The Use of Qualified Medical Interpreters in Health Care: Barriers for Health Care Professionals

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Abstract

Access to language services has become a fundamental component of care for patients who are not proficient in the English language. Patients who cannot effectively communicate in their preferred language require qualified bilingual support to ensure they receive equal access to health care. Despite the understood need for quality bilingual services, many health care professionals may be reluctant to use or provide qualified medical interpreters. A review of the literature is provided regarding barriers, which prevent or negatively influence health care professionals' decision to use a qualified medical interpreter, thus disregarding policies regarding language laws. The purpose of this literature review is to increase understanding of the benefits of interpreter utilization, which acknowledges the rights of Limited English Proficient (LEP) patients, and maximizes the use of collaboration among health care professionals.

Introduction

Approximately 22% of the US population age 5 and older speak another language at home other than English (U.S. Census Bureau, 2015). It can be assumed many Limited English Proficient (LEP) persons have sought health care services in the US. Confronted with LEPs in the acute care setting, many health care providers often rely on family members and other non-qualified sources to convey messages between the healthcare staff and the patient. This mode of communication increases the risk of performing a wrong procedure, can result in medication errors, and increase readmission rates (Jacobs, Shepard, Suaya, & Stone, 2004).

The Joint Commission requires all hospital systems implement a language access plan and include health care professionals' participation in educational trainings to promote understanding regarding the benefits of using qualified medical interpreters (JCAHO, n.d.). Any individual receiving federal financial assistance from the U.S. Department of Health and Human Services (HHS) is subject to Title VI of the Civil Rights Act of 1964. Title VI prohibits discrimination based on race, color, or national origin in any program or activity receiving federal financial assistance (HHS, 2014). The U.S. Office of Civil Rights (OCR) and the Department of HHS have released a summary of compliance reviews and complaint investigation summaries describing failures to provide language access when providing healthcare services to the LEP patient population (HHS, 2014) Many hospital systems have entered into voluntary resolution agreements with the OCR to improve access to language services for LEP patients (HHS, 2014). Memorial Hospital of California is an example of a healthcare agency which has implemented an agreement to expand and improve access to health care for LEP patients to ensure compliance with all provisions of Title IV are met (HHS, 2014). The purpose of the agreement is to increase and expand language access for the LEP patient population. Conditions of the agreement include implementation of a language access plan consistent with best practices, implementation of language policy, procedures for oral interpretation and written translation for LEP patients (HHS, 2014). The agreement included creation of a position for a language assistance coordinator and a community advisory board to ensure access to qualified medical interpreters and identify and provide interpreter training (HHS, 2014).

This purpose of this literature review is to describe barriers in the use of qualified interpreters by healthcare professionals. Barriers reported in the literature include interpreter utilization, time constraints, health care professional-interpreter collaboration, language and modes of interpreting services, and cost of using interpreters. This paper also describes recommendations for best practices to improve utilization of qualified medical interpreters in health care systems.

Methods

A search was conducted to retrieve journal articles containing references related to the research question. The databases used to find information were PubMed, Google Scholar, ProQuest, Wiley and Elsevier. In addition, other resources like Agency for Healthcare Research and Quality (AHRQ), the Centers for Medicare and Medicaid (CMS), and the Mendeley Library were utilized. The Mendeley citation manager served to categorize journals and articles, and to simplify retrieval of relatable data.

Library Databases

Articles were selected from the University of Cincinnati Langsam Library and Northern Kentucky University Steely Library, in addition to online resources. Databases used in the search for information included PubMed, Google Scholar, ProQuest, Wiley, Cochrane and Elsevier. Most of the relatable data needed to answer the research question were available in Google Scholar and Elsevier.

Journals

Mendeley citation manager was the main source used to categorize journal articles and simplify retrieval of relatable data. Among the twenty-five articles initially retrieved, six served as the primary sources of data and information from the following journals: The Journal of General Internal Medicine, American Journal of Public Health, International Journal of Evidence-Based Health Care, and Annals of Emergency Medicine.

Non-Refereed Sources

Non-refereed sources included health communications, Patient Education and Counseling, the Department of Human Health Service, the Office of Civil Rights (OCR) and Small Business Costhelper. Additionally, other resources like AHRQ, CMS and the Department of Health and Human Services (HHS) provided information on interpreter role and rules, language laws and language access plans.

Key Words

There were several key words used to search for articles and gather information to answer the research question and develop recommendations for practice. The list of key words, phrases and concepts included some or all of the following:

Factors influencing health care professionals' decision to avoid using a qualified medical interpreter,

Limited English proficiency (LEP) quality of care with and without an interpreter,

Health care professionals and interpreter collaboration,

Consequences of interpreters as patient advocate,

Bilingual health care and quality of health care delivery,

Cost of qualified medical interpreter usage and cost of not using qualified medical interpreters,

Differences in price between interpreter tools.

Literature Review

The Current Environment

Understanding how healthcare professionals view medical interpreters, along with expectations of how interpreters should behave during the patient-health care professional encounter, could provide essential clues for understanding the disregard of institutional policies regarding the use of qualified medical interpreters (Hsieh, Pitaloka and Johnson, 2013). The interpreter's potential interference with information shared may be viewed as disruptive to the patient-health care professional communication process and may offer an explanation as to why health care professionals may avoid using a qualified medical interpreter, despite the evidence of increased quality of healthcare when one is used (Hsieh et al., 2013). Allowing interpreters to modify communication methods during a medical encounter may hinder a health care professional's understanding of their responsibility over the medical encounter (Hsieh et al., 2013). Relying on another person to convey critically important information in a language not understood by the healthcare provider can create a sense of mistrust leading to conflict and lack of collaboration (Hsieh et al., 2013). The lack of understanding regarding the value of qualified medical interpreter roles and working in collaboration with the bilingual health care delivery team can negatively impact patient quality and the safety of health care delivery (Hsieh et al., 2013). Mistrust may ultimately explain why health care professionals would choose to go without using a qualified medical interpreter in future medical encounter with his or her patients (Hsieh et al., 2013).

Communication with the healthcare professional varies according to the nature of the appointment. For example, while a specialized health care professional may want to establish a long-term relationship with the LEP patient for continuing care, he or she may want to gather medical history information to decide on a prognosis that focuses on the patient's long-term care goals. An emergency care physician may want to focus on gathering information that focuses on the immediate health concern. The literature suggests health care professionals should be given the responsibility and opportunity to share their opinions as to what represents best practices when using qualified medical interpreters during bilingual health care delivery (Hsieh et al., 2013). Qualified medical interpreters must have the ability to adapt to the health care professional's needs and expectations during the encounter, without interrupting or interfering. This adaptation could ensure quality of interpreter interaction as well as improved healthcare professional attitude toward working with interpreters (Hsieh et al., 2013).

Health Care Professional's Expectations

A study on bilingual health communication compared different expectations for medical interpreter roles from different specialties (Hsieh et al., 2013). Thirty-nine providers were surveyed, with five different specialties from a major health care facility. The surveyor ranked the health care professional's preference based on the parameters of how important the items were from extremely unimportant to extremely important. The data also measured health care professionals' view of qualified medical interpreters as a patient's ally (advocate), interpreter as a health care professional (abstain from interference) and interpreter as a health care professional proxy (ability to ensure quality of care, viewed as member of healthcare team). The results of the survey revealed support for the use of qualified medical interpreters. Interpreters were viewed as an important resource in facilitating communication with LEP patients, rather than relying solely on a health care team member (Hsieh et al., 2013). Data regarding interpreter as patient ally varies according to health care professional specialty. Nurses may prefer interpreters to be more involved in advocacy due to the potential cultural barriers, physicians may disagree. Those who oppose the use of interpreters argue the clinical significance of the patient's condition may increase the possibility of interference with effective delivery of the message intended (Hsieh et al., 2013).

Interpreter Utilization

Use of qualified interpreters remains low, despite the increased quality of care and association with patient-centered care that qualified medical interpreters support. A sample of California oncologists (n=301) reported being more likely to "sometimes" elicit assistance from family members or friends (91%) over qualified medical interpreters (40%) when providing health care to LEPs with breast cancer (Karliner, Jacobs, Chen, & Mutha, 2007). A study of 4,224 patients outlined hospital outcomes and readmission rates according to patient characteristics, including language needs (López, Rodriguez, Huerta, Soukup, & Hicks, 2015). Of the 765 patients readmitted, 96 (13%) were LEP patients who qualified for bilingual health care services. Only 32 patients (33%) of those who qualified for bilingual support actually received the services of a qualified medical interpreter present (López, et al., 2015).

Another reason healthcare professionals may avoid using qualified medical interpreters is the belief their own language skills are sufficient for effectively conveying important information, including informed consent for surgical procedures to LEP patients (Diamond, Tuot, & Karliner, 2012). One study reported that 26 out of 68 physicians used their low level of Spanish proficiency to deliver bilingual health care

services (Diamond et al., 2012). Currently, no set policies and procedures are in place in health care systems to evaluate health care professionals' language skills in health care (Diamond et al., 2012). Therefore, health care professionals with limited language proficiency may still use insufficient language skills, even when sensitive and important information is being shared with LEP patients.

The use of a qualified medical interpreter may reduce errors while delivering health care services. A study conducted in two Massachusetts pediatrics' emergency departments reported that out of 50 encounters with LEP patients requiring bilingual health care services, 1,884 errors were observed. Only 12% of those errors resulted with using qualified medical interpreters, while 22% were the result of using a non-qualified interpreter and 20% with no interpreter used (Flores, Abreu, Barone, Bachur, & Lin, 2012). It is important to note that the level of training qualified medical interpreters possess significantly improves the quality and safety of bilingual health care delivery. The findings suggest that qualified medical interpreters receive at least 100 hours of training (Flores et al., 2012). The literature further suggests more research measuring the acceptance of medical interpreters as part of the health care team is crucial in order to address conflicts resulting from tensions brought on by working with medical interpreters who tend to play the role of patient ally, also identified as advocate and/or conduit (Hsieh et al., 2013).

Another factor influencing a health care professional's decision to use a qualified medical interpreter is lack of time management and tight time constraints. According to a study conducted by the Department of Communication, at the University of Oklahoma, lack of time is one of the leading reasons affecting a health care professionals' decision to avoid using a qualified medical interpreter (Hsieh, 2015). Their choice is usually affected by health care professionals' schedule; disruptions and organizational issues are not usually addressed prior to a patient encounter. This is the result of lack of firm health care system policies and/or a language access plan with protocols regarding a patient's accurately identified language needs (Hsieh, 2015). It is very common for healthcare professionals to face making the decision to prioritize their focus as to what medical condition requires immediate attention. In many health care settings within hospital systems, health care professionals are often required to provide immediate attention to a patient who requires urgent attention. This forces health care professionals to abandon the bilingual health care service patient encounter and the scheduled interpreter is left waiting for the health care professional to return to the session. The problem arises when the scheduled interpreter assigned to be at the patient encounter appointment for a calculated unit of paid hours has to leave, thus leaving the patient without an interpreter (Hsieh, 2015).

Health care professionals may find it challenging working in collaboration with medical interpreters. This is a direct result of undefined understanding of the interpreter's role and boundaries while conveying the intended message to the patient. Differences between health care professionals and interpreter experiences presents as a major barrier to facilitate collaboration between the two parties in order to effectively communicate the intended message to the patient. This conflict is avoid by appropriate implementation of trainings defining interpreter role and how to work in collaboration with medical interpreters by having an understanding of interpreter practices (Hsieh, 2010). Health care professionals also rely on interpreter emotional support during the interpreting session. This expectation is satisfied when the interpreter is able to remain neutral and accurately conveys the intended message (Hsieh & Hong, 2010).

Qualified medical interpreters are essential resources for communicating with the LEP patient population. Their role is not to participate in decision making during bilingual health care delivery, despite their knowledge regarding the patient's culture. This literature review suggests there is a culture of overlapping roles between qualified medical interpreters and health care professionals where the interpreter acts as a patient advocate interfacing with the integrity of the intended message the health care professional is trying to deliver. Medical interpreters are not viewed as part of the health care delivery team. Their role is to remain neutral and refrain from acting as a patient's advocate (Hsieh & Kramer, 2012). The manner in which health care professionals view interpreters can significantly affect the LEP patient's understanding of the health care plan and impact the quality of care they receive (Hsieh & Kramer, 2012).

Financial Burden

Risk and volume of LEP patients seeking care from health care systems may be two factors health care systems administrators consider when choosing not to use qualified medical interpreters and/or when selecting the type of interpreting tool to use in order to remain efficient while maintaining compliance. Data reported by the illustrating the financial burden interpreting services have on hospital systems is available in the HHS.gov website. This data explains how financial burden can affect the decision for healthcare professionals to do without interpreters, taking into account that interpreting services are a non-revenue generating service that must be offered to LEP patients by health care systems receiving government subsidies (HHS, 2014). An in-person interpreter has a price tag of $145-$450 per hour, phone interpreters are $75-$180 per hour, and video interpreters are $105-$420 per hour (Costhelper, Inc, n.d.). According to the 2016 Bureau of Labor Statistics report, a full time interpreter can earn an average salary of $46,120 per year, a maximum of $83,010 per year and a minimum of $25,370 per year (Medicaid Translation and Interpretation Services, n.d.).

Discussion

Literature regarding the rate of qualified medical interpreter use in health care is scarce. This gap in information contributes to the lack of effective solutions to address factors that may influence a health care professional's decision to avoid using a qualified medical interpreter (Meuter, Gallois, Segalowitz, Ryder, & Hocking, 2015). The current literature and research available is insufficient, does not apply to all clinical settings, and is unclear in most instances, which creates confusion about the importance of using qualified medical interpreters in health care settings.

Results of this literature review suggest there are solutions available to address language access to LEP patients; however, there is lack of evidence to address a health care professional's decision to avoid using a qualified medical interpreter. As a result, LEP patients continue to suffer adverse events in the healthcare system along with being exposed to the increased costs and liability imposed to hospital systems. Health care professionals' disregard of the importance of qualified medical interpreters and/or appropriate language tools to assess and treat LEP patients are primarily due to lack of collaboration with the qualified bilingual team and time constraints. The five elements of best practice identified solutions to increase qualified medical interpreter utilization. This model included effectiveness, reach, feasibility, sustainability, and transferability.

Interpreter Usage Protocol

Effective solutions are needed which significantly increase the use of qualified medical interpreter utilization and support improved health outcomes for the LEP patient population (Meuter, et al., 2015). Best practices suggested in the literature include addressing factors affecting a health care professional's decision to avoid using a qualified medical interpreter. The second best practice suggested by the literature is the improvement of collaboration between the health care professional and interpreter. This is to address the conflict arising from the lack of trust regarding the risk involving the integrity of the information conveyed by the interpreter. Can the interpreter effectively communicate the information the health care professional intended to deliver without changing the intended meaning? At this time, there is a lack of available measurements to evaluate the quality of the average interpreting session (Hsieh, 2010). Feasibility and considerations to increase qualified medical interpreter utilization provide barriers to implementation of solutions. Health care professionals are resistant to adopt policies that require the use of a qualified medical interpreter. In addition, the patient may decline an interpreter in many occasions do to longer wait times, privacy concerns and convenience.

Increasing Utilization of Interpreters

There are many hospitals across the U.S. who have implemented a policy requiring the use of a qualified interpreter with the LEP patient population, but they continue to see health care professionals resistant to adopt the idea of using a qualified medical interpreter (Torres, n.d.). An example of best practice recommendations for health care professional training is creating policies and procedures around language assistance. This is established by making health care professionals aware of these policies and procedures, as well as providing training on how to work in collaboration with qualified medical interpreters. Trainings are incorporated during employee orientation, staff meetings, in-services, risk management sessions, medical school seminars, grand rounds and continuing education programs (Torres, n.d.).

A barrier to solutions to increase qualified medical interpreter utilization is the lack of data available supporting effectiveness of proposed solutions. Capturing data regarding the effectiveness of these solutions, to increase qualified medical interpreter utilization, will provide case precedence to make available evidence that supports the importance of using a qualified medical interpreter.

Collaboration between Health Care Professional and Interpreter

Educating health care professionals regarding the value of working in collaboration with qualified medical interpreters is a challenge, especially if there is a diverse health care professional team varied in language themselves. Proving that effective communication is the key to healing in a way where LEP patients clearly understand is a major challenge. Centralized solutions to increase collaboration among the bilingual team and the use of qualified medical interpreters may ensure effective communication with the LEP patient population (Hsieh, 2010).

Full collaboration among the bilingual health care team offers the potential to improve their relationship. By collaborating, the bilingual health care team will improve communication between themselves, the health care professionals and the qualified medical interpreter, and they will increase cultural awareness among themselves while preventing adverse effects due to lack of communication. The benefit of establishing a relationship among the bilingual will result in improvement of patient satisfaction, it will prevent liability issues due to misinterpretation of information that can lead to misdiagnosis, and over ordering diagnostic tests that can result in an increase of health care cost (Hsieh, 2010).

Recommendations

The literature review identified time constraints as one of the factors affecting health care professional's decision to avoid using a qualified medical interpreter. One of the suggested solutions is to determine if the patient is LEP, and in what language the patient prefers to receive his or her health care service. This process will improve time management by identifying needs for bilingual health care ahead of time, and will ensure the use of a qualified medical interpreter.

To address the financial burden that may result from not complying with using qualified medical interpreters, is important to implement a language access plan. This language access plan must include solutions to increase the use of qualified medical interpreters. An example is The Health Collaborative, a Cincinnati nonprofit organization serving the tristate. This organization works alongside health care professionals and administrators to assist with creating health care solutions faced by many health care systems in the area. This Health Collaborative has implemented an initiative to control price of interpreting services by setting up price standards (Greater Cincinnati Regional Language Access Committee, 2018). This initiative forces competitive agencies to negotiate lower price. Despite this effort, the financial burden interpreting services may have over health care systems may impact administrators' decision to forgo using qualified medical interpreters.

To ensure that health care professionals use a qualified medical interpreter, a policy highlighting the benefits of using a qualified medical interpreter should be available twenty-four hours a day. In addition, this policy should stress that the interpreter has the professional obligation to maintain confidentiality during bilingual health care delivery, and that the health care professional has the responsibility to ensure care, quality and safety of effective communication via the qualified medical interpreter when it is required (Hadziabdic & Hjelm, 2013).

Conclusion

The literature was consistent regarding the necessity to implement solutions that can increase utilization of qualified medical interpreters in the healthcare environment. Effective implementation of these solutions will ensure compliance with language legislation, and with the standards of best practice set forth a customized language access plan. Health care systems that are not willing to implement solutions to increase utilization of qualified medical interpreters will be at risk of losing government subsidies (Hsieh, 2010). It is important to continue gathering data regarding utilization of qualified medical interpreters, and measurement for best solutions for health care systems based on LEP patient volume and service provided. Data which measures risks involved when qualified medical interpreters are not used will further provide validation of their importance in the bilingual health care delivery encounter. Finally, protocols which report incidents of clinical errors resulting from lack of use of a qualified medical interpreter will be essential for quantifying the significance of this problem.

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