

Patient Perspectives on the Need for and Barriers to Professional Medical Interpretation

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ABSTRACT

BACKGROUND: Individuals with limited English proficiency (LEP) constitute an increasing share of the patient population in American healthcare settings. Few studies have described the patient's perspective on barriers to medical interpretation and experiences in the clinical setting.

METHODS: We conducted focus groups with 22 LEP Spanish-speaking adults. Focus groups were transcribed and analyzed in their original Spanish.

RESULTS: LEP patients face significant challenges when accessing health care services due to inadequate or insufficient access to professional interpreters. Predominant themes include: lack of interpreter availability, fear of disclosing limited English skills, and language discordant providers overestimating LEP patients' understanding of English. Many participants felt they had received poorer quality care.

CONCLUSIONS: LEP patients face multiple barriers to accessing adequate interpretation leading to a perceived worsening in the quality of care. In order to improve health outcomes for LEP patients, routine provision of adequate interpretation is essential.

KEYWORDS: Medical interpretation, Immigrants, Hispanic Community, Language Barriers

INTRODUCTION

Healthcare providers nationwide are increasingly challenged with caring for patients with limited English proficiency (LEP).¹⁻³ Examining the quality of communication with LEP individuals is imperative, as patient-doctor communication is an important component of care.⁴

Previous research has shown that language barriers decrease quality of care and are a risk factor for adverse health outcomes.^{5,6} LEP patients who do not receive professional interpretation have longer inpatient stays and higher readmission rates.⁷⁻⁹ While commonly used, ad hoc interpreters such as family members are more likely to make errors of clinical consequence than professionally trained interpreters.^{10,11}

Several states, including Rhode Island, mandate provision of interpreter services for certain medical encounters.¹² Despite this legal framework, utilization of interpreters remains low.^{13,14} Prior studies have cited cost, time,

interpreter availability, limited knowledge of interpreter sources and inadequate legislation as barriers to appropriate interpreter use.^{15,16} Few studies have examined language barriers from the perspective of LEP patients themselves.^{14,17} The goal of this study was to elicit patient narratives to better understand how patients experience inadequately interpreted clinical encounters.

MATERIALS AND METHODS

Study Participants

The study took place in Providence County, Rhode Island, where 29.7% of the population speaks a language other than English at home, and in which 16.9% of households are Spanish-speaking.¹⁸ Participants were recruited from local businesses, churches, community organizations, and health clinics via study recruitment flyers in Spanish. Interested participants called a study recruitment phone-line and were screened for eligibility. Individuals aged 18 or older were considered eligible provided they spoke little to no English (per patient report) and had at least 2 medical encounters in the last 6 months.

Focus Groups

In September of 2013 we conducted four focus groups in Spanish using a semi-structured moderator guide based on themes addressed in the medical literature and personal experiences in clinical settings. Topics included demographics, recent encounters with health providers, barriers to care and interpretation, experiences using ad hoc versus professional interpreters, comparisons between healthcare in Rhode Island and their place of origin, as well as potential solutions for current challenges.

Moderators were bilingual and trained in focus group moderation. Each focus group consisted of 4–7 participants and was conducted at a local community organization or a community-based hospital. The study was approved by the hospital Institutional Review Board.

Data Analysis

Data was analyzed in multiple phases following the immersion/crystallization method.¹⁹ Immediately following each focus group, the moderators reviewed the themes discussed. Audio transcripts of the focus groups were transcribed verbatim in Spanish and the accuracy of the transcriptions was

verified by one investigator (KB).

One investigator (KB) read and analyzed the transcripts to identify themes and develop a thematic codebook. This investigator then used TAM Analyzer™ (Matthew Weinstein, GPL) software to code the transcripts. Two additional investigators (HRB and MAN) separately read and analyzed the transcripts using these thematic codes and verified their validity. Through meetings, investigators (KB, HRB and MAN) further discussed and interpreted common themes. Coded reports were used to identify representative participant quotations.

RESULTS

Participants Characteristics

Twenty-two focus group participants represented four countries/territories of origin: the Dominican Republic, Colombia, Guatemala and Puerto Rico. Participants had lived in the US between three months and 36 years (median 10 years, IQR 2-23). All participants had limited English proficiency.

Predominant Themes

Three predominant themes emerged from the focus groups: importance of professional interpreters, barriers to interpretation, and the perception that poor care resulted when interpreters were not used.

All participants emphasized the importance of language barriers in their daily life and in their interactions with the healthcare system. One said:

“Health is vital, it’s how you express what you feel, whatever is hurting you or whatever the problem is... it’s the most important thing. Transportation – you can ask for a ride. Money - you can ask to borrow or make a payment plan. But language is different. You have to be able to communicate.”

The frustration of navigating medical encounters in English became clear, since vocabulary is difficult and understanding certain life events is crucial. One woman said of the birth of her daughter, *“It was so complicated. I saw they gave me an oxygen mask and the nurse was talking to me...but I understood nothing.”* Some participants mentioned that their ability to express themselves in English worsens during medical encounters due to stress and that providers sometimes don’t make an effort to understand their attempts to speak English.

Participants described limited interpreter availability, causing delays that lengthen outpatient and emergency room visits. Access to interpretation was noted to be particularly absent in operative and procedural areas, ambulances, specialty visits and while participating in provider phone calls and navigating insurance enrollment. Patients also expressed a perception that interpreter availability is dependent on insurance status. Participants described situations in which they felt that interpreters inaccurately translated due

to time constraints. Miscommunications were also noted to occur among patients and interpreters who learned Spanish in different countries, as accents and vocabulary vary across Latin America. A few participants even mentioned encounters that were translated by Portuguese interpreters, either due to limited availability or because providers thought they were an appropriate substitute.

These barriers often led participants to rely on family members as substitutes for professional interpreters. Some participants said they preferred to use a family member to wait less time and benefit from the advocacy of someone who knows them. Others expressed that family members are not able to accurately translate medical jargon and only summarize what the physician says:

“Maybe this [ad hoc interpreter] does not have the necessary level to explain to the physician what I really need – as opposed to an interpreter that comes prepared...more familiar with what medicine is. It’s as if someone was going to translate for a car mechanic. The person already comes with knowledge about car parts.”

Moreover, participants described issues of confidentiality that arose when a personal acquaintance gets involved in their medical care. One patient described bringing a neighbor to her gynecologic appointment, *“Imagine you are getting a pap smear, and you are in that gynecologic position... It was really embarrassing because she was my interpreter but it was such a personal exam.”*

Many participants reported that barriers to professional interpretation lead them to delay care or brave medical encounters without assistance:

“I asked for an interpreter and the interpreter never showed up. So [the doctor] asked me if it was ok like that and you know, you think you can defend yourself. But that’s the mistake, to agree knowing that you’re not going to understand 100%, that you’re going to be limited in the questions you can ask... You end up lost.”

In these scenarios, they are limited in their ability to ask questions, adequately describe their symptoms or understand providers’ instructions:

“One does not get to express everything that one feels. No, not everything, only the basics...I feel like the same happens to all of us. We want to say more [during the appointment]. But to avoid being excessive or because we are afraid of making mistakes and making things worse, we thus only talk about: “how are you” – “good”; “are you walking?” – “yes.” ”

Some participants added that physicians think their patients understand more than they actually do. One patient shared that in one encounter her daughters could not follow her into the operating room to continue interpreting

for her. She said that she did not think the doctor realized her limited understanding. When asked how she knew this, she replied, *“I think the doctor thought I understood everything. [I saw it in her] attitude, [her] face, because I didn’t make a face that said I didn’t understand.”*

Poor outcomes due to inadequate or absent interpretation included medical errors and misunderstandings ranging in severity. One participant mistakenly answered that she had depression because she did not understand the question, then spent hours explaining herself to consulting psychiatrists. Another man had no interpreter present during a cardiac stress test. Unable to express that he felt unwell after the test, he fainted in the waiting room. A few participants expressed waiting in pain in the emergency room for hours, as medications could not be administered until an interpreted history was taken. Others described miscommunications about medication changes, appointment times or procedure details. Many patients shared that they felt their care was inferior when there was not adequate interpretation.

When participants were asked what improvements could be made to the system, almost all agreed that more interpreters were needed. Some additionally expressed that physicians should learn Spanish because being able to communicate directly with patients improves the doctor-patient relationship.

“What happens is that when someone speaks your same language, you feel more comfortable...With an interpreter, I know interpreters translate everything exactly as you tell them, but there are things you say in Spanish that if the interpreter says in English it’s a bit different, it’s not exactly what you wanted to express, so yes, it’s easier in Spanish.”

Some suggested that bilingual nurses and medical assistants should be given scholarships for training and hired more widely. However, regardless of language barriers, patients overwhelmingly shared that providers who spend time with their patients and made an effort to understand them are greatly appreciated. One participant spoke of his experience undergoing an endoscopy and his fear of finding out he had cancer. He spoke of how the doctor addressed his concerns, *“the doctor – even though it wasn’t in my language – he treated me with a lot of respect. I mean, I felt very comfortable with him.”*

DISCUSSION

In comparison to English speaking patients, patients with LEP are less likely to have medical services²⁰ and more likely to have chronic diseases with worse outcomes.^{21,22} Access to medical interpretation helps to reduce these disparities.⁷ Our study is, to our knowledge, the first to qualitatively explore patient experiences related to the barriers to medical interpretation. The results of these focus groups highlight the difficulties of navigating the healthcare system as

a person with LEP, describe patients perception that they receive worse care during encounters without interpretation and identify particular areas of the healthcare system in Rhode Island where interpreters are still lacking.

Even when interpreter services are available, patients often turn them down due to time constraints or mistrust. Many expressed frustration and embarrassment at their limited language skills, and described attempting to express themselves in imperfect English to avoid reliance on others. Perhaps the most crucial revelation was that patients sometimes express understanding to the provider, even when they do not actually understand. Participants perceived that providers did not check for understanding or recognize when miscommunications had occurred. Such gaps in understanding contribute to recurrent medical visits, poor treatment adherence, and additional costs to the patient and health system.^{5,7,8}

One limitation of our study is that we did not speak with providers about their reasons for choosing not to utilize professional interpreters.¹⁶ Most hospitals and clinics in RI require the use of professional translators when patients are not fluent in English - either in person or by phone. However enforcement of these policies has not been assessed. Further research is also needed to disentangle the intersections between limited health literacy and English proficiency. Lastly, while the optimal number of participants in this qualitative study is unknown, our sample size of 22 participants allowed us to reach saturation with regards to themes introduced by participants.

Provision of adequate interpretation for LEP patients is necessary to reduce health disparities associated with language barriers. As insurance reimbursement structures under the Affordable Care Act move more towards a-pay-for-performance model,²³ prioritization and enforcement of these services for LEP patients will be essential to ensure quality of care.

The major strength of our study was that we sought the perspectives of LEP patients interacting with the healthcare system. We suggest that if more interpreters were available and providers were trained to work with them, quality of care would improve.^{7,24} As patients may not voice their lack of understanding during visits, we encourage providers to routinely check for understanding, prioritize a request for professional interpretation and utilize interpreters effectively. Moreover, we encourage providers to use innovative methods such as video-based interpreting, to ensure that their patients understand their medical care when in-person professional interpretation is unavailable.²⁵

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