Review Article

Interpreting at the End of Life: A Systematic Review of the Impact of Interpreters on the Delivery of Palliative Care Services to Cancer Patients With Limited English Proficiency

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Abstract

Context. Language barriers can influence the health quality and outcomes of limited English proficiency (LEP) patients at end of life, including symptom assessment and utilization of hospice services.

Objectives. To determine how professional medical interpreters influence the delivery of palliative care services to LEP patients.

Methods. We conducted a systematic review of the literature in all available languages of six databases from 1960 to 2014. Studies evaluated use of language services for LEP patients who received palliative care services. Data were abstracted from 10 articles and collected on study design, size, comparison groups, outcomes, and interpreter characteristics.

Results. Six qualitative and four quantitative studies assessed the use of interpreters in palliative care. All studies found that the quality of care provided to LEP patients receiving palliative services is influenced by the type of interpreter used. When professional interpreters were not used, LEP patients and families had inadequate understanding about diagnosis and prognosis during goals of care conversations, and patients had worse symptom management at the end of life, including pain and anxiety. Half of the studies concluded that professional interpreters were not used adequately, and several studies suggested that premeetings between clinicians and interpreters were important to discuss topics and terminology to be used during goals of care discussions.

Conclusion. LEP patients had worse quality of end-of-life care and goals of care discussions when professional interpreters were not used. More intervention studies are needed to improve the quality of care provided to LEP patients and families receiving palliative services. J Pain Symptom Manage 2016;51:569–580. © *2016 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.*

Key Words

Cancer, end of life, interpreter use, non-English-speaking patients, hospice, palliative care, limited English proficiency

Introduction

The demographics of the U.S. have been changing throughout the years, with more than 60.6 million Americans (21%) over the age of five years now speaking a language other than English at home.[1] Of these individuals, approximately 25 million (41.8%) report speaking English less than "very well" or having limited English proficiency (LEP).

Language barriers contribute to worse health care quality and outcomes for LEP patients. It is well established that language barriers impede patient-provider communication.[2–4] LEP patients have lower satisfaction with care, lower rates of mental health visits, and more problems with communication in the acute

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care setting.[5–7] LEP patients are vulnerable to inadequate assessment of and poorly controlled pain.[6,8] Cultural and linguistic differences may influence how physicians assess pain in LEP patients[9] and how LEP patients report pain.[10] Language barriers also can lead to misunderstandings between physicians and patients and unnecessary physical emotional and spiritual suffering, particularly at the end of life.[11]

Effective communication, including delivering appropriate information and understanding the patient and his/her family, is critical to providing adequate palliative care and pain management.[12] Among Latinos, language barriers lead to lower utilization of hospice services and inadequate bereavement services for family members of LEP patients because of a lack of both hospice literature in Spanish and Spanish-speaking health care providers.[13–16] As physical symptoms rapidly change at the end of life, palliative care services are imperative even in the face of cultural and linguistic differences.[13,17]

Professional medical interpreters reduce errors in message delivery and improve patient understanding and comprehension.[4,18–21] The Office of Minority Health developed the National Culturally and Linguistically Appropriate Services Standards in Health and Health Care to improve the quality of care for LEP patients, which include a standard for timely access to language assistance for LEP individuals.[22] The type of interpreter provided to LEP patients can influence the quality of care delivered.[4] Professional interpreters have specific credentials and training to assure their competence.[23] A study of Spanish-speaking patients showed that using professional interpreters leads to increased patient satisfaction compared to untrained ad hoc interpreters.[24] Professional interpreters have been shown to improve clinical outcomes and patient satisfaction compared to ad hoc interpreters.[4,20,21] Despite this, many health care facilities attempt to bridge language barriers by using ad hoc interpreters, such as family members of patients or bilingual staff who have not had their language skills assessed.[25]

No previous reviews have assessed the impact of interpreters on the quality of care and outcomes at the end of life for LEP patients. We conducted a systematic review to understand the influence that interpreters have on communication across language barriers in palliative care, including goals of care discussions, family meetings, end-of-life care, and symptom management. The aim of the review was to narratively summarize the present literature, assess the quality of studies, identify gaps in the literature, and provide recommendations for further research to reduce disparities in the care provided to LEP patients at the end of life.

Methods

Data Sources

We conducted a literature search of six databases: PubMed (1966 to January 2013), PsycINFO (Psychological Abstracts) via OVID (1966 to January 2013), Web of Science (1966 to January 2013), Cochrane (1966 to January 2013), Embase (1966 to January 2013), and Scopus (1960 to January 2013). The original literature search strategy had three main components: 1) cancer and end-of-life care, 2) medical interpretation, 3) immigrant/minority status, which were linked together with "AND." For PubMed, the controlled vocabulary Medical Subject Headings was used. We searched for articles in all available languages. The search provided 6352 articles after removing duplicates.

Inclusion/Exclusion Criteria

The following inclusion criteria were applied to each article: 1) the study population included LEP patients in need of or receiving palliative and/or end-of-life care from any provider or setting, 2) interpreter services were used by these patients, 3) there was either (a) a comparison of the interpreter intervention to a control group or another intervention or (b) a qualitative analysis of interpreter use in palliative care, 4) there was an assessment of the outcomes of the interpreter intervention. Palliative care outcomes included goals of care discussions, completion of advance directives, symptom management, and prognostication discussions. Articles were eliminated without further review if they did not focus specifically on medical interpreting and the receipt of palliative care services such as symptom management, goals of care, or end-of-life care ($n = 6246$).

Study Selection

For the purpose of this review, a person acting as an interpreter was defined as any person attempting to bridge language barriers for LEP patients. These included bilingual staff, professional interpreters, health educators, and family members. A systematic title and abstract review was conducted by two authors (M. G. and A. Z.) using the PICO framework.[26] Articles were included for full review if it was unclear from the abstract that they contained data on the outcomes of language-concordant palliative care. This resulted in 38 articles for full review by four authors (M. D. S., M. G., A. Z., L. C. D.). During full review, additional 28 articles were eliminated that did not focus on the impact of an interpreter on palliative care outcomes (Fig. 1). A total of 10 articles were abstracted and appraised. The variability in study design and wide range of interventions and outcomes examined made pooling of results, quantitative meta-analysis, and calculation of statistical correlations infeasible.