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Certifying Medical Interpreters;
Need for Public Policy

by

Bonni Wagner, BA, CCE

A Comprehensive Article and Research Literature Review

to the Faculty of the Graduate School,

Marquette University

in Partial Fulfillment of the Requirements for

the Degree of Masters of Leadership Studies

Milwaukee, Wisconsin

2011

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Communication is the key!

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(Note: This article was written with the intention of consideration/publication in *Nursing Economics* or *Health Affairs*.)

Abstract

Barriers facing quality of care to Limited English Proficient (LEP) patients in the United States have been well documented. While several have studied the need for improving communication with LEP patients, this is the first to conduct a comprehensive literature review reviewing significant research in the area of advancing the profession of medical interpretation, and the need for public awareness and public policy around this issue. Twenty studies regarding LEP patients met criteria for inclusion in a comprehensive literature review, and many additional articles/reports were reviewed by key government and non-profit organizations with a reference summary provided. Themes include communication/language barriers, differences in care/services; issues surrounding accessing trained medical interpreters; and research supporting the development of national certification requirements for medical interpreters.

Keywords: medical interpreters, limited English proficient

Certifying Medical Interpreters: Need for Public Policy

Introduction

Major demographic changes shaping the US today is the growth of a foreign born population. US census data shows that between 1990 and 2000, the percentage of Americans (older than five) speaking a language other than English at home rose from 13.8% to 17.8%, causing the limited English proficient (LEP) population to grow by one third, from 6.1 percent to 8.1 percent in the year 2000 (U.S. Census Bureau, 2010). New data released in April 2010, indicates that between 2000 and 2007, the percentage of Americans (older than five) speaking a language other than English at home, rose again from 17.8% to 19.73% (U.S. Census Bureau, 2010), indicating that one in five people in the United States speak a language other than English at home. See Table 1 on page 9. More than 44 million individuals speak English "less than very well" in the United States and are thus said to be limited English proficient or LEP. The top five languages, other than English, spoken at home in the United States are Spanish or Spanish Creole, French, Italian, German and Polish. See Table 2 on page 10 for more information.

Federal laws going back to the Civil Rights Act of 1964 mandate access to language assistance in health care. While this obligates health care providers to supply language services, wide gaps persist because insurers typically do not pay for interpreters (Ku & Flores, 2005). All states have enacted regulations that clarify or broaden this federal requirement, however, no federal standards for health care interpreters exist (Youdelman, 2008). Some states have developed their own interpreter certification programs. For example, Washington has the oldest certification programs. Iowa, Indiana, and Oregon have required development of interpreter standards, and other

states (New Jersey, North Dakota, and South Dakota) mandate the use of certified or competent interpreters but do not specify standards. California, Massachusetts, and North Carolina are developing standards without legislation (Youdelman, 2008).

Research shows that persons with limited English proficiency experience disproportionately high rates of infectious disease and infant mortality. They are less likely to receive influenza and pneumococcal vaccines; and are more likely to report risk factors for serious and chronic diseases such as diabetes and heart disease (Center of Disease Control (CDC) Office of Minority Health, 2011). Many LEP patients may delay seeking care because of fear the physician will not speak their language or fear that the office staff will be less willing to assist them (Napoles-Springer, Santoyo, Houston, Perez-Stable, & Stewart, 2005). The Institute of medicine (IOM) report titled "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" found compelling evidence that disparities and barriers occur at every level of the health care system yet they remain largely unrecognized. Similarly, language barriers directly affect the patient's ability to give informed consent, and LEP patients are disadvantaged when it comes to receiving appropriate consultations, discussion of alternatives, and education without the availability and presence of a qualified medical interpreter (Hunt & de Voogd, 2007). Physicians were also found to engage in costly practices such as more diagnostic procedures, more invasive procedures, and overprescribing medication to compensate for language barriers (Ku & Flores, 2005).

Hospital guidelines now recommend the routine use of professional medical interpreters on a regular basis. However, research suggests that practitioners and interpreters still experience numerous difficulties in their access to interpreters and their collaboration, that can negatively affect

Table 1

Population 5 Years and Over Who Spoke a Language Other Than English at Home by Language Group and English-Speaking Ability, 2007

Characteristic	Number or percent	English-speaking ability			
		Very well	Well	Not well	Not at all
NUMBER					
Population 5 years and older	**280,950,438**	**(X)**	**(X)**	**(X)**	**(X)**
Spoke only English at home	225,505,953	(X)	(X)	(X)	(X)
Spoke a language other than English at home	55,444,485	30,975,474	10,962,722	9,011,298	4,494,991
Spoke a language other than English at home	**55,444,485**	**30,975,474**	**10,962,722**	**9,011,298**	**4,494,991**
Spanish or Spanish Creole	34,547,077	18,179,530	6,322,170	6,344,110	3,701,267
Other Indo-European languages	10,320,730	6,936,808	2,018,148	1,072,025	293,749
Asian and Pacific Island languages	8,316,426	4,274,794	2,176,180	1,412,264	453,188
Other languages	2,260,252	1,584,342	446,224	182,899	46,787
PERCENT					
Population 5 years and older	**100.0**	**(X)**	**(X)**	**(X)**	**(X)**
Spoke only English at home	80.3	(X)	(X)	(X)	(X)
Spoke a language other than English at home	19.7	55.9	19.8	16.3	8.1
Spoke a language other than English at home	**100.0**	**55.9**	**19.8**	**16.3**	**8.1**
Spanish or Spanish Creole	62.3	52.6	18.3	18.4	10.7
Other Indo-European languages	18.6	67.2	19.6	10.4	2.8
Asian and Pacific Island languages	15.0	51.4	26.2	17.0	5.4
Other languages	4.1	70.1	19.7	8.1	2.1
MARGIN OF ERROR[1]					
NUMBER					
Population 5 years and older	**17,610**	**(X)**	**(X)**	**(X)**	**(X)**
Spoke only English at home	109,811	(X)	(X)	(X)	(X)
Spoke a language other than English at home	106,562	91,882	63,961	62,294	52,259
Spoke a language other than English at home	**106,562**	**91,882**	**63,961**	**62,294**	**52,259**
Spanish or Spanish Creole	75,004	73,911	54,178	46,667	49,121
Other Indo-European languages	68,048	54,386	27,604	19,313	12,666
Asian and Pacific Island languages	45,036	32,514	24,871	25,587	14,138
Other languages	43,582	33,444	14,425	9,743	5,102

1 This number added to or subtracted from the estimate yields the 90-percent confidence interval. For more information on ACS see http://www.census.gov/acs/www/

Source: U.S. Census Bureau, 2007 American Community Survey.

Table 2

Languages Spoken at Home: 1980, 1990, 2000, and 2007.

	1980	1990	2000	2007	Percentage change 1980-2007
Population 5 years and over	**210,247,455**	**230,445,777**	**262,375,152**	**280,950,438**	**33.6**
Spoke only English at home	187,187,415	198,600,798	215,423,557	225,505,953	20.5
Spoke a language other than English at home[1]	23,060,040	31,844,979	46,951,595	55,444,485	140.4
Spoke a language other than English at home[1,2]	**23,060,040**	**31,844,979**	**46,951,595**	**55,444,485**	**140.4**
Spanish or Spanish Creole	11,116,194	17,345,064	28,101,052	34,547,077	210.8
French (incl. Patois, Cajun, Creole)	1,550,751	1,930,404	2,097,206	1,984,824	28.0
Italian	1,618,344	1,308,648	1,008,370	798,801	-50.6
Portuguese or Portuguese Creole	351,875	430,610	564,630	687,126	95.3
German	1,586,593	1,547,987	1,383,442	1,104,354	-30.4
Yiddish	315,953	213,064	178,945	158,991	-49.7
Greek	401,443	388,260	365,436	329,825	-17.8
Russian	173,226	241,798	706,242	851,174	391.4
Polish	820,647	723,483	667,414	638,059	-22.2
Serbo-Croatian	150,255	70,964	233,865	276,550	84.1
Armenian	100,634	149,694	202,708	221,865	120.5
Persian	106,992	201,865	312,085	349,686	226.8
Chinese	630,806	1,319,462	2,022,143	2,464,572	290.7
Japanese	336,318	427,657	477,997	458,717	36.4
Korean	266,280	626,478	894,063	1,062,337	299.0
Vietnamese	197,588	507,069	1,009,627	1,207,004	510.9
Tagalog	474,150	843,251	1,224,241	1,480,429	212.2

1 The languages highlighted in this table are the languages where data were available for the four time periods: 1980, 1990, 2000, and 2007.
2 The total does not match the sum of the 17 languages listed in this table because the total includes all the other languages that are not highlighted here.
3 This number added to or subtracted from the estimate yields the 90-percent confidence interval. For more information on ACS see http://www.census.gov/acs/www/

Source: U.S. Census Bureau, 1980 and 1990 Census, Census 2000, and the 2007 American Community Survey.

service and quality of care to patients with limited English proficiency (Dysart-Gale, 2007). Hiring, assessing, and training of qualified interpreters is often left up to individuals and the health care organization hiring them.

Medical interpreting is a field in evolution, with ongoing development of standards of practice and codes of ethics. When only professional interpreters are used, research findings are consistent and report positive benefits of professional interpreters on communication (errors and comprehension), utilization, clinical outcomes and satisfaction with care (Karliner, Jacobs, Chen, & Mutha, 2007). The need for accessible, licensed or certified medical interpreters is becoming more apparent today and is becoming an expensive public health problem. The purpose of this article is to review significant research efforts made in the last ten years toward improving culturally and linguistically appropriate services in health care and finding ways to continue to support and improve communication for the LEP population as well as lift the interpreter profession as a whole.

Methods

In order to locate articles for this comprehensive literature review, MEDLINE and CIHAHL were utilized. Key terms used were "medical interpreters", and "limited English proficient". The following criteria were used to exclude articles for this review: articles published prior to the year 2000, and articles relating to medical interpreters for the deaf or other disabilities. Non-profit and government agencies that research ethnic and language disparities in health care were also contacted and researched and a timeline and resource list is shown in Table 3.

Literature Review

Medical interpreters provide a bridge for limited English proficient (LEP) patients across the language gap for both patients and practitioners. Medical interpreting refers specifically to the process of facilitating communication between client and practitioner in a neutral setting, however researchers argue if neutrality is really even possible when life experiences and culture are worlds apart. A common misconception is that communication in health care settings is a relatively simple task in which much of the information can be gathered by scientific means or conveyed by gestures. The reality is that the clinical examination relies heavily on language for much of its history and information gathering. (International Medical Interpreters Association & Education Development Center, 2007).

Prior to the 1960s, interpretation was frequently provided by family members (including young children, friends, or a bilingual clinic employee). Such practices, although still found, are no longer the norm due to the awareness of practical and ethical difficulties that arise when nonprofessionals act as interpreters in a medical setting. Public and institutional demand for trained medical interpreters is growing and medical interpreting is developing into an established allied health profession. At present, however, there are no federal or board certification requirements for medical interpreters, so most health care organizations have developed guidelines and standards for hiring and training interpreters, however, a high quality of interpretation is no guarantee.

In a sociolinguistic analysis titled "Patterns of Communication through Interpreters" (Aranguri et al., 2006), researchers recorded and analyzed physician, interpreter and patient interactions. Sixteen patients were recorded interacting with nine physicians. Thirteen patients used an interpreter

with eight physicians, and three patients spoke Spanish with one bilingual physician. Minimally, they determined that content was often reduced, revised, and omitted. Reductions and changes made by an inappropriately trained medical interpreter can lead to misdiagnosis or emphasis on the wrong condition; the elaboration of a treatment plan and the patient's likely persistence on that plan can also be affected. On an interactional level, the patient's questions were short circuited at times by the interpreter. The perception of the patient when receiving an answer to his/her question by the interpreter's own perception of what is important is of tremendous implications in diagnosis and management, as the determination of clinical relevance. On an interpersonal level, the presence of a third person in the interview can add a level of "coldness" to the relationship between patient and physician. Not having "small talk" to build a relationship decreases the possibilities of developing a "friendly" trusting relationships that can lead to increased interest in learning about their disease. As a result, a patient may not feel comfortable telling the doctor sensitive details and symptoms through an interpreter (Aranguri et al., 2006).

In a 2005 a focus group study related to patient's perceptions (Napoles-Springer et al., 2005), interpreters were thought to enhance communication and add cultural expertise, however, even in the presence of interpreters, respondents felt that physicians needed to heed non-verbal cues as well, stating: "If they have an interpreter, then the doctor should actually pay attention because you can get a lot from a person's facial expressions. I've seen doctors writing notes while the patient's talking in the different language." Spanish-speaking respondents complained about longer wait times and the need to be assertive to obtain an interpreter. There were also complaints about interpreters and physicians impatience in language-discordant situations. (Napoles-Springer et al., 2005) Overall, Spanish-speaking participants reported greater satisfaction with Spanish-speaking physicians,

however felt they received poorer quality health care than English-speaking patients. Many Spanish-speaking respondents stated they delayed seeking care because of fear of non-Spanish-speaking physicians, viewing this as the greatest obstacle to accessing care. A common perception was that medical office staff was usually much less willing to assist Spanish speaking patients than English-speaking patients. However, a Spanish-speaking Latina was pleased that her physician, who spoke limited Spanish, repeated questions until they understood each other (Napoles-Springer et al., 2005).

A valid alternative to on-site interpreters is to have more staff that are bi-lingual, however, a recent study conducted at a large health care organization, concluded that out of 840 dual role interpreters tested, one in five had insufficient bilingual skills to serve as interpreters in a medical encounter. Health care organizations that depend on these dual role staff, are encouraged to assess their English and second language skills prior to utilizing them as medical interpreters (Moreno, 2007). There are also very few bi-lingual nurses practicing in the field. Researchers feel this may be due to minority populations, as well as the population at large, being poorly informed about careers in nursing (Cowen & Moorhead, 2001). Health care organizations that depend on dual-role staff interpreters, are challenged to assess their skills properly, as well as provide them access to appropriate training and support.

Another alternative to onsite interpreters is the routine use of telephonic interpreter services which can provide an interpreter over the phone in several languages. Australia is one of the more multilingual countries in the world and provides a suite of services, including qualified interpreters, and information resources (Phillips, 2010). In Australia, General Practitioners are responsible for ensuring an interpreter is present. They have the ability to contact a telephonic interpreter service

directly 24 hours a day and receive an interpreter on the phone within three minutes. Physicians can also order onsite interpretation (Phillips, 2010). The United Kingdom (UK) provides an online National Register of Public Service Interpreters, which can be viewed on the Internet at www.mrpsi.co.uk. Having the national register ensures that care providers not only employ a qualified interpreter, but that the interpreter can be held accountable should their competence fall below the established standards. The register lists interpreters who have satisfied entry criteria in terms of qualifications and experiences and have agreed to abide by an established Code of Professional Conduct (National Register of Public Service Interpreters, UK, 2011).

Most hospitals utilize a combination of interpretation methods, however consistent use of an interpreter varies. In a descriptive study based on a broad comprehensive literature review on attitudes and perceptions of both patient and providers toward treating Hispanic patients, thirty articles for Hispanic patients were analyzed (Mayo, Sherrill, Sundareswaran, & Crew, 2007). The results of the review indicate a wide range of interpretation services being used, and in many institutions they have at least two or more types of language services. However, several of the facilities expressed the need for better services or more assistance is providing language access (Mayo et al., 2007). In regards to types of language services available and their effectiveness: all eight health care facilities participating in this study provided language access for their Spanish-speaking LEP patients. Some facilities reported using family and friends as a means to interpret. In regards to assessment of linguistic competence: each institution had its own standards for interpreters as well as means of assessing language competency. Overall, this review illustrated the need for more or better trained professional interpreters and the consistent application of medical interpreting ethics, training assessment, and protocol for both interpreters and dual role health care providers.

Researchers determined that training is essential and needs to continue to be analyzed as more technology and standards are developed (Mayo et al., 2007).

Funding of Interpreters

Research indicates that the cost of providing one year of interpreter services for Spanish-speaking patients is approximately $240 with an average cost of $79 per documented interpretation during a hospital stay. One significant study found that enhanced interpreter service intervention did not significantly increase or decrease hospital costs, however, return ED visits did decrease (Jacobs, 2004). Health care providers need to examine all the cost implications of different language access services before they deem them too costly. There are a number of reasons why a clear impact of enhanced interpreter intervention on the cost and quality of hospital care cannot be determined. First, large firm effects mask the effect of enhanced interpreter intervention. Second, this study compared enhanced interpreter services available eight hours a day with usual care that included some hospital interpreter services available ten hours a day. Third, a large proportion of attending and resident physicians were fluent in Spanish. The study did provide useful information on the cost of providing enhanced interpreter services relative to the total cost of a hospital stay. Authors concluded that $240 was a small price to pay to ensure that hospital professional staff are able to provide the standard of care needed to a patient. It also highlights the valuable contribution bilingual physicians make to the provision of health care in our increasingly diverse society, underscoring the importance of efforts to increase the ethnic and linguistic diversity of the medical profession (Jacobs, Sadowski, & Rathouz, 2007).

Additional Research

Significant research efforts have also been made in the last ten years by non-profit and U.S. government agencies to clearly define ethnic disparities in health care today and define culturally and linguistically appropriate care. Table 4 provides a condensed summary of the research and guidelines that have been published in the area of medical and linguistically appropriate care during the last ten years.

Table 3
Providing Culturally and Linguistic Appropriate Care in the U.S.
Timeline and Important Resource List

In 2001, the U.S. Department of Health and Human Services, Office of Minority Health, issued a formal report titled "National Standards for Culturally and Linguistically Appropriate Services in Health Care". The fourteen Standards were developed with input from a broad range of stakeholders, including hospitals, community-based clinics, managed care organizations, home health agencies, and other types of health care organizations; physicians, nurses, and other providers; professional associations; State and Federal agencies and other policymakers; patient advocates, educators and consumers. The standards were published in the Federal Register on December 22, 2000, as recommended national standards for adoption or adaptation by stakeholder organizations and agencies. See Table 4 on page 20 (U.S. Department of Health and Human Services, Office of Minority Health, March, 2001).

In 2002, the Institute of Medicine (IOM), at the request of Congress, published an IOM study to assess the extent of disparities in the types and quality of health services received by U.S. racial and ethnic minorities and non-minorities. The research explored factors that may contribute to inequities in care and recommended policies and practices to eliminate these inequities. The report, titled "Unequal Treatment: What Health Care System Administrators Need to Know about Racial and Ethnic Disparities in Healthcare", found that U.S. racial and ethnic minorities are less likely to receive even routine medical procedures, and experience a lower quality of health services. The committee's recommendations included increasing awareness about disparities among the general public, health care providers, insurance companies, and policy-makers. The report also noted that more interpreters should be available in clinics and hospitals to overcome language barriers that may affect quality of care (Institute of Medicine of the National Academies, 2002).

In 2003, U.S. Department of Health and Human Services published a revised report titled "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons". This guidance was originally published in August 2000, and received nearly 200 public comments about coverage, compliance costs, and use of family and friends as interpreters. Many providers requested assistance from the Office for Civil Rights on how to comply with both general and specific provisions of the guidance so the guidance was revised based on that model for public comment (U.S. Department of Justice, Civil Rights Division, May, 2011).

In 2004, The National Council on Interpreting in Healthcare (NCIHC) developed a National Code of Ethics for Interpreters in Health Care and The National Standards of Practice for Interpreters in Healthcare was developed in 2005 (National Council on Interpreting in Healthcare (NCIHC), 2004, 2005).

In 2005, The Robert Wood Foundation launched a national program to improve the delivery of language services to patients called "Speaking Together" which included ten hospitals throughout the country who learned, participated, and measured their results in five different language service quality measures (Robert Wood Johnson Foundation, 2008).

In 2006, The California Endowment supported a detailed study, done by Cynthia E. Roat, M.P.H, to research considerations for national certification of medical interpreters titled "Certification of Health Care Interpreters in the United States". The report examined the importance of certification as part of quality assurance, current certification programs in existence in the U.S.; initiatives to established state and certifications programs currently occurring in Washington State, Oklahoma, Oregon, Indiana, Iowa, Massachusetts, North Carolina and Texas; and the process for developing a national certification process (Roat, Cynthia E., The California Endowment, 2006).

Table 3, Cont.
Providing Culturally and Linguistic Appropriate Care in the U.S.
Timeline and Important Resource List, continued.

In 2006, The International Medical Interpreters Association, (IMIA) updated their Code of Ethics for Medical Interpreters; and in 2007, updated their Medical Interpreting Standards of Practice supporting quality medical interpretation (International Medical Interpreters Association & Education Development Center, 2007).

In 2008, The Joint Commission, (an organization whose mission is to continuously improve health care for the public) with funding from The Commonwealth Fund, began an initiative to advance the issues of effective communication, cultural competence, and patient- and family-centered care in hospitals (The Joint Commission, 2010).

In 2009, IMIA co-founded a new national medical interpreter certification program overseen by the National Board of Certification for Medical Interpreters. www.certifiedmedicalinterpreters.org. Certification is currently available in Spanish, and additional exams are in development for Cantonese, Mandarin, Korean, Russian and Vietnamese and will be ready to launch later this year. Five more languages are projected next year, and additional languages in the future (The National Board of Certification for Medical Interpreters, March, 2011).

In 2010, The Joint Commission published *A Roadmap for Hospitals*, titled "Advancing Effective Communication, Cultural Competence, and patient-and Family-Centered Care. A part of the requirements includes organizational readiness and encourages health care organizations to target recruitment efforts to increase the pool of diverse and bilingual staff, ensure the competency of individuals providing language services, incorporate the issues of effective communication, cultural competence, and patient-and family-centered care to new or existing staff training curricula, and identifying staff concerns in providing care to patients with unique patient needs (The Joint Commission, 2010).

In 2011, the National Council on Interpreting in Healthcare (NCIHC), funded by a grant from The California Endowment, published National Standards for Healthcare Interpreter Training Programs. The standards are intended to serve as a guide for the development and ongoing review of "entry-into-practice" healthcare interpreter training programs - that is , programs designed for individuals who wish to acquire the background knowledge and foundational skills that every healthcare interpreter needs to know, divided into three major areas: program content standards, instructional methods standards, and programmatic standards (National Council on Interpreting in Healthcare & The California Endowment, April, 2011).

In 2011, The Joint Commission released new and revised standards for patient Centered Communication in their hospital accreditation program. The new standards include: ensuring appropriate qualifications for language interpreters; identifying the patient's oral and written communication needs, including the patient's preferred language for discussing health care; documenting of the patient's race and ethnicity in the medical record; prohibiting of discrimination based on age, race, ethnicity, religion, culture, language, disability, sex, sexual orientation, and gender identity; providing of language interpreting and translation services including appropriately translated documents based on patient population (The Joint Commission, 2011).

In 2011, Supported by the U.S. Attorney General, the Federal Coordination and Compliance Section of the Civil Rights Division of the U.S. Department of Justice, published a comprehensive document titled "Language Access Assessment and Planning Tool for Federally Conducted and Federally Assisted Programs". The objective of the document is to ensure that all agencies communicate effectively with LEP individuals. The report includes tools for self-assessment; as well as information on how to develop language access directives, plans, and procedures (U.S. Department of Justice, Civil Rights Division, May, 2011).

Table 4

National Standards for Culturally and Linguistically Appropriate Services in Health Care

U.S. Department of Health and Human Services, Office of Minority Health, March 2001

These standards for culturally and linguistically appropriate services (CLAS) are proposed as one means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers. The standards are intended to be inclusive of all cultures and not limited to any particular population group or sets of groups. However, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services. Ultimately, the aim of the standards is to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.

Standard 1. *Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.*

Standard 2. *Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.*

Standard 3. *Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.*

Standard 4. *Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.*

Standard 5. *Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.*

Standard 6. *Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).*

Standard 7. *Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.*

Standard 8. *Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.*

Standard 9. *Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.*

Standard 10. *Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.*

Standard 11. *Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.*

Standard 12. *Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.*

Standard 13. *Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.*

Standard 14. *Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.*

Discussion

The Joint Commission recently revised its' *Elements of Performance* for hospitals requiring them to now address qualifications of their language interpreters; identify patient communication needs; address patient communication needs; collect race, ethnicity, and language data; provide non-discrimination in patient care; and provide appropriate language services (The Joint Commission, 2010). The U.S. Attorney General is encouraging agencies to utilize the U.S. Department of Justice Planning Tool to self assess their LEP population and provide training and notice of their language assistance services (U.S. Department of Justice, Civil Rights Division, May, 2011). Health care administrators are watching for a credible external system to help them measure the quality of their medical interpreters, similar to the nursing profession, social workers, sign language interpreters, speech pathologists and physicians, who are required to obtain a license to practice in the State they live in. In the State of Wisconsin, the Department of Regulation and Licensing regulates 132 different types of credentials in more than 58 professional fields, including sign language interpreters, nurses, social workers, and dietitians (State of Wisconsin Department of Regulation and Licensing, 2011). Skilled interpreters themselves are anxious for a license or certification standard in order to increase respect for their profession and differentiate them from interpreters with less skill.

As significant changes are occurring in this field, certification programs are emerging on the state and commercial levels and interest is high among aspiring interpreters. A national registry of certified medical interpreters may be an important consideration and could provide a platform to locate and validate appropriately trained medical interpreters. The International Medical Interpreter Association has developed Standards for Medical Interpreters which include a Code of Ethics for

Interpreters and Medical Interpreting Standards of Practice (International Medical Interpreters Association & Education Development Center, 2007). The National Council of Interpreting in Healthcare (NCIHC) has published National Standards for Healthcare Interpreter Training Programs to raise the quality of healthcare education and standardize and advance the profession (National Council on Interpreting in Healthcare & The California Endowment, April, 2011).

Funding

With recent movement in the field of medical interpretation, Federal legislators will hopefully be more likely to allocate funding to pay for qualified interpreter services. Health care providers need the support from government officials to encourage the use of trained medical interpreters, requiring them to be licensed/certified. Through either centralized, direct reimbursement for medical interpretation; or increased payment to providers that care for patients with language barriers, funding considerations are needed. Another model for consideration would be to establish a national system of telephonic interpreters, similar to the Australian government, which provides interpreting services throughout the country, 24 hours a day for the cost of a local phone call (Chen, 2006).

Conclusion

Medical interpreting is a field in evolution, with ongoing development of standards of practice occurring rapidly. Research indicates that problems exist with providing a consistent, high level of interpretation for all LEP patients. The need for accessible, certified medical interpreters is becoming more apparent today and is becoming a serious public health issue. This article reviewed significant research efforts made in the last ten years toward improving culturally and linguistically appropriate services in health care and finding ways to continue to support and improve communication for the LEP population.

Future research will contribute most by focusing on how certified interpreters can decrease errors in comprehension and improve clinical outcomes and patient satisfaction. Research is necessary to guide legislation and to demonstrate whether assessing interpreters' language competence within the health care setting can impact quality of care. The availability of appropriate assessment methods to measure bilingual language competence of dual role interpreters is also necessary to allow for correct classification and usage of physicians, nurses, and staff that are qualified to interpret.

If public policy around certifying professional medical interpreters becomes a reality, a centralized register and formative evaluation is recommended to determine if the policies are effective and implemented. Included in this evaluation would be to measure if students are aware of and participating in the established certification program(s); the number of interpreters in training and certified per year by language; as well as employment data related to the number of certified medical

interpreters or dual role interpreters employed by a hospital or health care agency at any given time in relation to the LEP population they serve.

The United States is on their way to creating effective methods for providing high quality medical interpretation to all LEP patients as well as recognizing the importance of both oral and written medical interpretation. The momentum is strong for continuous improvement in this area and the door is open for creative solutions that take advantage of computer technology and high quality translation resources in a more centralized fashion.

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Annotated Bibliography/ Comprehensive Literature Review Supplement

Certifying/Licensing Medical Interpreters; Need for Public Awareness / Public Policy

Bonni Wagner, BA, CCE

Research Study A:

Patient Satisfaction with Different Interpreting Methods: **A Randomized Controlled Trial**
Society of General Internal Medicine, p. 312-318
Ganey, F., Leng, J., Shapiro, E., Abramsom, D., Motola, I., Shield, D., Changrani, J. (2007, October).

Purpose/Hypothesis/Type:

A quantitative, relational study measuring how interpreter methods relate to patient satisfaction for non-English speaking patients. RSMI (remote simultaneous medical interpreting) is analyzed as an efficient form of interpreting. This study attempts to address this knowledge gap about the RSMI interpreting method. The study is a longitudinal study utilizing a randomized controlled trial, with probability sampling.

Methodology

Primary care patients were recruited between November 2003 and June 2005 in a New York City Hospital. One thousand two hundred seventy-six English, Spanish, Mandarin and Cantonese speaking patients attending the primary care clinic and emergency department of a large New York City municipal hospital were screened for enrollment in this randomized controlled trial.

An eighty question demographic questionnaire was administered to all study patients prior to their encounters with the provider. After their medical encounter, participants were surveyed by a bilingual research assistant on their satisfaction with their provider, medical care, and interpreter and interpreting method utilizing a five point scale. Data was also collected on the actual method of interpretation received.

Findings:

For satisfaction with physician communication/care, patients randomized to receive RSMI were more likely than those receiving U&C to rate their physicians “very well” in treating them with respect (71% RSMI vs.

64% U&C, $p<0.05$) (Table 2). Patients also rated RSMI as better than U&C at protecting their privacy (RSMI 51% vs. U&C 38%, $p<0.05$) (Table 3). The mean satisfaction with interpreter score was higher for patients in the RSMI group (RSMI 0.528 vs. U&C 0.462, $p<0.05$) as well. There were no other significant differences between the groups.

In the analysis of satisfaction with physician communication/care by actual interpreting method received, patients in the RSMI group were more likely than those in the U&C trained interpreter group to rate their physicians "very well" in treating them with respect (70% RSMI vs. 57% U&C trained, $p<0.05$) and to think their physicians understood them "very well" (45% RSMI vs. 35% U&C trained, $p<0.05$).

There were a few areas in which patients in the RSMI group were more satisfied than in the U&C group. Patients felt they were treated with more respect by their physicians and that their privacy was better protected.

Summary:

Alarmingly, all groups reported poor satisfaction with important aspects of doctor–patient communication, in particular, feeling understood by the physician, understanding physicians' explanations of procedures and results, and understanding instructions for follow-up care. However, this was much worse for patients in the interpreted medical encounter, indicating that current interpreting strategies still do not approximate a language-concordant encounter. Among language-concordant patients, dissatisfaction may have been due in part to physician "false fluency", with physicians overestimating their language abilities; to patients' overestimating their English-speaking ability; or to other shortcomings in doctor–patient communication. In a separate study, we found a significantly lower error rate with RSMI compared with U&C interpreting in Spanish–English language-discordant encounters.

One weakness of this study is that if the participant was randomized to usual and customary interpreting, the physician was then to select an interpreter, or decide not to use one, as he/she usually would, he would then call the hospital interpreter service and wait for them to come. I see a significant difference in convenience here for the physician. With the RSMI method - he is literally handed the headset to begin communication by a research assistant right away. Also, if a physician determined he did not have time to wait for an interpreter, he could simply not call one at all and continue without a method of interpretation whatsoever to be compare.

Also, only one hospital is studied here with no comparative data with another demographic area or region. Content validity could have provided some additional comparison in this study if there were more references made to current literature on this topic. Language Concordant patients were compared to non-English speaking patients which provided a control group for this study.

In my experience, Hispanic patients absolutely benefit from interpreter services so that they can communicate their symptoms, concerns, questions clearly to their providers, as well as understand the treatment and follow-up being provided to them. There are many additional factors though and barriers that affect the interpreter's ability to do this effectively, including training, cultural biases and belief systems within the healthcare system, the patient's attitude toward their physicians and health care providers, level of trust and honesty present, financial/compensation issues, and much much more.

This study is helpful though for the sheer amount of data they were able to obtain in regards to non-English speaking patient satisfaction and the reference list as well. I am sure it was quite expensive to conduct this study and it appears to be fairly sound data. More studies are needed encompassing other languages and settings to further assess accuracy, efficiency, and patient satisfaction with the different methods of interpretation.

As stated in article, "Professional interpreters, physicians, and patients also need more training and education on how best to facilitate the interpreted medical encounter. Further studies need to be conducted on interpreting modalities, and should examine errors, medical outcomes, and costs. Physician-related factors should also be assessed, including physician satisfaction and barriers to utilization. We also need qualitative data to learn more about what specifically detracts from patient satisfaction with interpreting so that appropriate interventions can be developed to address the dissatisfaction documented in this study. Future studies should include additional technology-based interpreting delivery systems, including video and computer-assisted linguistic access.

Research Study B:

Patients' Perceptions of Cultural Factors Affecting the Quality of their Medical Encounters
Health Expectations, 8, pp 4-17 (2005)
Napoles-Springer, A., Santoyo, J., Houston, K., Perez-Stable, E., Steward, A..

Purpose/Hypothesis/Type:

Efforts to identify the components of culturally competent health care from the perspective of ethnically and linguistically diverse consumers are lacking. Many physicians lack the necessary skills and knowledge to identify, understand and bridge differences in cultural values and practices that influence the medical encounter. Thus, identifying the critical domains of cultural competence from the perspective of patients can guide the development of interventions at the clinical level. The purpose of this study was to understand from the perspective of patients of three ethnic groups as to how culture influences the quality of medical visits. The study is a cross sectional study, utilizing stratified random sampling. A purposive sample was recruited in the San Francisco Bay area from senior centers, unemployment agencies, community health clinics, and universities.

Methodology:

The study involved one-time focus groups in community settings with 61 African–Americans, 45 Latinos and 55 non-Latino Whites. Participants mean age was 48 years, 45% were women, and 47% had less than a high school education. Inclusion criteria were: self-reported ethnicity of African-Americans, Latinos or non-Latino Whites, English or Spanish speaking; 18 years of age or older; and at least one physician visit within the last twelve months. Participants in 19 groups were asked the meaning of culture and what cultural factors influenced the quality of their medical encounters. Inclusion criteria were: self-reported ethnicity of African-Americans, Latinos or non-Latino Whites; English or Spanish speaking; 18 years of age or older; and at least one physician visit with the past 12 months. Each text unit (TU or identifiable continuous verbal utterance) of

focus group transcripts was content analyzed to identify key dimensions using inductive and deductive methods. The proportion of TUs was calculated for each dimension by ethnic group.

Two moderators conducted each discussion of approximately 90 minutes. Focus groups were conducted at locations where participants were recruited; refreshments and a $20 compensation were provided. Discussion were audio-taped, transcribed and translated if necessary. Participants also completed a brief demographic questionnaire.

Two methods were used to code the qualitative data which consisted of the focus-group transcripts; grounded theory, and a constant comparative approach. Nineteen focus groups were conducted with a total of 163 participants.

Findings:

Definitions of culture common to all three ethnic groups included value systems (25% of TUs), customs (17%), self-identified ethnicity (15%), nationality (11%) and stereotypes (4%). Factors influencing the quality of medical encounters common to all ethnic groups included sensitivity to complementary/alternative medicine (17%), health insurance-based discrimination (12%), social class based discrimination (9%), ethnic concordance of physician and patient (8%), and age-based discrimination (4%). Physicians acceptance of the role of spirituality (2%) and of family (2%), and ethnicity-based discrimination (11%) were cultural factors specific to non-Whites. Language issues (21%) and immigration status (5%) were Latino-specific factors.

The effect of language on the medical encounter was mentioned exclusively by Spanish-speaking Latinos, focusing on the role of interpreters, satisfaction with the quality of care received, access to health care, and language-based discrimination. Interpreters were thought to enhance communication and add cultural

expertise. Even in the presence of interpreters, respondents felt that physicians needed to heed non-verbal cues, stating: If they have an interpreter, then the doctor should actually pay attention because you can get a lot from a person's facial expressions. I've seen doctors writing notes while the patient's talking in the different language. Spanish-speaking respondents complained about longer wait times and the need to be assertive to obtain an interpreter. There were also complaints about interpreters and physicians impatience in language-discordant situations. Overall, Spanish-speaking participants reported greater satisfaction with Spanish-speaking physicians. They felt they received poorer quality health care than English-speaking patients. Many Spanish-speaking respondents stated they delayed seeking care because of fear of non- Spanish-speaking physicians, viewing this as the greatest obstacle to accessing care. A common perception was that medical office staff was usually much less willing to assist Spanish speaking patients than English-speaking patients. However, a Spanish-speaking Latina was pleased that her physician, who spoke limited Spanish, repeated questions until they understood each other.

Participants overall reported feeling more satisfied when they thought physicians demonstrated versatility in dealing with patients of diverse ethnic and linguistic backgrounds, and treatment preferences.

Summary:

One weakness I noted in the study is there was a significantly larger number of Latino men than women in the study. 60% men and 40% women. Also 65% of the Latino's interviewed were unemployed and 61% had less than a high school education, compared to 80% of Whites interviewed were employed and only 6% had less than a high school education. 91% of all Latino's interviewed were foreign born and only 9% was US born. If these numbers were all switched, the feedback may have been significantly different.

This study confirmed the theory that interpreters were thought to enhance communication and add cultural expertise to the healthcare experience, however even with interpreters, respondents felt that physicians needed to heed non-verbal cues and still pay attention to their feelings and facial expressions.

Also this study provided clear evidence that Spanish speaking participants reported greater satisfaction with Spanish speaking physicians. Spanish respondents stated they delayed seeking care because of fear of not being understood. There was a lot of significant finding and clear, direct statements made in this study that were brought out by the researches in a very organized and subjective way.

Research Study C:

Addressing Language Access in Health Care
Hispanic Health Care International. Vol. 5, No. 3, 116-125
Martinez-Gibson, E., Gibson, T. (2007)

Purpose/Hypothesis/Type:

The purpose of the study was to analyze three areas of interpreter services provided in the Tri-County area of South Carolina. The first part of the survey was designed to elicit responses related to critical issues that the healthcare community faces in regard to language access. The second part covered questions only for those facilities that provide interpretation services. The third part contains questions related to gaining insight as to how facilities without interpretation services deal with Spanish-speaking LEP patients. This is a qualitative research study on language access for Spanish-speaking limited English proficient patients in a healthcare setting in the Tri-County area of South Carolina. The funding for this study is not noted so I assume it was self funded.

Methodology:

Eight healthcare facilities participated in a survey about language access. It is a cross sectional study with data collected at a single point in time - the fall of 2005.

A three part survey was designed to elicit responses to critical issues that the health care community faces in regard to language access. Random code identifiers were assigned to each institution and results were analyzed using statistical software.

Findings:

The results indicate a wide range of interpretation services being used, and in many institutions they have at least two or more types of language access. However, several of the facilities express the need for better services or more assistance to provide language access.

In regards to growth of Hispanic population: Results from the questionnaires showed that all eight HCPs have had an increase in the number of Spanish-speaking patients. At HCP D, 98% of their patients are Spanish speakers. At HCP G between 41% and 50% are Spanish speaking patients, while HCP E has between 51% and 60%.HCP B and F indicate that between 11% and 20% of their patients are Spanish-speakers; and HCP H has between 0% and 10%.

In regards to types of language access available and their effectiveness: All eight health care facilities participating in this study provide language access for their Spanish-speaking LEP patients. HCP A–D reported having professional medical interpreters. HCP A and F each had a similar ratio of approximately one interpreter for every 17,000 Spanish-speaking patients a year. Some facilities reported using family and friends as a means to interpret.

In regards to assessment of linguistic competency: Each institution had its own standards for interpreters as well as means of assessing language competency.

Summary:

Although the information gathered in this study if very informative about the interpreter services available in this particular area, and at these particular institutions studied, it really cannot be compared to any other community or area. Many threats to internal validity exist such as selection-regression in that each facility differs significantly from each other as well as selection-maturation as each facility is at a different level in

terms of the interpreter services they are able to provide based on the funding available to them as well as the type of population they serve and the services they provide.

This study very much relates to appropriate language access in healthcare through the services these institutions were are able to provide. Financial commitment is a huge factor here as well as funding provided to institutions in order to effectively service this population. The Research Study also provides valuable insight into the different methods being used as well as the reassurance that significant efforts are being made in this area.

The survey tool provided at the end of the study is valuable and could be replicated in my area or community easily if I needed it for comparison purposes. Also a literature review is also provided in this Research Study as well with some valuable connections to the research I have already done.

The need for more or better trained professional interpreters and the consistent application of medical interpreting ethics and protocol for both the interpreters and health care providers is essential and needs to continue to be analyzed and studied as more technology and standards are developed as well as more institutions improve their interpreter processes.

Research Study D:

Attitudes and Perceptions of Hispanic Patients and Health Care Providers in the Treatment of Hispanic Patients: A Review of the Literature.
Hispanic Health Care International, Vol. 5, No. 2, 64-72;
Mayo, R., Westbrook-Sherrill, W., Sundareswaran, P., Crew, L. (2007)

Purpose/Hypothesis/Type:

Issues surrounding working with Hispanic population are important for medical education at the early levels for providers as well as for seasoned providers. Research recommendations to understand and improve Hispanic healthcare are essential to serving the Hispanic population effectively. This is a descriptive study based on a broad comprehensive literature review on attitudes and perceptions of both patient and providers toward treating Hispanic patients. Thirty articles for Hispanic patients met criteria for inclusion and 20 articles met eligibility criteria regarding healthcare providers. The funding source is not noted.

Methodology:

The authors use textual analysis of the existing literature available. In order to locate articles for this literature review, MEDLINE, CINAHL, Health and Wellness Resource Center, and PsycINFO databases were used to complete the literature review. Articles prior to 1995 were excluded as well as studies not completed in the US. A table was utilized that summarized the 20 studies which were coded by publication date, study design type, provider type, and attitudes and barriers utilizing both experienced and inexperienced interpreters. The studies were analyzed descriptively and the findings compared.

Findings:

This study attempts to merge understanding of both the perceptions of healthcare providers and patients to reach greater understanding.

For Hispanic patients, recurrent themes were communications, attitudes/perceptions and cultural competence, and type of illness as primary factors affecting satisfaction. Lack of child care, release from work, embarrassment, and discomfort were barriers for the Hispanic patient. Hispanic patients prefer physicians who share their race and ethnicity and four studies found that providers need to recognize the importance of family for the Hispanic patient. Hispanic patients value being offered choices and asked opinions but they prefer that physicians make decisions for them. Hispanic patients are embarrassed about their inability to speak English and reported that front-desk clinical staff are culturally insensitive.

Provider's themes included communications and language barriers, perceptions of care, and differences in care/services. Providers' attitudes were determined to affect quality of care. Physicians also perceived that Hispanic patients do not accept responsibility for their own care and fail to comply with treatment instructions. Nurses were concerned about interpreter accuracy and its effect on quality of care and outcomes.

Summary:

There are several weaknesses to this study. Researchers include all studies conducted among Hispanic patients that met criteria, however, indicate that there are many subgroups within this ethnicity and this review does not allow for examination of those subgroups. There are also differences in training and roles of interpreters within healthcare. Attitudes and perceptions may be strongly influenced by providers; training, institutional setting, and even previous experience with Hispanic patients.

This study does directly address patient satisfaction and barriers for the Hispanic patient seeking healthcare. It provides valuable literary insight into both patient and provider perspectives.

Research Study E:

Experiences with Hospital Care: Perspectives of Black and Hispanic Patients
Journal of General Internal Medicine, 1234-1240
Hicks, L., Tovar, D., Orav, E. Johnson, P. (2008)

Purpose/Hypothesis/Type:

Significant racial and ethnic differences among several dimensions of patients' experiences with hospital care have been previously documented. However, the relationship between these differences and possible differences in processes of care has not been well described. This is a longitudinal study, whereby probability and modal sampling methods were utilized. Using hospital data from a large academic medical center in Boston, MA, a random list of two thousand eight hundred black or Hispanic patients recently surveyed was produced and utilized. The study was supported by a grant from the Commonwealth Fund. The Robert Wood Johnson Foundation's Harold Amos Medical Faculty Development Program and Dr. Hicks.

Methodology:

Patients were discharged between January 1, 2002 and December 30, 2003. Twenty-seven of the one thousand five hundred seventy-five eligible cardiovascular patients (two percent) and fourteen of the one thousand two hundred twenty-seven eligible obstetrics patients (one percent) were recruited (send a letter invitation) to attend the focus groups. Participants enrolled in the study a median of sixteen and a half months after their most recent hospitalization. The median age was twenty-five years for obstetrical patients and fifty-seven years for cardiovascular patients participated. Of the thirty-six participants with available insurance information, eight were uninsured.

Focus groups were conducted with thirty-seven black and Hispanic men and women who had recently been discharged from either medical or obstetrical services at an urban academic medical center to assess which

dimensions of these patients' experiences with care were most important in determining overall levels of satisfaction. Focus groups were conducted from March 2003 through August 2004. A structured focus group technique invited patients to describe the details of their personal experiences of care within seven dimensions of hospital care, including: respect for patient preferences, physical comfort, involvement of family/friends, coordination of care, continuity and transition, information and education, and emotional support.

After each participant consented, focus groups were conducted and audio taped for analysis. Two trained, professional focus group facilitators conducted six uniform focus groups utilizing open ended questions to elicit the kinds of experience the black and Hispanic patients had. Each moderator reviewed and edited a transcript of their focus groups to improve accuracy. Transcripts were translated immediately/simultaneously.

Investigators analyzed the transcripts and facilitator notes using qualitative analytical software (NVIVO 7). Nodes were created from the seven dimensions of patients' experiences of care and transcript data were coded accordingly. Rankings were given by the focus groups based on their influence on overall positive and negative hospital experiences in each dimension of experiences with care, stratified by patient race and ethnicity, and hospital service. Positive and negative themes were identified with representative quotes for each of the themes.

Findings:

The study found significant racial and ethnic differences among several dimensions of patients' experiences with hospital care. It also found that the racial and ethnic differences were greater among those who are hospitalized for surgical or obstetrical care. Comparison tables were provided of positive and negative themes

identified in the patient experienced by both race and ethnicity for obstetric patients and cardiovascular/Medical patients. The authors suggest that hospitals should pursue hiring a culturally diverse workforce and should collect racial and ethnically specific data about satisfaction with care including satisfaction with availability of social workers and interpreters.

Summary:

Although the focus group research is a valuable method, those that accepted the invitation may be more articulate about their opinions than nonparticipants or may have had more extremely negative or positive experiences than the norm, potentially leading to biased results. Also, more women participated than men so experiences may be biased based on gender differences in the groups.

My research does not focus on black patients, however the portion of the study that relates to Hispanic Patients is quite related to my research.

Further work needs to be done to better characterize the association between processes of hospital care and racial and ethnic differences in patients' perceived experiences with care. This research only begins to pursue that dimension.

Research Study F:

Are Good Intentions Good Enough?: **Informed Consent Without Trained Interpreters**
Journal of General Internal Medicine,Vol. 22, 598-605
Hunt, L., de Voogd, K. (2007)

Purpose/Hypothesis/Type:

Ensuring sufficient patient understanding for informed consent is especially challenging for patients with limited English Proficiency. While US law requires provision of competent translation for LEP patients, such services are commonly unavailable. In this study, authors present findings from a qualitative study of prenatal genetic consultations with Latina women in South Texas, and examine the content and quality of communication in seeking their informed consent for amniocentesis when trained Spanish interpreters were unavailable. Qualitative data was collected in eight prenatal genetic clinics in Texas, including interviews and observations with 16 clinicians and 30 Latina patients. This is a longitudinal study, whereby non-probability, convenience sampling was utilized. The research was funded by the NIH National Center for Human Genetic Research and by a grant from the San Antonio Area Foundation.

Methodology:

Over a five year period, clinical observations and/or interviews at 15 prenatal specialty clinics in the region were done. Interviews focused on the clinicians' strategies for offering prenatal diagnostic testing to Latina patients, as well as their approaches to language barriers. Authors also interviewed a convenience sample of 30 patients, all self-identified Latina women whom were observed being offered amniocentesis after an abnormal blood screening test. Interviews focused on their understanding and experiences with prenatal testing and for Spanish speakers, their impressions of the language interpretation issues. Patients were classified as having "no language problem" when their genetics consultation occurred between primary English speakers, or between primary Spanish speakers. All interviews consisted of standardized sets of open-ended questions,

averaged two hours in length and were tape recorded and transcribed. Careful field notes were taken to document clinician-patient interactions as full as possible, giving special attention to translation issues when the interaction took place across a language barrier.

This research was funded by the NIH National Center for Human Genetic Research and by a grant from the San Antonio Area Foundation.

Findings:

The study describes multiple communication problems related to the use of untrained interpreters, or reliance on clinicians' own limited Spanish. These LEP patients appear to be consistently disadvantaged in each of the criteria we examined, and informed consent scores were notably lower for consultations which occurred across a language barrier. It was uncertain in the study whether these LEP patients were provided the quality and content of information needed to assure that they were genuinely informed. The authors described themselves as being struck by the limited amount of information that was actually communicated. Interpreters often seemed to lack the linguistic fluency and/or technical medical understanding necessary to provide an adequate interpretation.

Summary:

The authors did not assess patient knowledge before the consultations, so there is really no way of knowing whether these differences exist outside the consultations themselves. Also, the conclusions cannot be generalized beyond describing this particular group. This was designed as a purely descriptive study, using a convenience sampling technique.

Informed consent is an important component of language interpretation and this study offers some possible reasons and new understanding of what Hispanic patients are being told and not being told prior to their procedures.

This study provides some low cost strategies that can certainly be useful in any healthcare setting, such as translating key documents in Spanish and other languages for the LED patients to inform them of what is about to occur and reach full consent in an ethical manner.

Further research with random samples from various healthcare settings would be valuable before general conclusions could be drawn about a broader population. It would also be useful to examine the effect of competing variables, such as education and income levels. It would also be helpful to compare differences in interpretation with trained versus untrained interpreters and levels of satisfaction.

Research Study G:

Patterns of Communication through Interpreters: A Detailed Sociolinguistic Analysis
Journal of General Internal Medicine 21: 623-629;
Aranguri, C., Davidson, B., Ramirez, R. (2006)

Purpose/Hypothesis/Type:

Although numerous articles have detailed how the presence of an interpreter leads to less satisfactory communication with physicians, few have studied how actual communication takes place through an interpreter in a clinical setting. In this study, authors outline the findings of an in-office linguistic study in which transcripts of physician-patient interpreter interactions were analyzed for content, form, and influence of the interpreter on the interaction as a whole. This is a qualitative study, utilizing non-probability, purposive sampling. The study was funded by Pfizer, Inc.

Methodology:

Recruiting letters were sent to a regionally diverse sample of 880 physicians from high volume practices and large Hispanic populations. Physicians were recruited and screened and sixteen were scheduled for a research day. Nine physicians were recruited from four regions (NY, CA, TX, and FL). On the appointed day, a research was sent to the physician's office to record interactions with patients with limited English speaking ability. Patients were screened on the day of a normally scheduled appointment and once consented, reported without a researcher present in the room. Sixteen patients were recorded interacting with nine physicians. Separate post visit interviews were conducted with the patient and the physician. All interactions were fully transcribed, coded, and analyzed. Thirteen patients used an interpreter with six physicians and three patients spoke Spanish with one bilingual physician.

Interactions were video recorded and audio recorded in the absence of an observer. All data was translated and every word of the transcripts was coded. Time spent was also measured and recorded. Key components of the discourse were identified through bottom-up hypothesis generation and were then applied to the transcripts systematically. All patient complaints were also identified and analyzed as was the patient's alignment with the physician on key aspects of "what was said" during the interview.

Findings:

There were many ways in which the presence of an interpreter changed the conversation, including balance of time spent speaking, content omissions/revisions/reductions, number of questions asked by the patient, and redirection of utterances. The implications of for these finds are wide-ranging. They confirm earlier findings that interpreted discourse follows a very different pattern from same-language conversations. In addition, this study reveals several areas that can form the basis for education in improved communication techniques.

Summary:

Although the study was relatively small, and the patterns of communication uncovered do appear valid and clear, and the sample is a random sample that covered four geographical areas. A larger study with a larger n might be able to explore more fully the systematic conversational differences that exist with more depth.

Although this study does not address the training of interpreters, it does provide greater understanding of how language barriers and the use of interpreters truly changes patterns of communication in very profound and significant ways including time spent speaking and number of words used.

The suggestions provided at the end of the study on how we can improve communication techniques by teaching communication principles to both interpreters and physician are valuable; as well utilizing interpreters

to make sense of the visit after the visit is over. In other words, stay with the patient a bit longer until all their questions are answered is valuable insight towards patient satisfaction.

Further areas of research would include repeating the study after training of both interpreters and physicians was done to try and improve the problems that were uncovered here in this study.

Research Study H:

The Pain Experience of Hispanic Patients with Cancer in the United States
Oncology Nursing Forum, Vol 34, 861-868
OkIm, E., Guevara, E., Chee, W. (2007).

Purpose/Hypothesis/Type:

Hispanic identity or immigrant status, financial difficulties, language barriers, and cultural values placing family as the highest priority interfere with descriptions and management of pain for the Hispanic patient. Because of traditional gender roles emphasizing machismo, Hispanic men rarely complain about pain. Cultural traditions among Hispanic women emphasizing an obedience and obligation to sacrifice for their families resulted in women enduring pain while fulfilling their multiple roles and responsibilities. Hispanic patients with cancer place their highest priority on family while managing cancer pain. The study explores how gender and ethnicity influences the cancer pain experience. The purpose of this study was to explore Hispanic patients' cancer pain experience from a feminist perspective to find explanations for inadequate pain management. 15 Hispanic patients with cancer were recruited using a convenience sampling method. This is a qualitative study, utilizing online forums. No funding source was noted.

Methodology:

The participants were recruited through the Internet and in community settings using a convenience sampling method. Data collection was done only through the Internet. Forty-four Hispanic participants in an Internet survey were invited to participate in the online forum; 15 remained in the online forum at the end of the six month period.

The participants included only patients with cancer who were at least 18 years of age, who could read and write "English or Spanish, whose self reported ethnic identify was Hispanic, who had access to a computer and the Internet and were able to use them, and who had experienced pain from cancer.

A six month online forum was conducted using nine discussion topics, and the data was processed using a thematic analysis. Topics covered were terms to describe cancer pain and their linguistic meanings; verbal and nonverbal communication styles used to relate cancer pain, culturally universal and specific descriptions of cancer pain; gender differences in pain descriptions; patients' response to cancer pain; patients evaluation of cancer pain assessment conducted by healthcare professionals; patients' evaluation of cancer pain assessment tools; patients' evaluation of cancer pain management provide by healthcare providers; patients preferences for cancer pain management strategies; other topics added based on participants feedback. During the six month period while the online forum was being administered, a total of 227 messages were posted. Each participant posted an average of .5 messages per month.

Findings:

Four major themes emerged: lack of communication about under medication; macho men tendencies; family is more important than cancer pain; and patient feeling like a prisoner.

Summary:

There is really no way of knowing if the participants is this study were really who they say they were based on its methodology - they could not see them to determine if they are truly a 45 year old Hispanic women for example. Also online forums are not a well-established data collection method, although recent studies indicate that they generate findings similar to those of traditional data collection methods. Also internet users tend to be educated, middle class, healthy, married, white and computer literate and this study was limited to

only those individuals who have access to and know how to use a computer.

The quality of medical interpretation is not directly addressed in this study however it provides an interesting parallel to understanding the limitations and difficulties in caring for the Hispanic patient.

I could apply this as additional research to understanding the needs of the Hispanic population and how they communicate or don't communication their perception of chronic pain. An interpreters knowledge of these tendencies would be helpful training for interpreters to go through.

Cultural values, beliefs, and attitudes related to cancer and pain need to be further explored among diverse ethnic subgroups of Hispanic patients. Also, because of the computer component of this study, further investigation with a more diverse Hispanic population is essential for complete knowledge of cancer pain management. Family members could perhaps also be studied and interviewed as they are at the center of these patients lives and are their only resources and support systems in many cases.

Research Study I:

Cultural Competency as a Skill for Health Care Providers.
Hispanic Health Care International. Vol. 6, No. 3, 115-121
Berry-Caban, C., Crespo, H. (2008)

Purpose/Hypothesis/Type:

As the US becomes more diverse, health care providers need to become more adept at working with a full range of cultures and languages. This paper examines the role that cultural competence can play. Culture and language impacts how patients access and respond to substance abuse services and influences health-seeking behavior, interpretation of symptoms, compliance with treatment regimens, satisfaction with care, and attitudes about death and dying. This is a literature review and summary on the general topic of cultural competency for health care providers. This is a literature review and summary on the general topic of cultural competency for health care providers. No funding source was referenced.

Methodology:

Key topics addressed in this literature review included: Cultural Clashes, Areas of Dissonance, Cultural Values, Cultural Competency, and Essential Elements of Cultural Competence. Online guides were also provided and references.

Findings:

Despite the rapidly growing demographics of the Hispanic and other cultural communities, there is a lack of general understanding as to the impact and the implications of this growth on the health care profession. Cultural competency is one way to meet the diverse needs of the communities. The lack of cultural competency has adverse consequences for the delivery of these services.

Summary:

Cultural awareness and competency is not directly related to my research on medical interpretation but is an important variable to delivering effective care. Many excellent references were cited here. This is a very well organized summary on the topic of cultural competency and the need for increased awareness of these skills for healthcare providers.

Further research could certainly be done with organizations who have rolled out cultural competency programs to measure the program's effectiveness and usefulness in promoting positive methods and strategies of delivery culturally competent care.

Research Study J:

Clinicians and Medical Interpreters, Negotiating Culturally Appropriate Care for Patients with Limited English Ability
Community Health, Vol. 30, No. 3, 237-246
Dysart-Gale, D. (2007).

Purpose/Hypothesis/Type:

A significant number of difficulties arise from unrealistic expectations about the nature of communication in the clinical setting. Interpreter practice is based on a theoretical understanding of communication that does not adequately describe the problems faced by interpreters in negotiating between immigrant and practitioner groups, the author argues that these difficulties result from the fact that interpreter practice is based on a theoretical understanding of communication that does not adequately describe the problems faced by interpreters in negotiating between immigrant and practitioner groups. This is a qualitative study whereby non-probability, convenience sampling was utilized. The study was conducted from the General Studies Unit of Concordia University, Montreal, Quebec, Canada. No funding source was noted.

Methodology:

Data from interviews with interpreters and practitioners is used to describe how three difficulties specifically stem from reliance on a simplified theory of communication that does not adequately describe the work performed by medical interpreters. The data came from field observations conducted in conjunction with the development of a course on medical terminology. The interpreters provided voluntary oral consent for participation in the observations and interviews. The author recorded field notes while observing 32 professional interpreters in a variety of clinical settings from two hospitals. She also conducted one-on-one semi-structured interviews with 27 interpreters. The interpreters interviewed and observed professional healthcare interpretation for immigrants from Latin America, Africa, the Middle East, or Asia. Twenty-three of

the interpreters were immigrants themselves who had come to the US as young adults. These interviews lasted from 30-90 minutes.

The interviews were audio taped and transcribed; pseudonyms were assigned and used in the research paper. A research assistant checked the transcripts for accuracy against the original audiotapes. Using qualitative analysis techniques based on grounded theory methodology, the author then coded the transcripts for themes related to interpreter role performance.

Findings:

Medical interpreters provide a bridge across the language gap for patients and practitioners. Research suggests that practitioners and interpreters experience numerous difficulty in their collaboration that can negatively affect service to patients with LEP patients, many of whom are immigrants. Results of interviews with medical interpreters indicate that many of these difficulties result from the fact that interpreter practice is based on a theoretical understanding of communication (bridging) that does not adequately describe the problems faced by interpreters today in negotiating between immigrant and practitioner groups.

Summary:

I was able to find really no detailed analysis given about the interviews themselves in this study. The Research Study provides only a literature review and a summary or discussion of the observations gathered. Two interpreter models are discussed in Research Study model however little information is given about those models. There is also no evidence that the sample is representative of interpreters in general or of LEP patients.

This study could be applied to processes that involve creating standards for interpretation and how to interpret effectively.

I would like to see further research like this done though as it takes us beyond the surface of what interpreting is and takes us into the specific details. Interpreting is not just the transferring of a message from the provider to the patient but it is transferring an accurate message that can be understood by the receiver and this may include knowledge of the persons medical condition, what is being prescribed, and perhaps negotiation and encouragement from the interpreter. I would like to see more research on methods of interpretation as it relates to outcomes and positive health care experiences.

Research Study K:

Working with interpreters across language and culture in mental health
Journal of Mental Health, June 2009; 18(3): 233-241
Tribe, R., Lane, P. (2009)

Purpose/Hypothesis/Type:

Authors from the School of Psychology, University of London, felt that medical professionals need to work more effectively with interpreters to promote good clinical practice and ensure equality of access and service delivery in the area of mental health. This article draws on literature and clinical accounts to provide a set of positive practice guidelines regarding working with interpreters in mental health. The study is a literature review and summary of findings and recommendations. No funding source is noted.

Methodology:

Key indicator words for a literature review were used to locate papers that related to interpreters and mental health as well as language and mental health. Authors also drew upon accounts of support and supervision groups for interprets and bicultural workers, expert panels on the topic, training programs and published guidelines for interpreters and clinicians.

Findings:

Mental health services around the world need to be accessible, inclusive, appropriate and in accord with best practice and national legislation. The paper reviews opportunities and suggestions in working with interpreters based on available literature. The authors suggest that interpreters be viewed as colleagues in the same way as another professional within a multi-disciplinary team. Interpreters can not only enhance clinical work and understanding but make it possible for mental health practitioners to fully communicate with their clients. Appropriate training for clinicians and interpreters will benefit the service offered to patients as well as enhance the confidence and skills of all participants.

Summary:

I found this to be a very helpful article related specifically to the delivery of mental health services and language services. Even though it takes place in the UK, the information is quite applicable here in the US. There was no new research done here. The authors cited their own work several times utilizing prior research studies one of the authors in particular (Tribe) had previously done, however many other references were utilized and noted as well with a comprehensive reference list provided. It is interesting to me that in a country where they have a national registered of certified medical interpreters, interpreter access and effective use is still and issue and highly researched.

Research Study L

A Targeted Review to Examine Reporting of Translation Methodology in Hispanic Health Studies
Hispanic Health Care International, Vol. 8, No. 3, 2010
Martha A. Medrano, MD, MPH, Pamela H. DeVoe, MA, Alixis Padilla, PhD., Lyda Arevalo, MSN, RN, Judith W. Grant, PhD., Anyssa Aldape, BS

Purpose/Hypothesis/Type:

This article is a targeted review and analysis to investigate whether appropriate translation methodologies were utilized for published studies that enrolled Hispanic participants who are Spanish speaking. Despite being the largest minority group in the US, authors feel that Hispanics are under-studied and under-represented in clinical research and data captured from poorly translated studies has been shown to be meaningless and misleading. A three point procedure for translation is discussed in the article as the "gold standard" for research. This double translation process, begins with the study being translated in the target language; then a different individual or group translating the instrument back to the original language; and finally an independent set of reviews compare the two versions to ensure that the translated instrument is conceptually equivalent to the original. A total of 100 articles were reviewed by researchers from the University of Texas Health Science Center and the University of New Mexico School of Medicine. The study is a literature review. Funding source is not noted.

Methodology:

The research included studies that utilized questionnaires, surveys, or standardized interviews including a Hispanic population and determined whether, for each study, appropriate translation methodologies were utilized/considered. Articles included in the study had to meet two criteria: to report data on Hispanic or Spanish speaking participants and utilize surveys, questionnaires, or interview instruments. Translator qualifications were discussed, translation technique, validity, reliability, measurement error; and the responsibility of researchers and IRBs.

Findings:

Data captured from poorly translated study instruments are meaningless and misleading. Of the 100 articles that fit the inclusion criteria, only 72% (n=28) of the studies conducting interviews and 48% of those utilizing surveys (n=32) offered them in Spanish. The majority of interviews (68%) and surveys (53%) failed to provide information regarding the translation methodology and the qualifications of translators were left out of 85% (n=24) of study interviews.

Summary:

Authors stressed the importance, in cross cultural studies, to describe the procedures involved throughout the translation process of all study instruments used. Furthermore, in these multicultural contexts, investigators need to include information about the process used when translating and administering study instruments, regardless of whether the instrument is standardized or newly created. Journals and funding agencies need to recognize and require the inclusion of translation techniques when reviewing manuscripts, and need to require that specific guidelines are met to ensure valid data.

Since much of the research I reviewed for this professional project is based on LEP participants, I found this study to be very surprising. Research indicates that racial and ethnic minorities receive a lower quality of health care compared with non-Hispanic whites, however when researchers seek to analyze this trend, if appropriate methodologies are not used in their research - the results are worthless, according to these authors. This was a unique study I think, looking at an important research issue when studying interpreting methods, patient satisfaction, quality of care issues, and even language access for non-English speaking patients and more research standards need to be put into place regarding this issue.

Research Study M:

Improving the Provision of Language Services at an Academic Medical Center: Ensuring High Quality Health Communication for Limited English- Proficient Patients
Academic Medicine, Vol 84 No. 12 / December 2009
Connie J. Standiford, MD, Elizabeth Nolan, RN, Michelle Harris, MA, and Steven J.Bernstein, MD, MPH

Purpose/Hypothesis/Type:

The purpose of this research was to evaluate and improve the provision of language services at an academic medical center caring for a diverse population of LEP patients. All four authors are from the Department of Internal Medicine at the University of Michigan. The University of Michigan Health System was 1 of 10 groups selected to participate in the Speaking Together program, sponsored by the Robert Wood Johnson Foundation. The program was designed for hospitals to use quality improvement tools and techniques to improve their language programs through a collaborative learning process. Hospitals selected to participate were asked to focus on one inpatient and one outpatient service. The study is a cross sectional study utilizing stratified random sampling. This research was funded by the Robert Wood Johnson Foundation.

Methodology:

The University of Michigan Health System performed a prospective observational study between November 2006 and December 2008 with patients who had diabetes. They used the University of Michigan Health System's diabetes registry to identify patients with diabetes. Patients were considered "active" if they had two or more outpatient visits within the last two years or one visit within the last 13 months. They looked at three measures:

1. Percentage of patients with preferred language documented in the electronic medical record
2. Percentage of patients receiving language services from a qualified language services provider
3. Percentage of LEP and English proficient patients who met diabetes specific quality criteria based on the "Healthcare Effectiveness Data and Information Set" quality measure.

Findings:

The proportion of patients screen for preferred language increased from 59% to 94% in two years with targeted inventions, such as training staff to capture preferred language for health care and correcting prior inaccurate data. The proportion of LEP outpatients with a qualified language services provider increased from 19% to 83% through the use of staff and contract interpreters, over the phone interpreting and bilingual providers. Lastly, there was no systematic differences in diabetes quality performance measures between LEP and English proficient patients.

Summary:

One weakness in this study is that it represents only a single medical center and may not be representative of all health care institutions. Also, they did not define what a "qualified language provider" was so if a patients was seen by a bilingual provider, it was assumed that they were seen by a "qualified language provider" which may or may not be the case. Research like this can and should be repeated though to measure language access services and compare it to quality and safety data among LEP and English speaking patients to identify disparities in care. This was a successful model and the Robert Wood Johnson Foundation should be commended for providing the tools and insight to implement this at ten US hospitals. Leadership support and ongoing training are needed to ensure language- access services are embedded into clinical care to meet the needs of diverse patient populations, and this provides a method to implement needed change as well as successfully track the results.

Research Study N:

Language Barriers among Patients in Boston Emergency Departments: Use of Medical Interpreters After Passage of Interpreter Legislation
Journal of Immigrant Minority Health (2009)
Adit A. Ginde, Sunday Clark, Clarlos A. Camargo, Jr.

Purpose/Hypothesis/Type:

Medical interpretation for limited English speaking patients significantly increases the quality of health care delivery, patient compliance, and overall patient satisfaction with the medical encounter according to article. Interpreter type also has an impact of the medical experience. The use of professional interpreters during an ED visit may lead to decreased ED re-visit rate and increased access to outpatient services, without simultaneous increase in length of stay or cost of the index ED visit. In 2001, a Massachusetts state law was passed stating that ED LED patients have a right to a professional interpreter.

The study was a comparative study utilizing stratified random sampling. Authors conducted a prospective multicenter study in Massachusetts one year later after the new legislation in Massachusetts whereby language access and interpretation method was assessed for patients coming into the ED at four hospital sites. Interviews were done in English and then compared with the observed use and type of interpreter utilized during the ED visit. The research was supported by a Grant from the National Institutes of Health (Bethesda, MD).

Methodology:

Researchers interviewed 530 patients (70% of eligible) at two university-affiliated hospitals and one community hospital in an urban setting, and one community hospital in a suburban setting. in 2002 to determine if professional interpreters were being used consistently after 2001 legislation. Consecutive patients age 18 or older were enrolled over two 24 hour periods on a Wednesday and a Saturday at each hospital site.

Exclusions included critical ill patients or potential victims of sexual assault and emotionally disturbed patients. Trained interviewers assessed the patients' need for an interpreter, based on patient preference and ability to respond to questions in English. All analyses was performed using STATA 9.0.

Findings:

Of 754 eligible patients, 530 agreed to participate. Among the 530, interviews were conducted largely or entirely in English. Only 45 participants (8%) had their interview move into a language other than English. Findings showed that only 4% of study interviews, in which language barriers were detected, were interpreted by hospital interpreter services. Interpretation was most often provided by a physician or other healthcare provider. The results in the four Boston EDs, indicated that 11% of patients had language barriers that required interpreters, but only 15% of these patients were assisted by professional medical interpreters, even though it is their right. One year after passage of legislation stating that Emergency Department patients had a right to professionally trained medical interpretation, the use of professional medical interpreters remained inadequate.

Summary:

The utilization of interpreter services in the Emergency Department prior to the passage of the medical interpreter law in MA was 12-15% which suggests that access did not improve with enactment of legislation. The study did find some variation by site in need and use of professional interpreters, which indicated that some hospitals may have adapted differently to the legal requirement. The ability of providers to accurately ascertain information from patients and help them to fully understand their diagnosis, risks, and follow-up instructions is especially important in the ED environment, where patients and staff are faced with complex medical decisions in the face of illness or injury.

Limitations of the study are that it was geographically limited to one area that may have actually had lower racial ethnic diversity compared to many other urban EDs. Critically ill patients were not included in study nor were emotionally disturbed patients, even though these LED patients also require professional interpreters and should not be bypassed. The study stated that 15% of the LED patients were assisted by physician or medical staff but no information was given on their education or ability to interpret. Regardless, this study shows clearly the problems with consistent access and use of interpreters in a medical setting relevant to medical interpreter usage, availability, and appropriate training, by hospital physicians, leaders, and staff to use interpreters consistently or become knowledgeable, qualified interpreters themselves.

Research Study O:

Predictors of Appropriate Use of Interpreters: Identifying Professional Development Training Needs for Labor and Delivery Clinical Staff Servicing Spanish-speaking Patients
Journal of Health Care for the Poor and Underserved
Tilly A. Gurman, Allisyn Moran

Purpose/Hypothesis/Type:

Between 1980 and 2000, authors noted that the Latino population more than doubled in the US and became the country's largest ethnic minority group. Trends in labor and delivery reflect this changing demographic trend, however Latinos are less likely than Whites to have health insurance and therefore less likely to go to see a health care provider. It is estimated that only 20% of Latinos in the U.S. are English dominant, with 20% being bilingual and the remaining 60% Spanish dominant. The authors discuss how providing trained medical interpreters when needed has been shown to reduce medical errors, increase patients' perceptions of a welcoming healthcare facility, as well as increase overall satisfaction with services rendered. Furthermore, effective interpretation increases the likelihood that patients understand medication instructions and return for follow-up appointments, and reduces the likelihood that they use the emergency department for future care. This study identifies predictors of appropriate use of interpreters by maternal labor and delivery service providers. The purpose being to identify predictors for appropriate use of interpreters to inform and the development of effective cultural competency professional development interventions. This study is a cross sectional study utilizing stratified random sampling. This study was a part of a larger project to improve the quality of labor and delivery services for Latinas. No funding source was listed.

Methodology

Clinical labor and delivery staff (n=200) at five hospitals between 2004 and 2005 in an Eastern U.S. city (population approximately 600,000) completed a survey about providing care to the Latina population. Inclusion criteria included employment in one of the five study hospitals as a physician, certified midwife, or

nurse providing labor and delivery services. There was no exclusion criteria. No compensation was provided for participation. Human subjects approval was granted. Staff members were given surveys during staff meetings. A description of the study purpose, disclosure statement, and detailed instructions introduced the survey, based on a five point Likert scale ranging from very likely to very seldom. Data analysis was conducted using Stata 8.0 software, including factor analysis and logistic regression.

Findings

The sample consisted of 200 providers, 46% whom were physicians/midwives and 54% of whom were nurses. Two percent identified Spanish as their native language. The majority of respondents were White (57%), Black (23.5%), and 2.5% were Hispanic. Overall 29.5% reported participating in professional development to enhance their knowledge and skill in providing services to ethnically and linguistically diverse groups, while 39% had never participated in such an activity. 47% felt confident in their ability to meet the needs of the Latinas. 88.5% reported that receiving training about new practice guidelines was important to them. Only 18.5% of participants offered responses that classified them as working appropriately with interpreters. Multivariate logistic regression identified significant predictors for appropriate use of interpreters. The strongest association with appropriately using interpreters was relying on general mass media for medical information. Other statistically significant variables included agreeing that learning about Latino history and culture could improve quality of care and seeking medical information from colleagues at the same hospital.

Summary

The majority of participants in the study did not feel confident in their ability to meet the needs of the Latinas, although they felt that receiving training about new guidelines was important. This study suggests the needs

for health care professionals to receive training related to the appropriate use of interpreters, especially for Spanish-speaking patients. Training should emphasize that learning about the history and culture of their Latina patients could improve the quality of the services they provide. Study findings highlight the need to discourage participants from turning to general mass media for information and encourage staff to participate in training development programs regarding how to effectively work with interpreters and Latino patients effectively. Limitations of the study were that the survey tended to take place during a staff meeting, a time when health care providers may have been juggling multiple activities concurrently and whereby participants may have felt like they were being judged by the spent completing the survey. It was also primarily based on physician and staff perception and was not compared to any real hospital statistics related to actual use of interpreters on the unit or method of interpretation most often used. Also, the study was based on one city and may not be representative of all health care providers in other specialties or other areas of the country.

Research Study P:

Overcoming Language Barriers in Health Care: Costs and Benefits of Interpreter Services
Research and Practice, May, 2004, Vol. 94, No. 5
Elizabeth A. Jacobs, MD, Donald S. Shepard, PhD, Jose A. Suaya, MD and Esta-Lee Stone, MS

Purpose/Hypothesis/Type:

Study was conducted from June 1995 - May 1997, at four health centers servicing approximately 122,000 patients. The health centers were staff by salaried physicians and were part of a large Massachusetts HMO that implemented comprehensive interpreter services for Spanish and Portuguese-speaking patients. Services were provided by five full-time trained interpreters who were available to help patients 24 hours a day either by phone or during walk-in visits and at all points of contact in the HMO. Study assessed the impact of interpreter services on the costs and the utilization of health care services among patients with limited English proficiency. This study was a longitudinal study utilizing a stratified random sampling method. The research was supported by the Center for Mass Health Evaluation and Research (CMER) and the University of MA Medical School.

Methodology:

A random sample of 10% of all eligible members who had accessed care at 1 of the 4 centers at least once during year two of the study formed the comparison group. Data was also abstracted from the automated medical record including demographic information and information about utilization of preventative, primary care, and emergency department services. Cost data included both the direct costs of providing interpreter services and the costs of net charges in health care utilization that occurred after the new services were implemented. Researchers measured the change in delivery and cost of care provided to patients enrolled in a health maintenance organization before and after interpreter services were implemented.

Findings:

There were 380 patients in the interpreter service group and 419 in the comparison group. The majority of interpreter service group patients spoke Spanish (n=300). Compared with English speaking patients, patients who used the interpreter services received significantly more recommended preventative services, more office visits, and had more prescriptions written and filled. The estimated cost of providing interpreter services was $279 per person per year.

Summary:

Providing interpreter services is a financially viable method for enhancing delivery of health care to patients with limited English proficiency. The majority of the increase in the cost of care was attributable to the provision of interpreter services. Patients who used the new services though had a significant increase in the receipt of preventative services, physician visits, and prescription drugs, which suggests that interpreter services enhanced these patients access to primary and preventative care for a moderate increase in cost. Limitations noted by the aurhors were that the sample size was small for the interpreter service group. Data was abstracted over a one year period only and the study did not measure benefits of the services such as improved communication and quality of care. All participants were from a well established staffed HMO with enrollees who were all insured for an average of more than three years. The is an important study addressing the value of providing interpreter services and why it is important to support and educate staff on how to provide language services effectively and consistently.

Research Study Q:

Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature
Health Research and Educational Trust,42:2 April 2007
Leah S. Karliner, Elizabeth A. Jacobs, Alice Hm Chen and Sunita Mutha

Purpose/Hypothesis/Type:

Given that over 100 languages are commonly spoken in the United States, it is often not possible to provide language concordant health care. Although some LEP patients are fortunate enough to be seen in settings where physician and office staff speak their primary language, this language concordance can readily disappear once these patients present for laboratory testing, emergency care, or are admitted to the hospital. therefore, the majority of providers must use other means to communicate with their LEP patients, and if they receive financial assistance, are required to do so by Title VI of the Civil Rights Act of 1964. The purpose of the study was to determine if professional medical interpreters have a positive impact on clinical care for limited English proficiency (LIP) patients. This was a systematic literature review, limited to publications between 1966 and Sept. 2005, and a search of the Cochrane Library. Sources of funding were: Health Resources Services Administration (HRSA) Fellowship Training Grant (Dr. Karliner); Robert Wood Johnson Generalist Physician Faculty Scholars program (Dr. Jacobs); and The California Endowment (Dr. Mutha).

Methodology:

Any peer-reviewed article which compared at least two language groups, and contained data about professional medical interpreters and addressed communication (errors and comprehension), utilization, clinical outcomes, or satisfaction were included. Of 3,698 references, 28 were found by multiple reviewers to meet inclusion criteria and, of these, 21 assessed professional interpreters separately from ad hoc interpreters. Data were abstracted from each article by two reviewers. Data were collected on the -study design, size, comparison groups, analytic technique, interpreter training, and method of determining the participants' need for an

interpreter. Each study was evaluated for the effect of interpreter use on four clinical topics that were most likely to either impact or reflect disparities in health and health care

Findings:

In all four areas examined, use of professional interpreters is associated with improved clinical care more than is the use of ad hoc interpreters, and professional interpreters appear to raise the quality of clinical care for LEP patients to approach or equal that for patients without language barriers.

Summary:

Medical interpreting is a field in evolution, with ongoing development of standards of practice and codes of ethics. Currently, training ranges from several hours to more than a year. This variation may result in a wide range of competency levels among professional medical interpreters. Of course, ad hoc interpreters - such as friends, family members, secretarial or custodial staff - have no training at all and their fluency in both English and their native language is not known. When only professional interpreters are used, the findings are more consistent; all studies which clearly identified the effect of professional interpreters show better results with use of interpreters. In summary, published studies report positive benefits of professional interpreters on communication (errors and comprehension), utilization, clinical outcomes and satisfaction with care. Limitations to the literature review were that researchers were unable to evaluate whether each individuals use of services was medically appropriate. It is possible that something other than interpreter use could account for differences in findings between studies and groups. Also some of the articles did not adequately separate the effects of different types of interpreters used, and half did not make it clear whether or not the professional interpreters in the study had undergone any training.

Research Study R:

Assessing Dual Role Staff-interpreter Linguistic Competency in an Integrated Healthcare System.
Journal of General Internal Medical, Vol. 22, 2007
Maria R. Moreno, M.P.H., Regina Otero-Sabogal, PhD. and Jeffrey Newman, M.D.

Purpose/Hypothesis/Type:

Interpreter services for medical encounters increases physician-patient communication and safety, yet a "formal certification" process to demonstrate interpreter competence does not exist. Testing and training is left to individual health care facilities nationwide. Bilingual staff are often used to interpret, without any assessment of their skills. Assessing interpreters' linguistic competence and setting standards for testing is a priority.

The objective of the study was to assess dual-role staff interpreter linguistic competence in an integrated health care system in California to determine skill qualification to work as medical interpreters. The healthcare system comprised 26 hospitals, 9 medical foundations, and more than 3000 physicians. It serves 22 counties throughout Northern California, delivering inpatient and ambulatory services to approximately 18.4% of the state's patients. This is a relational, longitudinal study, using a purposive sampling method. The study was supported by The California Endowment and Sutter Health.

Methodology:

Managers of the health organization completed an electronic survey to identify staff serving as dual role interpreters who had not previously received formal training or testing. Approximately 1200 staff members system wide were identified as potential candidates for Spanish, Chinese, Russian, Tigalog, Vietnamese, Punjab, and Hmong. Dual-role staff interpreters voluntarily completed a linguistic competency assessment using a test developed by a language school to measure comprehension, completeness, and vocabulary through

written and oral assessment in English and the second language. Pass levels were predetermined by school as not passing, basic (limited ability to read, write, and speak English and the second language) and medical interpreter level. Five staff-interpreter focus groups discussed experiences as interpreters and with language test.

Findings:

Between April 2003 and April 2007, a total of 840 dual-role staff interpreters were tested for Spanish (75%), Chinese (12%), and Russian (5%) language competence. Most dual-role interpreters serve as administrative assistants (39%), medical assistants (27%), and clinical staff (17%). Two percent did not pass, 21% passed at basic level, 77% passed at medical interpreter level. Staff that passed at the basic level was prone to interpretation errors, including omissions and word confusion. Focus groups revealed acceptance of exam process and feelings of increased validation in interpreter role.

Summary:

This study has significant implications in finding that 1 in 5 dual-role staff interpreters at a large health care organization had insufficient bilingual skills to serve as interpreters in a medical encounter. Health care organizations that depend on dual-role staff interpreters should consider assessing staff English and second language skills. It was the first of its kind to document dual-role language testing and provides an initial step toward developing a standard model for assessing language competence of dual role interpreters a large health care systems. The results support the Joint Commission report on the importance of assuring adequate language services to ensure quality care and patient safety in health care.

Interpretation is a learned skill; whereas it is true that every interpreter can speak at least two languages, it does not follow that every bilingual person in an effective interpreter. Current policies are limited and unclear as to

what constitutes appropriate language services. Health and Human Services developed its own guidance (Section VI.A. (August, 30, 2000) addressing considerations relating to interpreter and translator competence stating that any health provider that receives federal financial assistance from HHS must have a process in place to demonstrate fluency of speaking, reading, and writing in both English and a second language, including the ability to translate the names of body parts and to competently describe symptoms and injuries in both languages to be considered a "competent interpreter". Further research is necessary to guide legislation and to demonstrate whether assessing interpreters' language competence within the health care setting can impact quality of care and patient satisfaction. The availability of appropriate assessment tools to measure bilingual language competence of dual role interpreters and nursing staff will allow for correct classification of staff support and appropriate curriculum development within a continuum of skills.

Limitations noted were that more adequate participant data could have been obtained, such as country of birth, duration in the US., education, and age. Additionally, study focused on staff in one health care system. It did not measure other critical components of interpretation such as patient advocacy, cultural competence, emotional connectivity, an warmth. Interpreting for the elderly for example requires other skills such as patients and understanding, which was not captured here. Adverse effects were also not measured provide culturally appropriate health care to all patients is needed.

Research Study S:

Quality in Medical Translations: A Review
Journal of Health Care for the Poor and Underserved 18 (2007; 74-84
Maria R. Moreno, M.P.H., Regina Otero-Sabogal, PhD. and Jeffrey Newman, M.D.

Purpose/Hypothesis/Type:

Despite a growing number of U.S. citizens who do not speak English fluently, little literature attends to issues of accurate translation of medical documents. Authors conducted a systematic review of the World Wide Web and electronic library resources to identify sources on translating clinical and medical research documents. They identified and carefully examined 44 relevant articles. This is a relational, cross sectional study, utilizing purposive sampling. No funding source noted.

Methodology:

Of the 44 relevant articles examined, each article was coded with 5 to 10 key words that were used as a guide when we searched the articles for issues salient to assuring quality in medical translations. It was then divided these into two major categories, mechanics/practicalities of translating medical documents and extrinsic factors influencing medical translations.

Findings:

The results of this review confirm that medical translation is a complex process involving far more than mechanically converting one language to another. Attention to translation procedures can improve the quality of care for limited English proficient patients. To maximize cultural equivalence, researchers/health institutions should employ medical translators interested in the subject matter and target audience and able to judge how the audience will interpret the translated text. Knowledge of culture of the target language is a key tool for dealing with sensitive issues, including race, gender, age, and medical history. Medical translators must consciously consider the influence of their own culture and experiences on their translations. One means

of assessing translators proficiency is by consulting a second person who speaks the target language. People who have lived abroad for an extended period of time and currently use the language in daily work or life might also serve as screeners to evaluate translators. It is also important that medical translators leave a trail of documentation about how material was translated, where difficulties occurred, and when compromises were made. This is necessary when re-evaluate the quality of translation for improvement and recognition of errors.

Summary:

Limitations of this review is that it focused on electronic resources only. Other researchers might organize findings differently than these authors did. Medical translation is a complex process. Availability of best quality translations is essential for key documents in health care, such as consent and complaint forms, intake forms, written notices of rights and free language assistance, applications to participate is programs or activities, and patient feedback surveys and this study did not look at availability of these documents only quality of documents available electronically. Further research needs to be done on availability of these documents are that they are appropriately translated.

Although my research does not focus on written translation, this is a very important part of providing appropriate medical care to the LEP patient. Centralized processes that provide high quality translated medical documents such as complaint forms, intake forms, patient rights and language assistance notices, translated appropriately and available to be printed in various languages, could benefit all health care providers without each having to reinvent the wheel by having to translate all these documents themselves.

Research Study T:

The Impact of an Enhanced Interpreter Service Intervention on Hospital Costs and Patient Satisfaction
Journal of General Internal Medical, Vol. 22, (2007
Elizabeth A. Jacobs, MD,MPP, Laura S. Sodowski, MD, MPH, and Paul J. Rathouz, PhD

Purpose/Hypothesis/Type:

Many health care providers do not provide adequate language access services for their patients who are limited English-speaking because they view the costs of these services as prohibitive. However, little is known about the costs they might bear because of unaddressed language barriers or the costs of providing language access services. The purpose of this study was to investigate how language barriers and the provision of enhanced interpreter services impact the costs of a hospital stay. It is a prospective intervention study that took place from January 2005 - June, 2005. Two out of three firms offering internal medicine service of a large public hospital of Chicago, IL, were randomly selected to participate in the study and an enhanced interpreter intervention was randomly assigned to one of the two firms. This study was supported by a contract with the Office of Minority Health and the Department of Health and Human Services.

Methodology:

Patients were invited to participate if they were 18 years of age or older and stated that they spoke Spanish or had difficulty communicating in a language other than Spanish. English speaking patients were also recruited and matched to Spanish-speaking participants on gender, age, week of admission. Patients were excluded if they were unable to consent to participation. The Institutional Review Board of Cook County approved the study. There were 323 adult inpatients: 124 Spanish-speakers whose physicians had access to the enhanced interpreter intervention, 99 Spanish-speakers whose physicians only had access to usual interpreter services, and 100 English-speakers matched to Spanish-speaking participants on age, gender, and admission firm. Patient satisfaction, hospital length of stay, number of inpatient consultations and radiology tests conducted in

the hospital, adherence with follow-up appointments, use of emergency department (ED) services and hospitalizations in the 3 months after discharge, and the costs associated with provision of the intervention and any resulting change in health care utilization.

Findings:

The enhanced interpreter service intervention did not significantly impact any of the measured outcomes or their associated costs. The cost of the enhanced interpreter service was $234 per Spanish - speaking intervention patient and represented 1.5% of the average hospital cost. Having a Spanish - speaking attending physician significantly increased Spanish - speaking patient satisfaction with physician, overall hospital experience, and reduced ED visits, thereby reducing costs by $92 per Spanish-speaking patient over the study period.

Summary:

The enhanced interpreter service intervention did not significantly increase or decrease hospital costs in this study. Physician-patient language concordance reduced return ED visit and costs however. Health care providers need to examine all the cost implications of different language access services before they deem them too costly. There are a number of reasons why a clear impact of enhanced interpreter intervention on the cost and quality of hospital care was not determined. First, large firm effects may be masking the effect of enhanced interpreter intervention. Second, this study compared enhanced interpreter services available 8 hours a day with usual care that included the hospital interpreter services available 10 hours a day. Third, a large proportion of attending and resident physicians were fluent in Spanish. The study did provide useful information on the cost of providing enhanced interpreter services relative to the total cost of a hospital stay. Authors considered $240 to be a small price to pay to ensure that hospital professional staff are able to provide the standard of care needed to all patients. It also highlights the valuable contribution bilingual physicians

make to the provision of health care in our increasingly diverse society, underscoring the importance of efforts to increase the ethnic and linguistic diversity of the medical profession. The results of this study also indicate that more research needs to be done in settings where language concordance physicians and other linguistic access services are not as readily available.

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