



The High Costs of Language Barriers in Medical Malpractice



School of
Public Health

UNIVERSITY OF CALIFORNIA, BERKELEY

NHeLP
NATIONAL HEALTH LAW PROGRAM

Authors

Kelvin Quan, JD MPH, Assistant Dean of the University of California, Berkeley School of Public Health, served as the Project Director and primary author and Jessica Lynch, 2011 MPH candidate, served as Graduate Research Assistant.

Editors

Sarah Lichtman Spector, JD, Staff Attorney, and Mara Youdelman, JD, LLM, Senior Attorney, of the National Health Law Program, served as editors for the report.

Special Thanks

The authors would also like to thank Thomas Lonner, Ph.D., whose comments greatly strengthened this report.

IRB Approval

IRB Approval for this project was received from the University of California, Berkeley.

Support

This publication was made possible with the generous support of The California Endowment.

Table of Contents

Introduction 2
Analysis 4
The Seminal Case of the Failure to Provide Competent Interpretation 4
Failure to Provide Competent Interpreters. 5
Defective Informed Consent and Lack of Written Translations 8
Inadequate Documentation	12
Allegations of Discrimination	13
Conclusions	15
Recommendations for Malpractice Carriers	15
Recommendations for Providers	16
Appendix 1 — Methodology	18
Appendix 2 — Contingency Fee Structure of Malpractice Cases	20

Introduction

“[T]he failure of the doctor and the facility to provide a professional medical interpreter was a substantial factor in causing [patient]’s death.”

—Statement of an expert witness in the Tran malpractice case.¹

In 2008, according to the U.S. Census, nearly 20% of people living in the United States spoke a language other than English at home. In the Western U.S., the figure rises to 32%.² In California, the number is over twice the national figure at 42.4%. Of those populations, 44% (U.S.) to 47% (California) speak English less than very well. These individuals are considered “limited English proficient” (LEP) and would likely need assistance communicating with health care providers in health care settings.³

Patients and health care providers alike must have ready access to competent language services (including interpreting of oral communications and translating written materials), because language barriers increase avoidable risks to patient safety. A provider’s focus should be to ensure that the patient and provider can communicate effectively in the same language.

Health care providers report that language difficulties and inadequate funding of language services are major barriers to LEP individuals’ access to health care and a serious threat to the quality of the care they receive.⁴ Authorities such as the Institute of Medicine (IOM) and the Joint Commission agree. The Joint Commission notes that “[i]ndividuals whose care is inhibited due to a communication barrier. . . may be at risk for poor outcomes.”⁵ The IOM noted, in its report *Unequal Treatment*, “Language barriers may affect the delivery of adequate care through poor exchange of information, loss of important cultural information, misunderstanding of physician instruction, poor shared decision-making, or ethical compromises (e.g. difficulty obtaining informed consent; [citation omitted]).”⁶

This study analyzed medical malpractice claims⁷ of a malpractice carrier that insures in four states (the Carrier) to identify when language barriers may have resulted in harm to the patient. It was conducted by the University of California at Berkeley, School of Public Health pursuant to a contract with the National Health Law Program (NHLP).⁸ The purpose of the study was to identify malpractice claims in which language barriers may have had a direct or indirect impact on the patient’s health outcome.

1 See below, Tran case at p. 3.

2 U.S. Census Bureau 2006-2008 American Community Survey 3-Year Estimates; The Western States are California, Oregon, Washington, Idaho, Nevada, Arizona, Utah, Wyoming, Montana, Colorado, New Mexico, Alaska and Hawaii.

3 U.S. Census Bureau 2006-2008 American Community Survey 3-Year Estimates. Persons who speak English less than very well is the standard used to determine if some is Limited English Proficient (LEP). We use the standard of persons who speak English “less than very well” for purposes of discussing their health care given the complexity of medical terminology and the importance of the issues that are that are discussed.

4 Kaiser Commission on Medicaid and the Uninsured, *Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami, and Houston* at ii-iii (Feb. 2001) (prepared by Leighton Ku and Alyse Freilich, The Urban Institute, Washington, DC). See also Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health* 71–72 (2002) (describing recent survey finding 51% of providers believed patients did not adhere to treatment because of culture or language but 56% reported no cultural competency training).

5 Wilson-Stronks, Lee, Cordero, Kopp, and Galvez, *One Size Does Not Fit All: Meeting the Needs of Diverse Populations*, Oakbrook Terrace, IL: The Joint Commission (2008), available at http://www.jointcommission.org/PatientSafety/HLC/one_size_meeting_need_of_diverse_populations.htm.

6 Smedley, Stith, and Nelson, editors, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Board on Health Science Policy, Institute of Medicine, at 17, (2002), available at <http://www.iom.edu/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx>.

7 Every medical malpractice lawsuit is based upon two basic elements - liability and damages. There must be a determination that the health care provider was liable (i.e., legally responsible) through negligence for the patient’s injury or poor medical outcome. Once liability is established, the plaintiff might be entitled to damages. There are three types of damages: 1) compensation for past and future medical costs, incurred as a result of the injury; 2) lost wages; and 3) pain and suffering (which is limited to \$250,000 in California).

8 The National Health Law Program (NHLP) seeks to improve health care for America’s working and unemployed poor, minorities, the elderly and people with disabilities. <http://www.healthlaw.org/>.

In thirty-five claims⁹ – 2.5% of the Carrier's total claims reviewed – the Carrier paid \$2,289,000 in damages or settlements and \$2,793,800 in legal fees. These claims highlight several aspects related to the failure to provide appropriate language services:

- The cases resulted in many patients suffering death and irreparable harm. Two children and three adults died. In one case, the deceased child was used as an interpreter before suffering respiratory arrest. In another, the deceased child's 16-year-old sibling was used as the interpreter. One patient was rendered comatose, one underwent a leg amputation, and a child suffered major organ damage.
- In 32 of the 35 cases, the health care providers did not use competent interpreters.¹⁰ In 12 cases, family members or friends were used as interpreters, including minor children in two cases.
- Twelve of the claims involved the failure to translate important documents such as informed consent forms and discharge instructions.
- Nearly all the cases demonstrated poor documentation of a patient's limited English proficiency or the need for an interpreter (as well as documentation of other basic information).¹¹ Examples of poor documentation included: no recording of language spoken; no recording of a provider having offered or used a competent interpreter, or use of an interpreter brought by a patient; recording of language spoken in different places in the medical records; recording of language needs differently by providers at the same institution; and no recording of whether the physician spoke to the patient in the patient's primary language. None of the cases' medical records documented that the health care provider offered a competent interpreter, which was declined by the patient.
- Some cases illustrated how health care providers and lawyers alike presumed that the apparent concordance of race, ethnicity or language between patient and physician ensured effective communication. For example, one medical team incorrectly assumed that when the patient and physician were – or appeared to be – of the same ethnic background, they must have shared the same language. Sometimes the medical records of the same patient later showed the lack of language concordance between patient and physician.

This problem was more common with Asian patients because many providers tend to aggregate the diverse Asian languages and cultures as “Asian” or “Chinese.” Providers were confused about the distinctions between Cantonese, Mandarin, other Chinese dialects and Vietnamese; and the nationalities, races, and cultures of patients from Hong Kong, Taiwan, Vietnam and Macau. Even if the patient was correctly identified as Chinese, providers failed to consider the possibility of further barriers manifested in different language dialects – Mandarin, Cantonese or other Chinese dialect.¹² None of the cases noted any provider asking the patient for clarification of their primary language.

9 Researchers identified 35 closed claims that involved significant language barriers from January 2005 through May 2009. Most claims reviewed were litigated while a smaller portion of the cases were settled without litigation. See Appendix 1 for more information on methodology.

10 This report uses the term “competent interpreter” to include professional interpreters (including in-person, telephonic or video) or bilingual staff who serve as interpreters. A competent interpreter is someone who is knowledgeable in issues related to ethics, standards of practice, confidentiality, and the role of the interpreter, as well as one who is proficient in English and the non-English language, including specialized medical terminology in both languages. For more information on competent interpreters, see p.18-19 of the Conclusion section. One should not assume that a bilingual individual can be a competent interpreter if they do not possess the skills listed above. Further, family members, friends, and especially minor children are often not competent interpreters because they do not interpret accurately and are prone to omissions, additions, substitutions, and volunteered answers. For more information, see *Why Relying on Family Members, Friends and Children as Interpreters is Dangerous and Should be Discouraged*, available at <http://www.healthlaw.org>.

11 Physicians are taught that if an activity is not documented in the medical record, it did not happen. In reliance on this practice, if the medical chart did not show that a professional interpreter was used, this report concluded that none was used. In contrast, some medical charts specified those occasions in which patients, their family members – including minor children – and friends were used to interpret. The documentation of an offer of oral interpretation and the patient's response is required for Medi-Cal and Healthy Families (the California Children's Health Insurance Program) beneficiaries and increasingly by other authorities.

12 Although written Chinese can be read by speakers of numerous Chinese dialects, spoken Chinese varies greatly. The most common dialects spoken in the U.S. are Cantonese, Toisanese, Mandarin, Shanghainese and Chiu Chou. The differences between these dialects can be as distinct from one another as among Spanish, French and Italian.

Analysis

This analysis describes 35 cases and groups them by theme related to the provision of language services. The themes include failure to provide competent oral interpretation; failure to provide written translations of important documents, e.g. informed consent forms and discharge instructions; inadequate documentation; and allegations of discrimination. Note that the cases were assigned fictitious patient names to protect the patient's identities. All other details of the cases are factual.

The Seminal Case of the Failure to Provide Competent Interpretation

In the Tran case, the patient, a 9-year old Vietnamese girl, died from a reaction to the drug Reglan.¹³ Her parents primarily spoke Vietnamese, yet no competent interpreter was used throughout Ms. Tran's encounters with the medical system. Instead, records show that the 9-year-old patient and her 16-year-old brother served as interpreters during the medical encounter. The physician and hospital in this case settled for \$200,000 in aggregate, while the Carrier paid legal fees of \$140,000. The case demonstrates the failure to provide language access on multiple fronts – the failure to utilize a competent interpreter, the use of a minor child as an interpreter, and the lack of a translated informed consent form.

Clinically, the patient had an infection with a rapid onset and great severity, low blood volume, and a heart attack, which ultimately resulted in her death. The emergency room physician misdiagnosed the patient's condition as gastroenteritis. He admitted that he failed to advise the patient's parents of Reglan's side effects or warnings, or that Reglan was not recommended for pediatric use.

In the lawsuit, the Trans' attorney retained an expert witness who was a professional interpreter. After reviewing the medical records, the expert witness testified that:

Conducting the communications without a professional medical interpreter failed to meet the standards of care applicable for the physician and the facility. The effect is [that] she did not receive the care she should have. The parents were not able to adequately understand and address her medical needs. In my opinion, the failure of the doctor and the facility to provide a professional medical interpreter was a substantial factor in causing [patient]'s death.

The reasons for not using family members, friends and particularly minor children as interpreters are widely recognized.¹⁴ The expert witness further testified about the harm when a minor child is asked to be an interpreter for parents:

Upon arriving to the hospital, the need for the services of an interpreter should have been identified. This could have been done by asking the parents if an interpreter was needed. Even if the parents would have declined the service, the hospital should not have allowed a family member, in this situation a minor, to serve as an interpreter. This has been included in research involving the importance of a trained professional interpreter and the effects of utilizing an ad hoc interpreter. Although the patient spoke English, being a nine year old child, ultimately, the parents would be the ones asked to provide informed consent, would need to understand the further care and treatment of the child, and ask about information

13 Reglan is a drug used to prevent the nausea and vomiting caused by cancer chemotherapy, diabetic neuropathy, gastroesophageal reflux and similar conditions.

14 As noted above (see footnote 10), family members, friends, and especially minor children are often not competent interpreters because they do not interpret accurately and are prone to omissions, additions, substitutions and volunteered answers. See, e.g., Flores, et al., *Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters*, *Pediatrics*, Vol. 111, No. 1 (January 2003); and McQuillan & Tse, *Child Language Brokering in Linguistic Minority Communities: Effects on Cultural Interaction, Cognition, and Literacy*, *Language and Education*, 9(3) at 195-215 (1995). See also, *Why Relying on Family Members, Friends and Children as Interpreters is Dangerous and Should be Discouraged*, available at <http://www.healthlaw.org>.

regarding medications and possible consequences. Therefore, direct communication between the parents and provider was key during the entire encounter.

...The nuances of the medical issues presented in English, needed to be transmitted into the primary language of the parents in order to provide them with the opportunity of making an informed decision regarding their child's care. This, of course, after they have been provided with the means of presenting their questions. Culturally, it is not uncommon for patients to defer to the health care provider when it comes to instructions regarding treatment, taking the instructions given by the provider to the letter. An interpreter has the cultural acuity needed to facilitate the communication involving medical terms and nuances of the languages involved.¹⁵

The emergency room physician said that he discussed with the Trans that they should bring their daughter back to the emergency room if side effects arose. The written Hospital Discharge Instructions included warnings to “call your doctor if the patient has diarrhea... Return immediately to ER if ...” All documents from the outpatient and emergency room visits were in English – none were translated into Vietnamese. These documents were signed by the parents and counter-signed by the hospital nurse. The hospital did not provide competent oral interpreters nor translation of important written documents.

Failure to Provide Competent Interpreters

Thirty-two of the 35 claims had no documentation that the physician or hospital used a competent interpreter for the patient or patient's family. In 12 cases, family members or friends were used as interpreters. In two of these twelve cases, the interpreters were minor children. In the Tran case, the physician used the patient's 16-year-old brother to interpret and describe to his parents how his 9-year-old sister died from a heart attack.¹⁶ Some of the additional cases in which interpreters were not provided are described below.

The patient in the Lin case was a 17-year-old high school girl born in Taiwan. She was hit with a tennis racquet two weeks prior to going to the hospital emergency room with a fever lasting three days and an increasingly painful headache. The physician used the patient herself as the interpreter. She had to interpret the physician's comments about her condition until she went into respiratory arrest. She was transferred to the Intensive Care Unit and taken to surgery where it was confirmed that she had a brain abscess. She died the following day. The girl's parents alleged that a delayed response by the treating physician led to a delay in the surgery for her brain abscess.

15 Letter from the expert witness, a professional interpreter, to the plaintiff's attorney to advise of her professional opinion regarding the impact that a competent interpreter may have had in this case.

16 For more discussion of problems raised when family members, friends, and minor children are used as interpreters, see the Tran case, p.4-5 and Conclusions section, p.15, and footnotes 10 and 14.

Comparative Analysis of Cases

Chart 1: Amount of Damages Paid

35 detailed cases	Damages Paid by Carrier
\$0	25
\$1 to \$100,000	4
\$100,001 to \$200,000	2
\$200,001 or more	4

Chart 2: Amount of Legal Fees Paid

35 detailed cases	Legal Expenses Paid by Carrier
\$0 to \$50,000	17
\$50,001 to \$100,000	11
\$100,001 to \$200,000	5
\$200,001 or \$400,000	0
\$400,001 or more	2

The defendant later recalled that before the patient's respiratory arrest, he spoke with her, her mother, stepfather and her godmother, and the girl "acted as the interpreter" for her parents. Not only was the minor daughter acting as the interpreter for her parents, she was also interpreting complex medical terminology, *and* the life-threatening conditions she was communicating were her own. After the patient suffered the respiratory arrest, a family friend acted as the interpreter for the parents. The Carrier paid \$74,000 to the defense attorney but no damages for the alleged medical negligence.

In the Chan case, the 59-year-old male patient suffered from an overdose of a chemotherapy drug that resulted in a toxic reaction causing heart and systemic damage. The case was brought against Mr. Chan's oncologist. The medical records had conflicting information that the patient and his wife were from Hong Kong, Saigon or Macau, and they spoke Cantonese or Vietnamese. It was clear from the records, however, that the patient and his wife had a difficult time with English, and that a different physician relied on the patient's adult son as an interpreter to understand and convey the diagnosis, treatment and care to his parents. The case settled, and the Carrier paid legal fees of \$27,000 in defense of the oncologist and \$105,000 to the patient.

In the Jimenez case, the Spanish-speaking patient presented at the hospital with complaints of dizziness, nausea and vomiting. Her past medical history included kidney infection and chronic abdominal pain. But before Mrs. Jimenez could be treated, she went into cardiac arrest. As a result of untreated fluid in the brain, she suffered irreversible brain damage, became comatose and lapsed into a vegetative state. The emergency room physician wrote in the medical record, "Contact is the daughter, who speaks English and is translating tonight...by telephone." The medical record noted that one of daughters requested another neurologist because the treating neurologist allegedly did not answer the family's questions. The family alleged that the patient did not receive adequate medical care prior to cardiac arrest.

Based on the lack of documentation, no competent interpreter was used at any point during the medical encounter. Although the Carrier's insureds — the hospitalists¹⁷ — were not found liable, other medical malpractice carriers paid over \$2 million in damages on behalf of the co-defendants, the hospital and five other physicians. And the Carrier paid over \$125,000 in legal fees to defend the hospitalists.

The Agas case concerned a 56-year-old Filipina patient, who had an allergic reaction to the medication Toradol, which is prescribed for kidney stones. Patients known to be allergic to Motrin are not given Toradol. The Emergency Medical Technician (EMT) report stated that the patient was allergic to Motrin, but the emergency room physician failed to read the patient's allergy in the EMT report. The patient did not expressly inform the emergency room physician, who wrote in the medical chart that "the patient denied allergy at this time." During the lawsuit, he said that if the patient had disclosed to him that she was allergic to Motrin, he would not have ordered Toradol. He argued that the patient was responsible for not disclosing her allergy directly to the physician. Notably, the emergency room physician's notes recognized that his ability to take a complete and accurate history and physical was limited by the language barrier. If a competent interpreter had been used, the patient's allergy might have been reported directly to the emergency room physician, in addition to being documented in the EMT's report. No damages were paid, but the Carrier paid over \$10,000 in legal fees.

In the Ramos case, a 7-year-old boy's LEP father and grandparents brought him to his pediatrician a number of times over the span of several weeks. The father spoke very little English and had very little formal education. Both grandparents spoke only Spanish and required a court interpreter at the deposition. The child presented with a fever and sore throat, which the pediatrician misdiagnosed as strep. That misdiagnosis delayed the correct diagnosis of Kawasaki's disease, which resulted in damage to the child's organs. Based on the lack of documentation in the medical records, the pediatrician did not use an interpreter to communicate with the father or grandparents. The case was settled, and the Carrier paid the patient's family \$50,000 in damages and the defense attorney over \$50,000 for legal fees.

In the Sokolov case, the patient was a 78-year-old, Russian-speaking woman who was recovering from a stroke when she was transferred from one hospital to another. The defendant internist was assigned to oversee her general medical issues after the transfer. The internist recalled that because the patient did not speak English, she could not describe the quality nor severity of her pain when he evaluated her. However, he recalled

17 A "hospitalist" is a specialty physician whose focus is inpatient hospital medicine. The practical effect of the hospitalist is to act as a case manager, due to the tremendous growth in medical knowledge and need to coordinate medications and diagnostic tests.

that she was holding her leg at the time. One of the nurses acted as an informal interpreter at different times during the patient's hospital stay, but she was not present during the exam. The morning after the exam, the internist discovered the patient's leg was cold below the knee and, according to the nurses' notes, had been since the middle of the night. Subsequently, the leg had to be amputated. With the use of an interpreter, the patient could likely have described the severity of her pain and the lack of sensation that might have led to a timely intervention. Although the lawsuit was dismissed and no damages paid, the Carrier paid legal fees of \$37,000.

The Hernandez case demonstrated the failure to clearly understand English-only discharge instructions and ineffective oral communication in spite of the presence of numerous bilingual providers. The patient presented with a workplace injury after heavy metal rollers fell on his foot. He later alleged that the physician negligently treated his injury thereby causing the amputation of his lower leg. The patient spoke both English and Spanish at home. The patient's wife was born and educated in Mexico until she was 21 years old. Although she understood a little bit of English and used some at work, she was more comfortable using Spanish. No mention was made in the medical records of any use of a competent interpreter.

The defendant and one medical assistant testified that they spoke Spanish "well enough" to communicate with patients. The depositions noted that the co-defendant orthopedist spoke Spanish but also noted that although he did not consider himself fluent in Spanish, he felt reasonably comfortable with Spanish-speaking patients during exam and treatment. When he asked the patient if he could examine the leg, it became clear that Mr. Hernandez spoke Spanish better than English. From that point on, the co-defendant asked every question in both English and Spanish. The ability of the provider to speak Spanish and the patient to speak English was important to the case because the physician argued that the patient's leg might have been saved if he had followed up with his orthopedist within 24 hours of discharge. The only written discharge instructions found in the file was in English.

Ineffective oral and written communication may have resulted in the patient's lack of understanding of the urgency for follow-up. This case demonstrated how a provider's self-identified language skills can cause a provider to forego use of an interpreter despite sufficient proficiency to obtain complete information from and effective communication with the patient. The court ruled on summary judgment in favor of the defendant with no damages paid to the plaintiff. The Carrier paid legal fees of \$46,500.

In the Vargas case, the defendant was a home health agency that treated a 90-year-old Latina who suffered from Parkinson's disease and dementia. The lawsuit alleged negligent treatment of wound care, which resulted in the premature termination of home health services. The physician's assistant relied upon the patient's husband, who was nearly deaf and Spanish-speaking, to interpret for the patient. The physician's assistant only visited the patient at home when her bilingual (Spanish and English) daughter or other caregiver was present to act as interpreter. No competent interpreter was provided. This case turned on whether the communication by the home health employee was defective because she failed to provide instructions on the signs and symptoms of infection. The Carrier paid no damages but paid \$119,000 in legal fees.

The patient in the Chongrak lawsuit was a Thai woman who sued her endocrinologist alleging that his delay in correctly diagnosing her condition caused its advancement to a cancerous blockage of her lymph nodes.¹⁸ The endocrinologist graduated from medical school in China and, according to the case file, spoke "only broken English, making him often difficult to understand." Although Mrs. Chongrak, her husband and sons spoke some English, Thai was their primary language. The endocrinologist's primary language was Chinese with English as a secondary language. This case illustrated how ineffective communication can result when neither the physician nor patient shared the same primary language, and both struggled to speak in English to each other. The Carrier paid legal fees of \$70,000. No damages were paid when the patient dismissed the case.

In the Aguimbag case, an 85-year-old Filipino patient aspirated and died of an allergic reaction to penicillin. Mr. Aguimbag had a history of type 2 insulin-dependent diabetes, anemia of chronic disease, and coronary artery disease. The key issue was whether the pulmonologist knew, or should have known of, the patient's allergy to penicillin. Although his allergy was documented in a medical chart, that medical chart was at another office location and unavailable when the penicillin was prescribed and administered. The pulmonologist was of Middle Eastern descent but had a Filipina nurse assistant who spoke with the patient at all times in Tagalog. She testified that the patient told her on the phone that he had no allergies.

18 Also known as "lymphedema," the blockage of the vessels that drain fluid from tissues throughout the body and allow immune cells to travel where they are needed.

The Hospital Death Summary recorded that the patient failed to tell the pulmonologist of his penicillin allergy “even though he was asked.” Yet the case documents recorded that there were many communication problems between the pulmonologist, the patient and the patient’s family. Collectively, these facts suggest that there may have been a breakdown in communication between the patient and pulmonologist. The pulmonologist admitted that cultural issues may have kept him from diagnosing dementia in the plaintiff earlier. Although the patient’s family dismissed the claim against the pulmonologist, they settled for \$245,000 with other co-defendant physicians. The Carrier paid \$89,000 in legal fees in defense of the pulmonologist.

In the Rodriguez lawsuit, the Columbian patient had lived in the U.S. for a number of years. The radiologist failed to inform the patient’s primary care physician that her ultrasound indicated the palpable mass on her left breast as “probably benign, but requires biopsy for possible malignancy.” The hospital sent the plaintiff a letter stating the opposite; that is, the exam findings were normal. The plaintiff was able to read the letter in English and understood that both breasts were normal. This misplaced reliance then led to a delay in her diagnosis and treatment of breast cancer, which increased twentyfold in volume and progressed from regional to extensive. The patient needed a Spanish interpreter during the court proceedings, which suggests that she may also have needed an interpreter during the medical encounters, as well as having the hospital’s letter translated into Spanish. This case settled for \$250,000. In addition, the Carrier paid legal fees in excess of \$111,500.

In the Morales lawsuit, Mr. Morales was a 41-year-old Mexican who was brought to the hospital emergency room, where a CT scan revealed that he had blood under the membrane enclosing his spinal cord and brain.¹⁹ The patient was left in the hallway outside of the emergency room for 3 1/2 days because no ICU beds were available and the surgeon did not secure a transfer to another hospital. The patient went into a respiratory arrest, developed a cerebral edema and later died. His wife sued, alleging that the neurosurgeon failed to timely transfer her husband to a higher level acuity hospital. The patient’s wife spoke primarily Spanish and limited English. The hospital records recorded that the wife spoke English at the hospital. The conversations between the physician and the patient’s wife were conducted in English. During the deposition, the physician’s attorney acknowledged that the wife needed an interpreter for her testimony because of the strain of reliving the emotional events surrounding her husband’s death. This same issue likely arose in the hospital while the emotional events were occurring although no interpreter was provided at the hospital. The Carrier paid \$200,000 to settle the case and \$413,000 in legal fees.

Even if some of these claims did not result in damages awarded to the plaintiffs, many costs borne by the health care provider and malpractice insurer could have likely been avoided with effective communication. Those costs include legal fees; the lost time from one’s medical practice to defend oneself; the loss of reputation and patients; the reporting to the National Practitioner Data Bank;²⁰ the fear of possible monetary loss; and the stress and distraction of litigation. The heightened risk of patient harm is also a critical and avoidable cost when providers fail to use competent interpreters.

Defective Informed Consent and Lack of Written Translations

Twelve of the claims involved defective informed consent forms or failure to translate vital medical or legal documents. Repeatedly, the cases indicated patients having signed informed consent forms written only in English, in spite of other acknowledgments that the patient spoke or read no or limited English.

Effective communication should include provision of a translated written informed consent form when the patient is LEP.²¹ If an informed consent document is not translated, a provider should have a competent interpreter present for the provider to explain the form to the patient and obtain the

19 The CT scan revealed subarachnoid blood in intrahemispheric fissure and interpeduncular system. When the patient went into respiratory arrest, he was successfully resuscitated, but developed cerebral edema, diabetes insipidus and secondary hypernatremia. Another surgeon performed ventriculostomy. Post-operatively, the patient remained intubated in a medically induced coma with pentobarbital.

20 The National Practitioner Data Bank (NPDB) is maintained by the U.S. Department of Health & Human Services and contains information on physicians and dentists, including paid medical malpractice judgments and settlements. The NPDB is intended to keep unprofessional or incompetent practitioners from moving from state to state without disclosure or discovery of their previous damaging or incompetent performance.

21 Effective communication is critical to informed consent. Generally, courts have found that informed consent requires more than just providing a “form,” and a patient must understand the issues and information that is material the decision at hand. *Macy v. Blatchford*, 8 P.3d 204 (Or. 2000) (discussing whether a physician failed to obtain a patient’s informed consent for surgery, the court stated “a physician can mouth words to an infant, or to a comatose person, or to a person who does not speak his or her language but, unless and until such patients are capable of understanding the physician’s point, the physician cannot be said to have explained anything to any such person”); *McQuitty v. Spangler*, 976 A.2d 1020 (holding that an informed consent violation can be based on the omission of important information the patient needs to make decisions about his/her medical care. The court said, “The gravamen of an informed consent

patient's consent; the presence of the interpreter should then be noted in the patient's record. Under well-established common law, a patient must be given sufficient information about the treatment, benefits, risks and alternatives to make the consent meaningful.²² Further, medical treatment without any patient consent may constitute battery.²³ In many of these 12 cases, the representation of informed consent was supported only by an informed consent form signed by the patient in English, without any translation into the patient's primary language. Most cases also had no further documentation in the medical chart that the physician discussed the proposed treatment with the patient using an interpreter – going beyond obtaining the patient's signature on the form.²⁴ Below are details of some of the cases in which failure to translate important written documents arose.

The parents of the patient in the Rivera lawsuit spoke only Spanish, but the orthopedist did not. Their 4-year-old son lost the use of his right arm when he broke his right elbow jumping on a moon bounce and suffered a blocked artery,²⁵ resulting in arm fatigue and risk of gangrene. The record notes that the orthopedist “stated that there was a definite language barrier making communications difficult.” According to the hospital chart, “Language problems prevent in-depth questioning of his past medical history; however, there are no recorded abnormalities.”

The lawsuit complaint revolved around informed consent and standard of care. The patient chart did not document the use of any interpreter to secure informed consent for the first surgical procedure, a reduction of the fracture. However, the medical chart noted that a family member was used to interpret the discussion of the next surgical procedure for removal of pins, as well as for the surgery to remove some of the muscle tissue to relieve the pressure in the arm.²⁶ The orthopedic surgeon testified that a consent form for his surgical involvement was given to and signed by the patient's parents before any consultation between the physician and family, in addition to no documentation of use of a competent interpreter during the consultation.

While the providers asserted that they went to “great lengths” to communicate the medical findings with the parents, the records showed that a family member interpreted for only two conversations regarding specific procedures performed. The hospital and surgeon did not use interpreters for other key communications during the series of medical encounters, and they provided no Spanish translation of the informed consent forms. The Carrier paid the patient \$650,000 in damages and paid legal fees in excess of \$80,000.²⁷

In the Karapetian case, the 79-year-old Armenian female patient underwent surgery²⁸ for a kidney stone. The alleged negligence was that the urologist failed to perform adequate evaluation and an EKG following her surgery. The patient alleged that she was prematurely discharged from the hospital without being treated for a disease of the heart muscle²⁹ that could lead to an irregular heartbeat, sudden cardiac death, or both. She later suffered a heart attack. The hospital chart repeatedly noted that the patient was “Armenian-speaking,” yet the outpatient surgery patient instruction sheets were all provided in English. The Carrier paid \$50,000 in legal defense costs.

Mr. Ortiz was a 51-year-old, Spanish-speaking patient who filed a claim alleging that his surgeon failed to follow up after a laparoscopic abdominal surgery for the removal of his gall bladder. As a result of the surgery, Mr. Ortiz experienced perforation of his intestine, contamination of his organs, and extended hospitalization. Mr. Ortiz claimed that his surgeon told him “there were no risks associated with the removal of his gallbladder as it

claim, therefore, is a healthcare provider's duty to communicate information to enable a patient to make an intelligent and informed choice, after full and frank disclosure of material risk information and the benefit of data regarding a proposed course of medical treatment”).

22 See previous footnote 21; “If there is no credible evidence that the physician and patient have had an oral discussion about the proposed treatment, a patient's mere signature on a standard consent form may not be sufficient to supply that evidence.” California Physicians' Legal Handbook, 9:8 (2008); See *Keane v. Sloan-Kettering Institute for Cancer Research* 464 N.Y.S.2d 548 (1983); California Physicians' Legal Handbook, 9:1-8 (2008).

23 In a medical battery case, the plaintiff must establish either that the patient was unaware that the doctor was going to perform the procedure, or that the patient did not authorize the procedure. Medical battery cases include those in which the doctor performs a surgery that has been discussed with the patient, but performs the surgery on the wrong part of the body (i.e., amputation of the wrong limb). The California precedent was established in *Perry v. Shaw*, 88 Cal. App.4th 658, 106 Cal.Rptr.2d 70 (2001).

24 See previous footnotes 21 and 22.

25 Occluded brachial artery.

26 Fasciotomy.

27 Additional damages may have been awarded from the other co-defendants, but these were not documented in this case file.

28 Lithotripsy.

29 Cardiomyopathy.

would be done with a laser.” The surgeon recalled that Mr. Ortiz didn’t speak English, so his daughter or other family member interpreted during their informed consent discussion. The surgeon testified that the consent form was in Spanish and signed by patient. However, another consulting physician contradicted the surgeon when he wrote in the medical chart that there was no mention of a discussion with patient or family, and no rationale given for the decision to perform the surgery. For much of the pre-trial evidentiary stage of the lawsuit, the attorneys for both sides could not find documentation of translated documents or use of an interpreter. A review of the Carrier’s files also yielded no translated documents.

The Carrier acknowledged the surgeon would have exposure should this case be litigated if: there were no informed consent in the records; no documentation that an interpreter was used for the LEP patient; or perforation was not a risk during the surgery. The court found in favor for the surgeon for an unrelated reason. The Carrier paid legal fees of \$588,000.

In the Perez case, Mr. Perez was a 45-year-old who sued his gastroenterologist for medical negligence. The gastroenterologist recorded in the medical chart Mr. Perez’s need for an interpreter because he only spoke Spanish. After surgery and discharge from the hospital, the patient vomited blood and required treatment for a blood clot that obstructed blood flow through the circulatory system. Prior to discharge, the gastroenterologist instructed Mr. Perez to go to the nearest emergency room if he started to vomit fresh blood. He wrote in the medical chart that the patient verbalized his understanding of all that was discussed and wished to proceed. The gastroenterologist testified that he asked Mr. Perez if he had any questions, and all questions were answered to the patient’s satisfaction. Yet there was no acknowledgement that the patient spoke and understood only Spanish, or that the physician did not speak Spanish or use an interpreter. Furthermore, an English hospital form entitled, “Insurance Policy - Please read carefully” was signed by the patient with no mention of a Spanish translation being provided to the patient nor an interpreter providing a sight translation³⁰ of the document. Similarly, notes in the record indicated that informed consent form and discharge instructions were given, but there was no reference to a Spanish translation for either document. The notes regarding the post-surgery instructions specify that the document was not signed by the nurse or the patient. The lawsuit was dismissed in favor of the gastroenterologist; however, the lawsuit proceeded against the other physicians sued by the patient. The Carrier paid legal fees of \$7,700.

In the Zhang case, the 49-year-old, female Mandarin-speaking patient specifically sought care from her gynecologist because of his ability to speak Mandarin. But even a concordance of language does not preclude argument over whether patient’s consent was informed or effective. The gynecologist performed a total abdominal hysterectomy on the patient for treatment of her endometrial cancer (in the lining of the uterus). The patient sued because of the physician’s alleged negligence in lacerating her left urethra. Mrs. Zhang argued that her gynecologist failed to recognize this during the surgery when he could have repaired it. As a result, she had to undergo a follow-up surgical procedure.³¹

The patient testified that she discussed surgery with her gynecologist, consented to it, and signed the consent form. However, the consent form was only written in English, and she denied that it was translated for her. Likewise, she also denied receiving any literature or watching any educational videos about the intended surgeries. The court ruled in favor of the gynecologist, because the court was persuaded that the gynecologist assisted in the surgery and did not have a clear view of the disputed part of the surgery. Still, the Carrier paid legal fees of \$134,000.

In the Singh case, the primary defendant was the hospital and the co-defendant was the radiologist. The suit alleged failure to diagnose a jaw fracture of the 61-year-old female patient. According to the defense attorney’s written notes, the patient did not speak English with ease and was more comfortable and accurate conversing in Hindi or Punjabi. Her adult daughters explained the hospital’s Patient Instruction sheet, written only in English, upon discharge and signed the document for her. This raises the question whether the communication of the discharge instructions, a vital document, was defective because the patient did not sign that document even though she was legally competent to do so. Mrs. Singh dismissed the case and the Carrier paid \$6,000 in legal fees.

In the Martinez case, the 25-year-old, only Spanish-speaking mother delivered her child prematurely in fetal distress with diabetes and placental insufficiency. The baby was born with brain injury. The obstetrician of Korean descent was deceased at the time the lawsuit was filed. Much of the case turned on whether the obstetrician was fully informed by the hospital nurses about the patient’s condition or whether the lack of information caused his late arrival at the hospital to treat the mother. The hospital and obstetrician’s response to the patient’s language needs

30 A “sight translation” is when an interpreter takes a document written in English and orally reads it to a patient in another language. Undertaking “sight translation” requires special skills, and interpreters should not be assumed competent to sight translate a document even if competent to interpret.

31 Cystoscopy.

were inconsistent. Although they sometimes translated vital documents, often times they did not. The information headers of the medical form “Patient Information for Medical Records” were hand translated into Spanish. The hospital records had the following hand-written note in Spanish (without an English translation) about a missed appointment with the obstetrician. “*No atendiste a tu cita el dia 17 de febrero 2004. Por favor llama para hacer atra cita gracias.*” Translated, this read: “You didn’t make it to your appointment on February 17, 2004. Please call to make another appointment, thanks.”

The “Acknowledgement of Receipt of Notice of Privacy Practices” and “Authorization for Release of Medical Information” were in English without a Spanish translation, yet signed by the patient. The patient alleged that the obstetrician negligently failed to properly advise of any other alternative methods of diagnosis or treatment, and the possible risks attendant to the diagnosis or treatment. As a result, the obstetrician may have failed to obtain an effective informed consent. However, the case was dismissed for reasons unrelated to these arguments. The Carrier paid \$43,000 in legal fees in defense of the obstetrician.

In the Abadi case, the 59-year-old female patient was from Egypt and spoke either Amharic or Arabic according to the hospital records, which noted both inconsistently. The patient died following a surgical procedure by her urologist to remove her kidney. The allegation was that the urologist’s actions fell below the standard of care by failing to recognize and control the ongoing blood loss, which led to irreversible hemorrhagic shock, cardio-respiratory failure and ultimately death. The words “possible nephrectomy” were not on the informed consent form or the pre-op checklist. The urologist said that although he could not recall when he included “possible nephrectomy” in the informed consent form, he said that he discussed the possibility with the patient, and the patient was aware that she might have her kidney removed during the surgery.

The consent form for the surgery was in English, signed by the patient and a hospital employee witness. Similarly, hospital staff presented the Conditions of Admission in English, not translated in Amharic (or Arabic), yet the patient still signed the form. The patient’s son acted as interpreter, and there was no use of a competent interpreter noted in the hospital records. Not only did the consent seem defective for lack of a translation and a competent health care interpreter, there was also a question of whether the patient was adequately informed that removal of her kidney was a possibility. The case settled with the Carrier paying Mrs. Abadi’s family \$85,000 and legal fees of \$10,870.

The Cantonese-speaking, 31-year-old female patient in the Wong lawsuit alleged that her Taiwanese obstetrician negligently performed a Cesarean section, which resulted in an inadvertent laceration of her bladder and necessary follow-up repair. The patient signed a generic surgical consent form in English, which was then witnessed and countersigned by the obstetrician. There is no documentation that a competent interpreter was used during the course of her medical care, nor that the consent form was translated. Although the obstetrician was Chinese, he was from Taiwan and spoke Mandarin – not Cantonese, which was the patient’s primary language. The patient dismissed the case, not due to the merits of her claim, but because her attorneys withdrew representation. While Mrs. Wong received no damage payment, the Carrier paid \$22,000 in legal fees.

In the Nguyen case, the Vietnamese family of a 2-year-old boy sued his Vietnamese pediatrician for his failure to diagnose the obstruction of the nasal passage, leading to the boy’s difficulty in breathing and sleeping. Later, a hospital emergency room physician ultimately found and removed a foreign object that obstructed his breathing. The lawsuit was filed against the pediatrician for medical negligence,

Comparative Analysis of Cases

Chart 3: Amount of Damages Demanded

35 detailed cases	Damages Demanded in Lawsuit
\$1 to \$1,000,000	13
\$1,000,001 to 2,000,000	2
\$2,000,001 to \$3,000,000	2
\$3,000,001 to \$4,000,000	2
\$4,000,001 to \$5,000,000	1
\$5,000,001 to \$10 million	0
\$10 million or more	2
Unspecified general and special damages, medical expenses and interest “according to proof”	13

Comparative Analysis of Cases

Chart 4: Languages Spoken by Patient

33 detailed cases*	Primary Language of Patient	# Times Physician Spoke Primary Language of Patient
Spanish	17	2
Cantonese	2	0
Vietnamese	3	2
Mandarin	2	1
Korean	1	1
Punjabi	1	0
Thai	1	0
Tagalog	2	0
Farsi	1	0
Russian	1	0
Amharic or Arabic	1	0
Armenian	1	0

* The total is 33 because two patients spoke English as their primary language and had providers who spoke non-English languages or had accents that made communication difficult.

notwithstanding his good practices of translating vital documents and communicating in the patient's language. The headers on the patient chart were pre-printed and translated into Vietnamese. The language deficiencies in this case were found at the hospital where the medical problem was corrected. The hospital medical chart recorded that the parents verbalized their understanding of the procedure, but with no documentation of the language spoken or whether an interpreter was used. Further, the hospital emergency room's written discharge instructions were only in English. The patient's family dismissed this lawsuit and no damages were awarded. The Carrier paid legal fees of \$15,000.

Inadequate Documentation

Physicians are frequently admonished with requirements to document thoroughly and clearly in their patients' medical records.³² Health care providers are familiar with the mantra that "If an activity isn't recorded in the patient's record, it didn't happen."³³ This practice is intended to instill a discipline that results in a careful, consistent and comprehensive set of actions that optimize quality care.

In this study, some of the case documents recorded that the patient was limited or non-English speaking, but the patient's spoken language was not noted consistently throughout key documents such as the physician's office charts, specialists' office charts and hospital medical charts. Although these collectively are defined as the patient's medical records, they are each completed by someone different, and often times the recordings of one provider are not read by others. Sometimes, the primary language of the patient was noted in the Social History of the hospital's history form, but documents from other distinct medical encounters failed to note the non-English primary language. Even if the notation acknowledged that the patient did not speak English, there was often no documentation of whether the patient was accompanied by an interpreter or that the intake staff person used a competent interpreter. The failure to consistently and accurately document a patient's language can lead to providers missing important issues relevant to the medical issue and can result in the denial of language services. Requirements to document information, such as language need, are widespread. For example, the Joint Commission's hospital accreditation standards require that the medical record include the patient's language and communication needs.³⁴

In the Abadi case (described in full on p.11), the documentation of the language spoken by the patient was inconsistent. The hospital chart listed the patient's language as Amharic,³⁵ while the ambulatory surgery progress record simply noted "Arabic speaking female..." Elsewhere her medical records stated that her primary language was Amharic, but that was crossed out on some of the pages and "Arabic" was written in. If a provider cannot identify the patient's language, the provider may have difficulty meeting the patient's language needs in a timely manner.

32 Lichtstein, Materson, and Spicer, *Reducing the Risk of Malpractice Claims*, Hospital Practice, Volume 34, Issue 7, at 5 (July 1999).

33 *See id.*

34 Joint Commission: Record of Care, Treatment, and Services chapter Standard RC.02.01.01, EP 1.

35 Amharic is a Semitic language spoken in North Central Ethiopia.

Comparative Analysis of Cases

Chart 5: Specialty of Provider

35 detailed cases	Specialty of Physician
Primary Care Total	4
Surgery – General, Neuro, Pediatric, Thoracic	7
OB/GYN	5
Radiology	2
Emergency Medicine	2
Urology	2
Other Specialty Care	13
Specialty Care Total	31

Like the Abadi case, the physician's documentation in the Kuo case was confused. The patient was a 7-year-old girl whose family practice physician allegedly failed to diagnose her progressive vision loss. The girl's parents did not speak English well and communicated primarily in Mandarin, a Chinese language. Yet in the physician's medical chart, he referred to the patient as a *12-year-old Vietnamese* patient whom he had been treating for several years. Although the lawsuit focused on the medical negligence and the confused documentation was not relevant, this example demonstrates the inability to plan for needed language services if providers can not accurately document the spoken language of the patient and family.³⁶ The Kuo family dismissed the case and no damages were paid.

A Cantonese-speaking, 59-year-old male patient in the Chan case (full case description on p. 6) alleged that his oncologist had miscalculated the doses of a chemotherapy drug, which resulted in a toxic reaction that led to heart and systemic damage. The medical records included reports from over 20 different medical consultants, yet none acknowledged the language need of the patient. Only one mentioned Mr. Chan's race as "Asian." The medical records inconsistently documented in different reports that the country of origin of the patient and his wife was Hong Kong, Macau or Saigon. An accurate and consistent identification could have allowed the providers to identify whether their language need was Cantonese or Vietnamese. The medical records only acknowledge that the patient and his wife were not fluent in English, and the oncologist used the son as an interpreter. Here too, the use of Mr. Chan's son as an interpreter poses accuracy, confidentiality and ethical concerns.³⁷ The accurate identification of the patient's primary language as Cantonese was only made by the defense attorney during pre-trial preparation. The patient received a settlement of \$105,000, and the Carrier paid legal fees of \$27,000.

The physician and patient in the Kim case were both Korean. Mr. Kim had an infection and lost the use of his eye. The physician attended medical school in Korea, and the patient emigrated from Korea many years previously. The medical charts lacked adequate documentation – failing to record whether their conversations were in Korean, which may be reasonable to expect given both of their backgrounds. Just as the medical records should have documented if an English-speaking physician used an interpreter for a Korean-speaking patient, the medical records should document if the physician and patient communicated in Korean. The case settled for \$450,000. In addition, the Carrier paid over \$61,000 in legal fees.

Allegations of Discrimination

This research focused on medical malpractice claims based on negligence. Cases that claimed discrimination in addition to medical negligence have also been included. The Garcia and Karapetian lawsuits alleged discrimination in addition to medical negligence. It was likely that the charge of discrimination would not have been made had it not been for the underlying malpractice claim. In these two cases, the patients alleged a violation of California's Unruh Act, holding that the provider withheld language services with the intent to discriminate. This statute prohibits discrimination and provides that all persons are entitled to equal accommodations, services, and facilities regardless of race, national origin, color, sex, religion, disability or medical condition. In California, recoveries for medical malpractice lawsuits for

³⁶ Note that the age of the child was also documented inconsistently.

³⁷ For more discussion of the problems when family members and friends are used as interpreters, see the Tran case on p. 4-5, the Conclusions section at p. 15 and footnotes 10 and 14.

pain and suffering are limited to \$250,000.³⁸ In contrast, the Unruh statute does not impose a limit for the damages that could be awarded, thereby providing plaintiffs and their attorneys an avenue to recover more in damages.

In the Garcia lawsuit, the patient was a Spanish-speaking pregnant woman in her second trimester who died from complications caused by pork tapeworms.³⁹ Her neurologist testified that he did not require the use of an interpreter. He admitted that while his Spanish was “somewhat limited,” he said that he spoke “medical Spanish” and could take a medical/neurological history in Spanish. He spoke with the patient in Spanish and asked all of his questions in Spanish. Notwithstanding the neurologist’s self-assessment of his Spanish-proficiency, Mrs. Garcia still complained that she was unable to effectively communicate her condition to the treating physicians because they did not provide her with an interpreter.

The attorney for the patient’s husband argued that discrimination arose when non-English speakers were denied competent interpretation. The expert witness acknowledged that the neurologist should have diagnosed pork tapeworms earlier because it is a medical condition that is a common cause of increased intracranial pressure in patients residing in third world countries. With the influx of immigrants, pork tapeworms have become a more common diagnosis in California and the United States. Ms. Garcia later dismissed her lawsuit and the Carrier paid over \$40,000 in legal fees. Also, the physician had to undergo the ordeal of defending against a lawsuit claiming \$3.25 million in damages.

Mrs. Karapetian (see full description on p. 9) and her daughter, both of Armenian descent, alleged medical negligence and that the physician discriminated when he made ethnic slurs stating all Armenians have “stomach pain” and that “Armenian families live in ten person households.” The court did not find that these allegations were intentional within the meaning of the governing statute. The lawsuit claimed damages totaling \$2.85 million for the alleged medical negligence as well as the discrimination. The case was dismissed in favor of the defendant, yet the Carrier paid legal fees of \$50,000.

While the patients did not prevail in these two discrimination claims, the facts of the cases suggest that more effective communication could have improved the patient-physician relationships and reduced the physicians’ exposure to these charges.

38 The Medical Injury Compensation Reform Act of 1975.

39 Cysticercosis.

Conclusions

The importance of and need for effective language services is increasingly critical in the delivery of quality health care for an increasingly diverse population.

Health care providers, insurers and patients bear many costs – both monetary and non-monetary – that could be avoided with effective communication. Those costs include damages paid to patients, legal fees, the time lost when defending a lawsuit, the loss of reputation and patients, the fear of possible monetary loss, and the stress and distraction of litigation. Of course, the heightened risk of patient harm from poor medical care is the ultimate critical and unacceptable cost. These can be avoided by setting objective standards of performance and implementing systems to meet them that include the provision of language services for LEP patients. The investment in language services is far less than the direct and indirect costs of not providing language services.

The 35 cases identified in this study represented 2.5% of the Carrier's total claims reviewed and resulted in significant financial outlays for the Carrier. Yet, many factors exist that could lead one to conclude that a greater number of incidents involving language barriers give rise to malpractice, negligence and/or discrimination that are not filed as malpractice claims. A number of factors may deter LEP patients from filing claims that have merit. They include:

1. The discomfort and possible intimidation of LEP persons unfamiliar with navigating the legal system;
2. Finding an attorney who speaks the patient's primary language or has the ability to provide effective language services for communication between attorney and client;
3. Finding an attorney willing to take on the patient's case based upon the likelihood of a significantly large settlement or award;⁴⁰ and
4. Overcoming the intimidation and social barrier of typically being significantly less educated and acculturated.

Therefore, it is likely that there are many more cases in which lack of competent language services may have impacted the quality of an individual's medical care, but for any number of reasons the patient may not have brought a malpractice case against the provider.

The following sections outline specific recommendations for malpractice carriers and health care providers to help identify, but more importantly, prevent, miscommunication between patients and providers that leads to negligence and malpractice.

Recommendations for Malpractice Carriers

Medical malpractice carriers should explore ways to improve monitoring and tracking of claims brought by LEP patients due to ineffective communication. Further, carriers should consider establishing specific codes for their cases to identify languages spoken by patients and providers, as well as which language services were (or were not) provided.

Anecdotal evidence relates that most carriers cannot readily identify or track claims involving language barriers that may have had a direct or indirect impact on the harm suffered. For this research, authors had to manually review the Carrier's closed cases because there was no code to readily identify these cases. Yet 2.5% of the Carrier's cases revealed language barriers and resulted in a significant financial impact on the Carrier. By establishing separate codes, a carrier could analyze its claims by language spoken and by language services provided; identify needed corrections; and offer education to its insureds to explain the connections between language services and effective communication.

In addition, carriers should consider methods to improve insureds' documentation of data on plaintiffs' language needs, and provision and documentation of language services. This could include amendments to its contract language with insureds to specifically require documentation of

⁴⁰ Attorneys generally agree to represent patients in malpractice cases on a "contingency" basis, meaning that the patient pays no legal fees up-front and the attorneys retain one-third of the damages recovered. Thus, attorneys often do not choose to represent patients without both a likelihood of winning and the possibility of significant financial awards. For more information on contingency fees, *see* Appendix 2.

language needs of patients and language services provided, and/or offer insureds incentives for providing and documenting languages services.

The recommendations for malpractice insurers are to:

1. Develop specific code(s) to track claims that potentially involve language issues;
2. Conduct ongoing analysis of claims to identify risks and trends related to claims involving language issues;
3. Identify methods of reducing claims based on language issues, including education of insureds and contract requirements for insureds to provide language services as a condition of insurance; and
4. Explore methods of improving documentation by insureds of patients' language needs and the provision of language services.

With better documentation and access to data on language spoken and language services provided, medical malpractice carriers can increase the use of language services through education of their insureds, readily analyze the risks and trends in this patient population speaking non-English languages (which is growing exponentially), and ultimately identify ways to reduce the carrier's exposure to claims.

Recommendations for Providers

The avoidable and unreasonably high risk of poor medical care to LEP patients, as well as the risk of legal exposure to health care providers, can be significantly reduced when competent language services are provided. To ensure necessary language services are available when needed, providers should collect and record accurate language data; recognize a patient's language needs at each key patient encounter; and document the language services provided throughout the series of patient-provider encounters.⁴¹ With accurate data, providers can identify needed language services and have the appropriate plans in place to ensure the timely provision of language services throughout the care continuum. This could include arranging for a competent interpreter before the patient's appointment; obtaining translated information about health benefits, notices of vaccinations, and other needed medical services or health education; and obtaining translated vital documents used during the health encounter such as consent forms and discharge instructions. Providers can use accurate language data to improve quality and eliminate health care disparities on a larger population basis.

Greater appreciation of the significant consequences caused by language barriers can be gained by understanding problems discussed in the cases detailed in this report. Providers should consider following the seven recommendations, beginning with data collection and documentation.⁴²

1. Clearly and consistently document a patient's primary language in the patient's medical chart (and, for patients who are minors or incapacitated, the primary language of the patient's parent(s)/guardian(s));
2. Offer every LEP patient a competent interpreter at each provider encounter and, if refused, document the patient's response in the patient's medical chart;
3. Record the use of language services and name of the interpreter in the medical record;
4. Provide competent interpreters at each key point of non-healthcare contact (such as member services or billing) throughout in the health care encounter;
5. Document and describe the informed consent discussion, not merely the paper consent form, in the patient's chart also noting the use of a competent interpreter;⁴³
6. Translate informed consent forms, written discharge instructions and other key medical and legal documents into the primary language of the patient; additionally, explain the forms and provide time to answer any questions from the patient, using a competent interpreter. Document usage of translated documents and include translations in the patient's chart;⁴⁴ and
7. Use methods to ascertain the patient or patient's family's understanding of the provider's conversations, instructions, diagnoses, and other important verbal and written interactions.⁴⁵

41 Chandrika, Koss, Schmaltz, and Loeb, *Language Proficiency and Adverse Events in US hospitals: A Pilot Study*, International Journal for Quality in Health Care, Vol. 19, No 2: pp 60-67, 2 (Feb. 2007).

42 Recommendations 1 to 4 are required by California's Medicaid contract.

43 Lichtstein, Materson, and Spicer, *Reducing the Risk of Malpractice Claims*, Hospital Practice, Volume 34, Issue 7, at 3 (July 1999).

44 *California Physicians' Legal Handbook*, 1:66-67 (2008).

45 Recommendation 7 is recommended in many authorities for health literacy and this practice is even more critical for LEP patients. *Assessing the Nation's Health Literacy*, National Center for Education Studies, American Medical Association Foundation (2008) (<http://www.ama-assn.org/ama1/pub/upload/mm/367/>)

Further, it is important to use a competent interpreter to ensure the communication between patients and providers is accurate and effective. The reasons for not using family members, friends and particularly minor children as interpreters are widely recognized.⁴⁶ Federal and state regulations, quality assurance organizations and many contracts require that health care providers use competent interpreters for LEP patients.⁴⁷ A competent interpreter for health care settings includes someone who is:

- An objective third party;
- Knowledgeable in medical terminology of both English and the non-English language;
- Able to balance the need to provide a literal and accurate interpretation with the importance of occasionally bridging cultural differences;
- Not a family member or friend who may have complications from his/her own relationship with the patient that could compromise the objectivity, confidentiality and accuracy of the interpretation;
- Not a minor child who would be far less likely to comprehend medical terminology, to interpret accurately in either English or the non-English language, and to participate fully in the medical discussion;⁴⁸
- Not the patient who will likely be struggling with the emotional and physical burden of the medical condition and far less capable to interpret objectively or accurately; and
- Knowledgeable of the ethics and standards of practice for interpreting as well as other relevant issues such as maintaining confidentiality.⁴⁹

By working together, malpractice carriers and health care providers can improve the quality of care provided to LEP patients while reducing their exposure to and risk of malpractice and negligence claims arising out of poor communication.

hl_report_2008.pdf); *Better Communication, Better Care: Provider Tools to Care for Diverse Populations*, Industry Collaboration Effort (ICE) Health Plans, Providers, Associations, Agencies.

46 See footnote 14.

47 Federal Title VI Civil Rights Act (42 U.S.C. 1981 et seq.); Federal Executive Order 13166 "Improving Access to Services for Persons with limited English Proficiency"; U.S. Department of Health & Human Services Policy Guidance on Foreign Language Interpreters, (<http://www.lep.gov>); California statute (implementing Senate Bill 853) related to Hospitals and Health Plans responsibility for providing interpreters; Medicaid managed care contract requirements; California's Cultural and Linguistic Competency of Physicians Act; California's Dymally-Alatorre Bilingual Services Act.

48 For example, a mother may be more reluctant to speak of gynecological problems for her minor child to convey to her physician. Also, a child would be emotionally unprepared to convey that his father's oncologist just told him he has terminal cancer.

49 California Standards for Healthcare Interpreters – Ethical Principles, Protocols and Guidelines on Roles and Interventions. California Healthcare Interpreters Association (2002). http://hiaonline.org/images/Publications/CA_standards_healthcare_interpreters.pdf.

Appendix 1 – Methodology

Researchers identified 35 claims that involved significant language barriers from 1,373 medical malpractice claims from January 2005 through May 2009. 1,326 cases were litigated and closed claims and 47 cases were closed claims, settled without litigation. All of the cases were from a medical malpractice carrier that insures in four states (“the Carrier”).

The criteria for identifying the 35 cases was based on whether the patient or physician 1) spoke a primary language other than English, 2) was unable to speak English, or 3) was limited English-speaking proficient (“LEP”). These cases highlighted several insights related to the failure to provide language services. Ineffective communication can result in a lawsuit specifically alleging the provider’s legal violation of a statute, regulation or contract requirement to provide language services. In two of the claims that alleged negligence causing a medical injury, the aggrieved patients also sued for discrimination based on national origin. Many cases involved the failure to provide oral interpretation and/or to translate important documents, such as informed consent forms and discharge instructions.

The 35 cases were analyzed and grouped in major themes. Note the cases were assigned fictitious patient and plaintiff names to protect the true identities of the parties, however all other details of the cases are factual.

Study Description

The Carrier provides professional liability insurance to physicians in four states. A significant number of the Carrier’s covered physicians are non-surgical, non-specialty primary care physicians. Approximately 1,000 claims are closed each year, of which about one-third have been litigated or settled.

The researchers manually reviewed all of the Carrier’s closed claims (either litigated or settled) from January 2005 through May 2009 (four years and five months) and identified those that involved any spoken or written language other than English. The Carrier does not currently have the technical ability to do a keyword search on the electronically imaged claims documents to narrow those cases, which contain any element related to deficiencies in communication. Other methods of identifying cases involving a non-English language – such as by plaintiff/patient surnames – were deemed to be an ineffective method of identification and not utilized.

The researchers compiled de-identified information, tallied the data, and then analyzed the data qualitatively and quantitatively. The claims detailed did not identify the name of any physician, health care provider, patient or any private health information. Relevant attributes (e.g. language proficiency, location of medical training, country of nativity, medical condition) of the physician and patient were included to explore the impact that these attributes may have on promoting or hindering optimal communication in the delivery of health care.

The study relied on the oft-repeated mantra in medical documentation that “if an activity wasn’t documented, it didn’t happen.” For example, if the documentation does not expressly state that an interpreter was utilized with a patient, the study assumed that the provider did not use an interpreter. At times, however, researchers note the question of whether the patient and physician may have spoken to each other in a language other than English when it was recorded that the patient and physician spoke the same non-English language. The medical records did not identify the language spoken during the medical encounters.

The researchers also reviewed risk management and educational documents that the Carrier’s Loss Prevention unit regularly distributed to their insured.

Study Design

The claims documents were paperless and stored electronically as PDF (“portable document format”) documents. The software application, “IR Portal,” contained all of the Carrier’s claims since year 2000. The IT staff provided a list of case numbers for those that “resulted in lawsuit” or were closed during the time period in question. At any given time, inventory of active claims range between 1,500 - 1,700, of which 20% were litigated. Those litigated remain active an average of three years. Those closed without litigation typically remained in inventory for 12 months. There were no database fields or codes to query or search directly. Claims were not readily coded by any of the data fields in the research parameters (e.g., medical specialty, type of loss).

The relevant folders of the document library were (a) “Correspondence,” which contained all legal documents and internal Carrier’s Case Documentation; (b) “Medical Records,” which included doctors’ and hospitals’ charts and records; and (c) data file, which included the one-page “Pink Sheet” case summary. The Correspondence files were complete, while the Medical Records were incomplete and included only those documents considered relevant for the claim. The Case Development documents were helpful summary documents prepared by the Carrier’s staff to highlight the case at a particular point in time.

Data and Database Design: The physicians’ foreign⁵⁰ language abilities were based on the online database of the Medical Board of California. Physicians self-report their foreign language abilities and don’t use any objective measure of fluency or proficiency to provide medical care in that language. When a physician “declined to disclose” language ability, the researchers assumed that the physician had limited or no proficiency in that language.

The age of the physician that was recorded was the physician’s age as of the date of the loss, rather than the date of litigation. For the purpose of de-identifying the physician, the names of medical schools and city of their medical practice were omitted in lieu of the country of the medical school and the county in which they practiced.

50 To distinguish the language abilities of the physician’s office staff.

Appendix 2 – Contingency Fee Structure of Malpractice Cases

In addition to the specific reasons already stated as to why LEP patients may not file malpractice claims, additional issues may further reduce the number of meritorious claims that patients pursue. The structure of contingency fees used in malpractice cases creates disincentives for attorneys and patients to bring malpractice cases, regardless of the merit.

Issues for Malpractice Attorneys

The threshold for an attorney to agree to represent a patient alleging any medical malpractice is high. From Tom Baker, a professor of law and health sciences at the University of Pennsylvania School of Law and the author of “The Medical Malpractice Myth”:

Imagine you go to the emergency room with appendicitis. For whatever reason, they fail to diagnose it. Your appendix bursts, and you spend a couple weeks in the hospital. I’ve had lawyers tell me they would not take a case like that, even if it’s a slam-dunk. The damages wouldn’t be enough – medical expenses, maybe a month of lost salary, although the patient might have short term disability insurance that would cover a large part of that. It’s not enough to justify going to court.⁵¹

Trial attorneys represent patients in medical malpractice claims on a contingency fee basis rather than an hourly rate basis. They only get paid if their client is awarded money, so the attorneys are less likely to take cases in which there will be no recovery (or little chance of recovery), like a case in which a jury may find in favor of the defendant.

In contrast, attorneys who bill hourly would be paid regardless of the legal outcome. Some opine that if attorneys only work on an hourly basis, many people would not be able to afford their time. Also, when attorneys are paid by the hour, they have little incentive to settle quickly.⁵² Therefore, potential damages often must be substantial for attorneys to take on a medical malpractice case because of the significant out-of-pocket costs for attorneys. It’s not unusual for a lawyer to spend \$30,000 to \$50,000 before a case is resolved, with much of this expended on expert witnesses to analyze the actions or omissions of the provider, state the appropriate standard of care, and compare the two to determine negligence.⁵³

Issues for Patients

In addition to reasons attorneys may not want to take on malpractice cases, patients may decide that the time and effort involved in filing a claim – both financial and emotional – outweigh the potential remedies. To illustrate:

On February 11, 2003, Linda McDougal, a mother of three, testified before the Senate Labor and Judiciary Committees about her experience with medical malpractice. Mrs. McDougal had a double mastectomy after being diagnosed with breast cancer. Two days after her surgery she was told that her biopsy slide had been confused with someone else’s, that she did not have cancer after all, and her surgery had been needless. Mrs. McDougal testified that her economic damages from missed work were approximately \$8,000, while insurance covered her medical costs.⁵⁴

51 Underwood, *Would Tort Reform Lower Costs?*, *New York Times*, (August 31, 2009).

52 Madrigal, *Contingency Fees are the best way to prevent “Frivolous Lawsuits,”* *InjuryBoard.com*, (June 18, 2008).

53 <http://medical-malpractice.lawyers.com>.

54 Perl, *The Medical Malpractice Controversy*, *The Century Foundation Issue Brief* (2004).

As a small-business owner, she would have to take additional time away from her work (already \$8,000 in loss) to participate in legal proceedings. She would be responsible for paying her overhead costs during that time. For other patients, taking time off from work to pursue a legal claim may not be feasible. Patients also face other hurdles such as finding an attorney who wants to take the case given the contingency fee structure, and possibility of obtaining damages, attorneys fees, and recovering the attorney's costs.

Conclusion

Due to the financial and other issues involved in pursuing a malpractice case, many more cases likely exist in which language issues impact the quality of care but a malpractice claim is not filed. In part, fewer filings may occur because attorneys do not think the potential award is sufficient to justify their time and effort.

Further, few of the cases focused on language barriers as a contributing factor to the alleged medical outcome. This suggests that plaintiff attorneys may not be aware of the legal rights of patients to language assistance and the relevance of these legal rights to the claim. Additionally, few of the cases indicated patient complaints about language barriers. It is likely that patients may not be aware of their legal rights to language services in health care settings, and their ability to file a claim when malpractice or negligence occurs.



Los Angeles Office

2639 South La Cienega Blvd
Los Angeles, CA 90034-2675
ph: (310) 204-6010
fx: (310) 204-0891
nhelp@healthlaw.org

Washington, DC Office

1444 I Street NW, Suite 1105
Washington, DC 20005
ph: (202) 289-7661
fx: (202) 289-7724
nhelpdc@healthlaw.org

North Carolina Office

101 East Weaver Street, Suite G-7
Carrboro, NC 27510
ph: (919) 968-6308
fx: (919) 968-8855
nhelp@healthlaw.org