores, 2005; Lesage, 2006; Nailon, 2006; Partida, 2007)

Other types of information cited below include policy documents, laws, standards, accreditation information, manuals and guides, issue briefs and other valuable sources of compelling information. While at best these types of documents and references might be considered "D" category evidence, they are often more practical than medical research in convincing hostile skeptics about the value of language services. Furthermore, such references may address issues of legal obligation or liability.

## **PART 1: ARGUMENTS AGAINST LANGUAGE SERVICES**

### ***ARGUMENT #1: “THEY SHOULD LEARN ENGLISH”***

Many Americans today voice the strong sentiment that immigrants have a responsibility to learn English and that language barriers should not be the problem of American institutions, including hospitals. Here are the facts:

- No one learns a new language overnight.
- Health emergencies occur 24/7, regardless of length of stay in the U.S.
- About 12.4 percent of the U.S. population is foreign born, and nearly 55 million U.S. residents speak a language other than English at home; about 24 million residents speak English “less than very well” and may be considered LEP. (U.S. Census Bureau)
- More than 300 languages are spoken in the U.S. (U.S. Census Bureau)

*Suggested references:*

U.S. Census Bureau at [www.census.gov](http://www.census.gov) (especially American FactFinder)  
The language map of the Modern Languages Association at  
[http://www.mla.org/map\\_single](http://www.mla.org/map_single)

### **But how long does it take to learn English?**

No study agrees on exactly how long it takes to learn any language. In general, a growing body of research strongly suggests that:

- It takes several years (perhaps four to seven) of ongoing study and practice to become proficient in any language. English is no easier to learn than other languages.
- College-educated learners who are literate and proficient in their native language learn English far more quickly than those who are less educated.
- Those who speak a language within the same family as English (such as German) find it much faster to acquire English than those in distant language families (such as Japanese).
- The U.S. government estimates that 3,000 to 5,000 hours of study and practice are required for adults to become reasonably fluent in nearly any language.

*Suggested references:*

Thomas and Collier (1997): a classic, seminal study on how long it takes to learn a language.  
<http://www.ncela.gwu.edu/pubs/issuebriefs/ib5.htm>  
The U.S. Interagency Language Roundtable: [www.govtilr.org/](http://www.govtilr.org/)

**Myth:** Immigrants do not wish to learn English.

**Fact:** Most immigrants are eager to learn English, and most do (Tse 2001), but they face many obstacles, especially the poor, the less educated and the elderly (multiple sources). In addition, 89 percent of Latinos report that English is necessary to succeed (Hakimsadah & Cohn, 2007) while only two percent of foreign-born Latinos feel that it is not important to teach English to immigrant children (Pew Hispanic Center, 2006).

### **So why don't all immigrants learn English eventually?**

- A number must work two to three jobs to support their family because immigrants

overall, particularly those from certain regions such as Central America and Mexico, earn less money than native-born Americans (U.S. Census Bureau).

- Free English classes often have long waiting lists; other classes may not be affordable. Massachusetts classes in 2006 had a waiting list of 17,000 immigrants (Pope, 2006).
- The following points may lack scientific evidence but they are WIDELY reported by organizations that serve immigrants and refugees:
  - Many LEP residents lack transportation to English classes.
  - It may be difficult for LEP residents to locate appropriate English classes, and parents often find it difficult to afford child care while they attend class.
  - LEP workers who speak the same language may find it harder to practice English.
  - Those illiterate in their own language have far greater difficulty learning English.
  - Many older immigrants face a challenge: it becomes progressively more difficult to learn as we grow older, particularly for the elderly, who are often isolated or ill.
  - Those with disabilities may also have obstacles to studying English.
  - Many immigrants lack basic education, so any type of study is more difficult.

*Suggested references:* See Tse, L. (2001) *Why Don't They Learn English: Separating Fact from Fallacy in the U.S. Language Debate*. For a longitudinal study about contemporary immigrants as they learn English, see Portes and Rumbaut (2001). Many recent relevant media articles address this subject, e.g., Cabrera (2006).

#### ***ARGUMENT #2: "I CAN GET BY WITH MY SPANISH"***

Many health care providers believe that using their high school Spanish with patients will be quick, inexpensive and convenient. Others feel they can get by using a few simple words in the client's language combined with hand gestures.

The evidence says otherwise. LANGUAGE BARRIERS HAVE A NEGATIVE IMPACT. Individual hospitals and other health care organizations who test their "bilingual" providers and employees discover that anywhere from 20 percent to 40 percent or more of bilingual staff tested for language proficiency fail to demonstrate that they are sufficiently proficient in both languages to provide services safely (see e.g., Moreno *et al*, 2007). Yet the majority of health care organizations still do not test bilingual employees for language skills, failing to realize that using *quality* language assistance (trained interpreters, bilingual providers tested for proficiency and accurate, appropriate document translation) helps to:

- Reduce health care disparities/increase access to health care
  - Jacobs *et al* (2001): Disparities in certain tests and immunizations between LEP and English-proficient patients were reduced after implementation of language services.
  - Jacobs *et al* (2004): LEP patients with interpreters received more preventive services, made more office visits, and had more prescriptions written and filled.
  - Hablamos Juntos (2007b): Patients with language barriers are less likely to have a regular source of care. Interpreter services increase use of preventive services and reduce hospitalization rates.
  - Kuo *et al* (2007): Patients with LEP confronted multiple barriers to health care access.
  - LeSage (2006): Addressing language barriers enhances access to health care
  - Morales *et al* (2006): Use of interpreters reduced White-Hispanic disparities in reports of care by up to 28 percent and White-API disparities by as much as 21 percent. Using more interpreters could reduce racial/ethnic disparities and improve health plan performance.
  - Timmins (2002): Not speaking English is associated with decreased access to care.

- Enhance quality of care
  - Kuo *et al* (2007): Reimbursement for language services may improve quality of care.
  - Flores (2005): LEP patients' quality of care was inferior; however, using trained medical interpreters or bilingual providers positively affected quality of care.
  - Gerrish *et al* (2004): Using untrained interpreters and nurses adversely affected the quality of care; many untrained nurses used family to interpret.
  - Ginsburg (2007): Of 2,002 internal medicine physicians surveyed, 92 percent agree it is somewhat (31 percent) or much more difficult (61 percent) to treat LEP patients without language services.
  - Green *et al* (2005): Perceived quality of interpreters influenced perceived quality of care.
  - Karliner *et al* (2007): Use of professional interpreters is associated with improved clinical care and appears to raise the quality of care as high as that for fluent English speakers.
  - Timmins *et al* (2002): Language barriers adversely impacted quality of care.
- Reduce errors (clinical or interpreter)
  - Cohen *et al* (2005): Language barriers contributed to medical errors
  - Flores (2006): Untrained/ad hoc interpreters more likely than trained interpreters to make errors with adverse medical consequences.
  - Flores *et al*, 2003: Errors by untrained interpreters are very common; most errors have potential clinical consequences.
  - Gany *et al* (2007): Using remote simultaneous medical interpreters reduced errors.
  - Flores (2005): More interpreter errors occurred with untrained interpreters.
  - Hablamos Juntos (2007b): Family/friends who interpret often misinterpret/omit doctor's questions and patients' complaints. They fail to mention side effects and make errors with clinical consequences.
  - Wilson *et al* (2005): Limited English proficiency is a barrier to medical comprehension and increases the risk of adverse medication reactions.
- Improve patient health outcomes
  - Cohen *et al*, (2005): Language barriers increased the number of adverse medical events.
  - Divi *et al* (2007): Using interpreters reduced adverse events (which ranged from moderate harm to death)
  - Flores (2005): Using trained interpreters or bilingual providers optimized outcomes.
  - Timmins (2002): Language was a risk factor for adverse outcomes.

### ***ARGUMENT #3 COSTS: "HOW ARE WE SUPPOSED TO PAY FOR THAT?"***

Across the country, health care organizations insist that they lack the funding to pay for interpreters. However, the costs of *not* providing language services are rarely considered. In addition, other factors that add to costs, such as the increased numbers of medical tests performed in the absence of interpreters, are often ignored.

Ultimately quality language services can:

- Reduce the cost of services
  - Bernstein *et al* (2002): Use of trained interpreters was associated with reduced ED return rate, increased clinic utilization and lower 30-day charges without any increase in length of stay or cost of visit.
  - Graham *et al* (2008): LEP patients with professional medical interpreters were 94% more likely to use primary care and 78% less likely to use ED than English proficient patients, resulting in lower cost and more access to preventive care.
  - Jacobs *et al* (2004): Cost of interpreter services was \$279 per patient, seen as a financially viable cost, esp. since patients received significantly more preventive services.

- Jacobs *et al* (2007): Enhanced interpreter services did not increase costs; using language concordant physicians reduced return ED visits and costs.
- Reduce the cost of patient tests and/or ensure appropriate tests ordered
  - Ramirez *et al* 2008: LEP had different rates of diagnostic testing than English speakers.
- Make services affordable
  - Flores (2006): U.S. Office of Management and Budget estimated that it would cost, on average, only \$4.04 (0.5 percent) more per physician visit to provide all U.S. LEP patients with appropriate language services for ED, inpatient, outpatient, and dental.
  - Ku (2006). Medicare can develop a viable mechanism for reimbursing language services.
  - NHeLP/APIA HF (2007) Webinar on how to get Medicaid pay for language services.
  - Youdelman (2007) and National Health Law Program (2007) discuss Medicaid and SCHIP reimbursement models for interpreters.
- Clinical/human costs outweigh or have an impact on fiscal costs
  - Ku and Flores (2005): Interpreter services reduce costs by reducing medical errors.
  - Hablamos Juntos (2007): Affordable language services help to avoid dangerous clinical consequences of language barriers.

#### ***ARGUMENT #4 “INTERPRETERS GET IN THE WAY OF DIRECT COMMUNICATION.”***

Many providers feel that using interpreters feels inconvenient, awkward and problematic. On the contrary. Though a few studies find the use of interpreters reduces direct communication between patients and providers, that is generally only true for untrained interpreters. The overwhelming body of research so far suggests that using *trained, professional medical interpreters* who adhere to a code of ethics greatly enhances communication with LEP patients.

*Failing* to use trained interpreters, in fact, severely undermines the quality of patient-provider communication according to research literature supported by the voices of experts and large numbers of health services across the country specialized in services to immigrants. *Trained, professional* medical interpreters can:

- Enhance patient-provider communication
  - Bethel *et al* (2006): Language and culture greatly affect communication
  - Burbano O’Leary (2003): Residents did not use interpreters with LEP mothers and thereby compromised effective communication.
  - Cunningham *et al* (2008) LEP mothers felt pediatricians understood them if interpreters were provided; Ramirez *et al*, 2008: LEP patients received less explanation/follow-up;
  - Bischoff *et al* (2008): Using an interpreter reduced gender-related communication barriers.
  - Flores *et al* (2003): Using *trained* interpreters/bilingual providers provides optimal communication with LEP patients.
  - Flores (2006): *Untrained/ad hoc* interpreters lack knowledge of terminology, inhibit discussions on sensitive issues and may conflict with patient wishes and priorities.
  - Garcia *et al* (2004): Hospital-trained interpreters are a valuable resource to facilitate communication, superior to other interpreter resources.
  - Hablamos Juntos (2007b): Patients who need but don’t get interpreters often report a poor understanding of their diagnosis and treatment.
  - Nailon (2006): Culturally competent care requires accurate communication; nurses need training on how to work with interpreters.
  - Norris *et al* (2005): Interpreter recommendations enhanced quality of communication to end-of-life patients.
  - Novak *et al* (2005): Patients with language barriers do not understand vital information from clinicians; their clinicians also fail to obtain needed information.
  - Schenker *et al* (2007): LEP patients less likely to have documented informed consent;

- McCabe *et al* (2006): Professionally trained interpreters were more accurate.
- Increase patient satisfaction
  - Cunningham *et al* (2008): LEP mothers wanted interpreters.
  - Flores (2005): Trained medical interpreters/bilingual providers positively affect LEP patients' satisfaction.
  - Ramirez *et al* (2008): LEP patients without interpreters were less satisfied.

### ***ARGUMENT #5 "IT'S NOT MY PROBLEM"***

Language barriers are everyone's problem. Federal, state and local laws make this clear. So do risk management and liability concerns coupled with professional guidelines and accreditation requirements and competency standards. Let's consider each of these areas.

## **Language Access laws**

### ***Federal laws***

Any health care organizations that receive federal funding, and many that receive state funding, are required by law to take reasonable steps to ensure meaningful access to their programs by LEP patients. They are usually required to provide qualified language assistance such as interpreters and the translation (in many cases) of vital documents. For details on the legal obligations of health care organizations, see the following::

- For information on Title VI of the Civil Right of 1964, go to [www.lep.gov](http://www.lep.gov).
- For the U.S. Department of Health and Human Services LEP policy guidance document on Title VI, go to [www.usdoj.gov/crt/cor/lep/hhsrevisedlepguidance.pdf](http://www.usdoj.gov/crt/cor/lep/hhsrevisedlepguidance.pdf).
- For information about Executive Order 13166 and Title VI: [www.lep.gov/13166/eo13166.html](http://www.lep.gov/13166/eo13166.html) or Commonly Asked Questions and Answers Regarding Executive Order 13166 at [www.healthlaw.org/library/topics.1333-Cultural\\_and\\_Linguistic\\_Access\\_to\\_Health\\_Care](http://www.healthlaw.org/library/topics.1333-Cultural_and_Linguistic_Access_to_Health_Care)

See also:

- **S. 1833/H.R. 3459: The Healthcare Equality and Accountability Access Act of 2003**  
[http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108\\_cong\\_bills&docid=f:s1833is.txt](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_cong_bills&docid=f:s1833is.txt)

For an overview of the legal issues, see

- *Ensuring Linguistic Access in Health Care Settings: Legal Rights & Responsibilities*, 2003 at:  
<http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=22093>
- Chen *et al* (2007) at  
<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2150609#CR1>.

### ***State laws:***

Today a vast number of state laws touch on language services in health care. For a 2008 compendium of such laws in the U.S., published by National Health Law Program, go to [www.healthlaw.org/library/item.174993](http://www.healthlaw.org/library/item.174993).

Some of these laws provide detailed guidance; others are more general. California has the largest number of such laws. Laws affecting services in mental health have been enacted in Arizona, Massachusetts and Illinois. Legislation enacted in Colorado, Massachusetts and New Jersey also links facility licensure to the provision of language services. Ten states have enacted laws addressing language access for older LEP

individuals, while Illinois requires health care facilities to offer language services. To see examples of such laws, go to:

- California: AB 801 (2003) Cultural and Linguistic Competency of Physicians Act:  
[www.healthlaw.org/library/item.177018-AB\\_801\\_2003\\_Cultural\\_and\\_Linguistic\\_Competency\\_of\\_Physicians\\_Act](http://www.healthlaw.org/library/item.177018-AB_801_2003_Cultural_and_Linguistic_Competency_of_Physicians_Act)
- Massachusetts Emergency Room Interpreter Law (2004):  
[www.mass.gov/dph/omh/interp/interpreter.htm](http://www.mass.gov/dph/omh/interp/interpreter.htm)

Many states have also enacted laws that require cultural competency training for doctors, training that typically addresses language barriers. For more information about “cultural competence laws” go to [www.thinkculturalhealth.org](http://www.thinkculturalhealth.org) and click on “Cultural Competency Legislation” on the left. Below are a few examples of such laws from

[http://www.qualityinteractions.org/cultural\\_competence/cc\\_statelicreqs.html](http://www.qualityinteractions.org/cultural_competence/cc_statelicreqs.html):

State	Bill Number	Sponsor/Committee	Status
Washington	ESB 6194	Senator Rosa Franklin	Passed by Governor 3-27-06
California	AB 1195	Assemblyman Joe Coto	Passed 10-06-05
New Jersey	SB 144	Senator Wayne R. Bryant	Effective: 4-07-08
Illinois	SB0522	Senator Iris Y. Martinez	Session sine die
Arizona	SB 1468	Senator Richard Miranda	In Committee
Ohio	SB68	Senator Ray Miller and Senator Shirley Smith	Introduced 2/20/2007, Currently in committee
Joint Commission I		<a href="http://www.jointcommission.org">www.jointcommission.org</a>	

### ***Municipal laws***

Some municipal laws also exist, e.g., Oakland, CA (which in 2001 claimed to be the first city to enact such a law: see <http://www.oaklandnet.com/government/Equalaccess/English/Flyer.pdf>), New York City ([http://www.nyc.gov/html/imm/downloads/pdf/language\\_access\\_law.pdf](http://www.nyc.gov/html/imm/downloads/pdf/language_access_law.pdf)) and Washington, D.C. (<http://www.ohr.washingtondc.gov/ohr/cwp/view,a,3,q,636135,ohrNav,%7C30953%7C.asp>).

### **NATIONAL AND STATE STANDARDS**

In addition to the landmark federal Culturally and Linguistically Appropriate Services Standards (<http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15>), a growing number of states have adopted cultural and linguistic competence training standards for health care providers that includes language access concerns. See the table above for examples.

### **LIABILITY**

The CLAS Standards 2000 on p. 24 states that “The Mutual Insurance Corp of America sees enough of a link between these factors [cultural and linguistic barriers to health care] and liability that it offers a discount on malpractice insurance to physicians who participate in cultural competence training.” In general, hospital and other organizations may be legally liable for medical errors caused by language barriers if the organization failed to take reasonable steps to provide qualified language assistance.

Two decades ago, Miami paramedics defined "intoxicado" as "high on drugs" instead of "nauseous." This led to a series of emergency room miscommunications and a malpractice settlement that could amount to \$71 million over the lifetime of a former high school athlete. William Ramirez was 18 and able-bodied before he collapsed; when he awakened, he was quadriplegic. More than 36 hours reportedly passed without treatment for what really ailed him -- an acute subdural hematoma and other brain injuries (Abramson 2006)

Kelvin Quan (2002) offers a model that lists a number of compliance and liability concerns:

<b>A Case for Linguistic Competence</b>	
<b>Corporate value</b>	<b>Compliance concerns</b>
Enhances provider ability to diagnose	Medicaid Contract
Decreases medication errors	Healthy Families (SCHIP) Contract Requirement
Increases patient compliance & follow up	Title VI Requirement
Decreases "no-show" appointments	DHHS OMH CLAS Standards
May avoid costlier services later	DHHS OCR Guidelines
Promotes quality care	Federal Executive Guidelines
Improved patient satisfaction/member retention	Tort Liability
Enhanced community perception in target markets	State laws

In addition, a growing number of organizations that support large health care organizations recognize the complexity of these liability issues. See, for example, the 2008 article, *Reduce liability risk when treating non-English speaking patients. Make sure you comply with antidiscrimination laws to avert legal problems* online at [http://goliath.ecnext.com/coms2/gi\\_0199-7768842/Reduce-liability-risk-when-treating.html](http://goliath.ecnext.com/coms2/gi_0199-7768842/Reduce-liability-risk-when-treating.html)

#### **Legal cases:**

For the following articles, made available by the National Health Law Program on their website, go to [http://www.healthlaw.org/library/topics.1333-Cultural\\_and\\_Linguistic\\_Access\\_to\\_Health\\_Care](http://www.healthlaw.org/library/topics.1333-Cultural_and_Linguistic_Access_to_Health_Care). Examples of articles available include:

- Resolution Agreement between the Office for Civil Rights (HHS) and Maine Medical Center (2001)
- Revised NC Voluntary Compliance Agreement (2004)
- Resolution Agreement between the New York Attorney General and Faxton St. Luke's Health Care (2004)
- Resolution Agreement between the New York Attorney General and St. Elizabeth Medical Center (2004)
- St. Vincents' Agreement with Attorney General re Language Assistance (2006)
- Reyes v. Thompson Agreement of Settlement and Consent Order (1991)
- Supreme Court *Opinion* in Sandoval Case (April 2001)
- Supreme Court Dissent in Sandoval Case (April 2001)

Today, details of dramatic legal settlements from the lack of medical interpreting make health industry rounds, but untold numbers of lawsuits based on such interpreting errors settle out of court, away from public scrutiny. Most malpractice insurance companies report that they don't track claims based on linguistic errors and prefer to offer seminars on language access to insured health care providers rather than pressure them to offer medical interpreting (Abramson 2006).

#### **Accreditation**

Some accreditation agencies urgently promote linguistically and culturally competent services. Work by The Joint Commission, in particular has caught the attention of many large health care organizations concerned with issues of accreditation, reputation and quality services. (See <http://www.jointcommission.org/NR/rdonlyres/88C2C901-6E4E-4570-95D8-B49BD7F756CF/0/HLCOneSizeFinal.pdf>). Such organizations include:

- The National Committee for Quality Assurance in health care now offers a new CLAS standards award for managed care plans at [www.ncqa.org/communications/news/CLAS.htm](http://www.ncqa.org/communications/news/CLAS.htm)
- The Liaison Committee on Medical Education (LCME, [www.lcme.org](http://www.lcme.org))
- The Accreditation Council for Graduate Medical Education (ACGME, <http://www.acgme.org/outcome/comp/compFull.asp#5>).
- Association of American Medical Colleges
- The Joint Commission ([www.jointcommission.org](http://www.jointcommission.org))

Many organizations have also developed policies to support equal access to health care and/or linguistic and cultural competence in health care, including health disparity centers, academic institutions, government agencies and alliances, among others. See also the HHS Office of Minority Health's online training for up to 9 Continuing Medical Education (CME), Continuing Education (CE) credits or contact hours (<https://cccm.thinkculturalhealth.org>), for nurse practitioners, physicians, physician assistants and pharmacists. A number of professional associations have also developed guidelines. To name just a few:

- American Academy of Family Physicians
- American College of Emergency Physicians
- American College of Obstetricians and Gynecologists
- American College of Physicians
- American Medical Student Association
- American Nurses Association
- American Academy of Pediatrics
- American Psychiatric Association
- American Psychological Association
- National Association of Social Workers
- Society of Teachers of Family Medicine

Government organizations involved in health care have also issued some form of cultural and linguistic competence guidelines that address language services, including SAMHSA (for Managed Care Mental Health Services) and state governments such as the New York State Office of Mental Health. Sometimes concepts of linguistic competence are incorporated into core documents such as a professional code of ethics or strategic goals.

## **PART II OTHER REASONS TO SUPPORT LANGUAGE SERVICES**

Know your audience. There are many sound reasons to support language services, but which reasons would interest the person YOU are addressing?

Some managers focus on costs. Some health care providers care about patient outcomes. CEO's may be looking at the big picture. Ultimately, each hostile skeptic you encounter is a human being. You are the person who knows that human being. Look at the list below for other documents, arguments or approaches that are best suited to convincing the individual person you are speaking to about the value of language assistance.

**ARGUMENT: "WE CAN'T DO IT. IT'S TOO COMPLICATED."**

### **RESOURCES**

No, it's not that hard! Today, there are truly a wealth of valuable resources available to help health care organizations begin or expand language service programs! Here are just a few:

- Get it from the horse's mouth—the Joint Commission! Practical, timely information. *One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations*, 2008:

<http://www.jointcommission.org/NR/rdonlyres/88C2C901-6E4E-4570-95D8-B49BD7F756CF/0/HLCOneSizeFinal.pdf>

- A toolkit on how to get interpreter services running smoothly. *Language Services Action Kit: Interpreter Services in Health Care Settings for People with Limited English Proficiency*, 2003: <http://www.jointogether.org/resources/language-services-action-kit.html>
- This toolkit focuses on simple, practical tips: *Better Communication, Better Care: Provider Tools to Care for Diverse Populations*, 2004: [http://www.iceforhealth.org/library/documents/ICE\\_C&L\\_Provider\\_Tool\\_Kit.10-06.pdf](http://www.iceforhealth.org/library/documents/ICE_C&L_Provider_Tool_Kit.10-06.pdf)
- For hospitals who want to see how other hospitals are managing the situation: *Hospital Language Services for Patients with Limited English Proficiency: Results from a National Survey*, 2006: <http://www.hret.org/hret/language-services/>
- Assessing where you stand: *Addressing Language and Culture: A Practice Assessment for Health Care Professionals*, 2006. <http://www.familydocs.org/files/AddressingLanguageandCulture.pdf>
- From California Primary Care Association comes a report on what works: *Providing Health Care to Limited English Proficient (LEP) Patients: A Manual of Promising Practices*, 2004 at [www.hhs.gov/ocr/lep/ProvidingHealthcareToLEP.pdf](http://www.hhs.gov/ocr/lep/ProvidingHealthcareToLEP.pdf)
- Mincing no words! *Straight Talk: Model Hospital Policies and Procedures on Language Access*, 2005: <http://www.safetynetinstitute.org/publications/documents/StraightTalkFinal.pdf>
- Getting health staff trained: *A Guide to Incorporating Cultural Competency into Health Professionals' Education and Training*, 2005: [http://www.healthlaw.org/library/topics.1333-Cultural\\_and\\_Linguistic\\_Access\\_to\\_Health\\_Care](http://www.healthlaw.org/library/topics.1333-Cultural_and_Linguistic_Access_to_Health_Care)
- How to make it happen: *Promising Practices for Patient-Centered Communication with Vulnerable Populations: Examples from Eight Hospitals*, 2006: [http://www.commonwealthfund.org/usr\\_doc/Wynia\\_promisingpracticespatientcentered\\_947.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/Wynia_promisingpracticespatientcentered_947.pdf?section=4039)

#### **ARGUMENT: “THEY’RE ALL LATE OR NO-SHOWS, SO WE CAN’T SCHEDULE INTERPRETERS.”**

- Using language services reduces late appointments or no-shows, see e.g.,
  - Hablamos Juntos (2007b): Patients with language barriers are more likely to miss appointments.

#### **ARGUMENT: “MY BOSS/MANAGER/CEO IS HEARTLESS.”**

Tell stories! Stories about bad things that happen (without interpreters/translations) or good things that happen (with quality language assistance) are both effective. Many of the articles quoted in this document include little stories you can use. Here are two examples:

Thirteen-year-old Gricelda Zamora was like many children whose parents speak limited English: she served as her family’s interpreter. When she developed severe abdominal pain, her parents took her to the hospital. Unfortunately, Gricelda was too sick to interpret for herself, and the hospital did not provide an interpreter. After a night of observation, her Spanish-speaking parents were told, without the aid of an interpreter, to bring her back immediately if her symptoms worsened, and otherwise to follow up with a doctor in three days. However, what her parents understood from the conversation was that they should wait three days to see the doctor. After two days, with Gricelda’s condition deteriorating, they felt they could no longer wait, and rushed her back to the emergency department. Doctors discovered she had a ruptured appendix. She was airlifted to a nearby medical center in Phoenix, where she died a few hours later.

From Ask Doctor Alice: Is the Doctor In? Not if You Don’t Speak English. *Asian Journal Publications*, 2004; p. 23, quoted in Chen *et al* (2007), p. 1

A 12-year-old Latino boy arrived at a Boston emergency department with dizziness and a headache. The patient, whom I'll call Raul, had limited proficiency in English; his mother spoke no English, and the attending physician spoke little Spanish. No medical interpreter was available, so Raul acted as his own interpreter. His mother described his symptoms:

*“La semana pasada a el le dio mucho mareo y no tenía fiebre ni nada, y la familia por parte de papá todos padecen de diabetes.”* (Last week, he had a lot of dizziness, and he didn't have fever or anything, and his dad's family all suffer from diabetes.) “Uh hum,” replied the physician. The mother went on. *“A mí me da miedo porque el lo que estaba mareado, mareado, mareado y no tenía fiebre ni nada.”* (I'm scared because he's dizzy, dizzy, dizzy, and he didn't have fever or anything.) Turning to Raul, the physician asked, “OK, so she's saying you look kind of yellow, is that what she's saying?” Raul interpreted for his mother: *“Es que si me vi amarillo?”* (Is it that I looked yellow?) *“Estaba como mareado, como pálido”* (You were like dizzy, like pale), his mother replied. Raul turned back to the doctor. “Like I was like paralyzed, something like that,” he said.

If Raul received inappropriate care owing to his misinterpretation, he would not be alone. One interpreter, mistranslating for a nurse practitioner, told the mother of a seven-year-old girl with otitis media to put (oral) amoxicillin “in the ears.” In another case, a Spanish-speaking woman told a resident that her two-year old had “hit herself” when she fell off her tricycle; the resident misinterpreted two words, understood the fracture to have resulted from abuse, and contacted the Department of Social Services (DSS). DSS sent a worker who, without an interpreter present, had the mother sign over custody of her two children. (Flores, 2006, p. 229)

### **ARGUMENT: “I CAN'T FIND AN INTERPRETER!!!”**

Resources abound to help agencies find the interpreters they need. Perhaps the best national resource currently available is the *Language Services Resource Guide for Health Care Providers*, 2006, available at: <http://www.healthlaw.org/library/item.118835->

[Language\\_Services\\_Resource\\_Guide\\_for\\_Health\\_Care\\_Providers\\_Oct\\_06](http://www.healthlaw.org/library/item.118835-Language_Services_Resource_Guide_for_Health_Care_Providers_Oct_06). Other sources include:

- Local nonprofit agencies that serve immigrants or specific ethnic groups such as Latinos and Asian Americans/Pacific Islanders..
- State refugee resettlement offices.
- Local affiliates of national agencies such as International Rescue Committee, Lutheran International Refugee Services, Catholic Relief Services, Church World Services, etc.
- State or municipal offices on Hispanic affairs and/or Asian Americans/Pacific islanders.
- State court interpreter registries, which list interpreter by language and locality and are often publicly available.
- The website of the American Translators Association has a publicly available database at [www.atianet.org](http://www.atianet.org) of member interpreters and translators specifying the type of work they do.

### **PART 3: A PRACTICAL BIBLIOGRAPHY**

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[http://news.ncmonline.com/news/view\\_article.html?article\\_id=a2ccf312598b4820d1d0ac25265fc91e](http://news.ncmonline.com/news/view_article.html?article_id=a2ccf312598b4820d1d0ac25265fc91e)

This news article mentions the famous story of how one misinterpreted Spanish word—“intoxicado” led a hospital to pay a settlement of \$71 million.

Bethell, C., Simpson, L., Read, D., Sobo, E.J., Vitucci, J., Latzke, B., Hedges, S., Kurtin, P.S. (2006) Quality and safety of hospital care for children from Spanish-speaking families with limited English

proficiency. *Journal for Healthcare Quality*. 28(3): Web Exclusive: W3-2-W3-16.

All aspects of quality care and patient-provider communication can be affected by language and culture. These problems also affect safety of care.

Bernstein, J., Bernstein, E., Dave, A., Hardt, E., James, T., Linden, J., Mitchell P., Oishi, T., Safi C. (2002). Trained medical interpreters in the emergency department: effects on services, subsequent charges, and follow-up. *Journal of Immigrant Health*. 4(4): 171-6. (11 ref)

Use of trained interpreters was associated with increased intensity of ED services, reduced ED return rate, increased clinic utilization, and lower 30-day charges, without any simultaneous increase in length of stay or cost of visit.

Bischoff, A., Hudelson, P., Bovier, P.A. (2008). Doctor-patient gender concordance and patient satisfaction in interpreter-mediated consultations: an exploratory study. *Journal of Travel Medicine*. 15(1):1-5.

The presence of a professional interpreter may reduce gender-related communication barriers during medical encounters with foreign-language-speaking patients; 363 consultations were included in the analysis.

Burbano O'Leary, S.M. (2003). The truth about language barriers: one residency program's experience. *Pediatrics*, 111(5 Pt 1):e569-73.

Residents rarely use professional interpreters with LEP patients. Instead, they tend to rely on their own inadequate language skills, impose on their Spanish-proficient colleagues, or avoid communication with Spanish-speaking families with LEP.

Cabrera, Y. (2006). Immigrants are eager to learn English. *The Orange County Register*, July 4, 2006, [http://www.ocregister.com/ocregister/news/atoz/article\\_1201782.php](http://www.ocregister.com/ocregister/news/atoz/article_1201782.php)

An example of a growing number of news articles that show immigrants making every effort to learn English.

Chen, A.H., Youdelman, M.K. and Brooks, J. (2007). The legal framework for language access in health care settings: Title VI and beyond. *Journal of General Internal Medicine*, 22 Suppl:362-367.

A clear overview of the legal issues surrounding language access by recognized experts.

Cohen, A.L., Rivara, F., Marcuse, E.K., McPhillips, H., Davis, R. (2005). Are language barriers associated with serious medical events in hospitalized pediatric patients? *Pediatrics*, 116(3): 575-9.

Language barriers may lead to medical errors by impeding patient-provider communication. Spanish-speaking patients whose families have a language barrier seem to have a significantly increased risk for serious medical events during pediatric hospitalization compared with patients whose families do not have a language barrier.

Cunningham H., Cushman L.F., Akuete-Penn C., Meyer D.D. (2008). Satisfaction with telephonic interpreters in pediatric care. *Journal of the National Medical Association*. 100(4):429-34.

LEP mothers who used telephonic interpretation reported significantly greater communication and overall satisfaction compared to mothers in routine care. Pediatric residents substantially underestimated their patients' desire to use telephonic interpreters.

Divi, C., Koss, R.G., Schmaltz, M.S. Loeb, J.M. (2007) Patients with Limited English Experience More Serious Errors. *International Journal for Quality in Health Care*, 19(2):60-67

Adverse event data on English speaking patients and LEP patients were collected from six hospitals over 7 months and classified using the National Quality Forum endorsed Patient Safety Event Taxonomy. About 49.1% of LEP patient adverse events involved physical harm vs. 29.5% of adverse events for patients who speak English; 46.8% of LEP patient adverse events had a level of harm ranging from *moderate temporary harm to death*, compared with 24.4% for English

speaking patients.

Flores G. (2005). The impact of medical interpreter services on the quality of health care: a systematic review. *Medical Care Research & Review*. 62(3):255-99.

Five database searches yielded 2,640 citations and a final database of 36 articles, after applying exclusion criteria. Multiple studies document that quality of care is compromised when LEP patients need but do not get interpreters. LEP patients' quality of care is inferior, and more interpreter errors occur with untrained ad hoc interpreters. Inadequate interpreter services can have serious consequences for patients with mental disorders. Trained professional interpreters and bilingual health care providers positively affect LEP patients' satisfaction, quality of care, and outcomes. Evidence suggests that optimal communication, patient satisfaction, and outcomes and the fewest interpreter errors occur when LEP patients have access to trained professional interpreters or bilingual providers.

Flores, G. (2006). Language barriers to health care in the United States. *New England Journal of Medicine*, 355(2):229-231.

An overview that includes compelling personal stories to share.

Flores, G., Laws, M.B., Mayo, S.J., Zuckerman, B., Abreu, M., Medina, L., Hardt, E.J. (2003). Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics*, 111(1): 6-14.

Errors in medical interpretation are common, averaging 31 per clinical encounter, and omissions are the most frequent type. Most errors have potential clinical consequences, and those committed by ad hoc interpreters are significantly more likely to have potential clinical consequences than those committed by hospital interpreters.

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income limited English proficient adults. *Journal of Immigrant Health*, 10(3):207-17.

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A valuable look at many factors that suggest providing linguistically and culturally competent services is less costly—and far more risky—than failing to provide it.

Ramirez D., Engel K.G., Tang T.S (2008). Language interpreter utilization in the emergency department setting: a clinical review. *Journal of Health Care for the Poor & Underserved*. 19(2):352-62.

Compared with-English speaking patients, LEP patients report less satisfaction with medical encounters, have different rates of diagnostic testing, and receive less explanation and follow-up. Although professional interpretation has been associated with improvements in patient satisfaction, communication,

and health care access, these services are largely under-utilized in ED settings. Reliance on untrained ad hoc interpreters, perceived time and labor associated with obtaining and working with an interpreter, and costs of implementing professional interpreter services serve as barriers to implementation and utilization.

Schenker, Y., Wang, F., Selig, S.J., Ng, R., Fernandez, A. (2007) The impact of language barriers on documentation of informed consent at a hospital with on-site interpreter services. *Journal of General Internal Medicine* 22 Suppl 2:294-9

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