Use of Interpreter Services in the Emergency Department

Jay M. Brenner, MD*; Eileen F. Baker, MD; Kenneth V. Iserson, MD, MBA; Nicholas H. Kluesner, MD; Kenneth D. Marshall, MD; Laura Vearrier, MD, MA

*Corresponding Author. E-mail: brennerj@upstate.edu, Twitter: @dr_jaybrenner.

0196-0644/$-see front matter

https://doi.org/10.1016/j.annemergmed.2018.05.009

[Ann Emerg Med. 2018;■:1-6]

INTRODUCTION

People with limited English proficiency cannot speak, read, or write English well enough to communicate effectively in the language.[1] Approximately 8% of the US population older than 5 years have limited English proficiency; this number is increasing overall.[2] This group includes not only those whose primary language was not English but also those who have sensory impairments: diminished hearing or deafness, partial sight or blindness, or physical inability to speak. Limited English proficiency is associated with disparities in access to health care, lower health literacy, and poorer health care outcomes.[3] As of October 2015, 21% of the US population did not speak English as a first language at home. Rather, they spoke one of approximately 380 other languages or language groups. Half of them spoke English less than "very well."[4,5]

Federal law addresses this in Title VI of the Civil Rights Law of 1964 that requires recipients of federal financial assistance, including virtually all US hospitals and their emergency departments (EDs), to provide meaningful linguistic access to health care for patients with limited English proficiency. Because patients with limited English proficiency who require interpreter services use ED services significantly more often than those of similar ages not needing an interpreter,[6] emergency medical providers must be educated in the importance of interpreter services, how to use these services, and current laws and guidelines in regard to these services.[7] Emergency providers must strike a balance between the most feasible, ethical, and legal modalities of communicating with patients with limited English proficiency and advancing health equity and improving their emergency health care outcomes.

INTERPRETER USE

Interpreters facilitate communication between 2 individuals who do not speak each other's language, as opposed to translators who convert written text. Interpretation often involves not only reexpressing a spoken (or signed) message in the target language but also framing the message in an appropriate cultural and social context. In an ED setting, interpreters may both translate documents and explain conversations between providers and patients.

Clinicians often use any available person as an interpreter, even though it has been shown that using trained interpreters or interpreter services increases patient and provider satisfaction, improves informed consent, and decreases readmission rates.[8,9] Additionally, using ad hoc or untrained interpreters doubles interpretation errors compared with discussions with trained interpreters.[10] In time-sensitive ED situations, providers may need to use, at least initially, ad hoc interpreters to communicate with patients and families. However, they must do this with the understanding that using untrained interpreters often yields significantly degraded information and may result in misdiagnoses and unnecessary testing and procedures.[11] Just as an emergency physician would not, when there is time, cut short a patient relating his or her history because his or her speech is slow and halting, so also providers should use markedly inferior techniques to communicate with patients with limited English proficiency only when it is absolutely necessary.

Nevertheless, providers continue to underuse professional interpreter services even when they recognize their benefit and have the services readily available.[12] This underuse of interpreter services may exist because of insufficient training in how to work with interpreters and because no specific guidelines seem to exist for emergency health care providers to implement this requirement.[7] This article offers an ethical framework for the use of interpreter services in the ED.

LEGAL AND REGULATORY ISSUES

Case 1: Feasibility

A 55-year-old Mayan woman presents alone to the ED, demonstrating that she has anterior chest pain, but is found

to have normal vital signs and physical findings. Recently arrived from southern Mexico, she speaks only Cakchiquel and Kekchi, but not Spanish. You obtain the only available Kekchi interpreter through a local, very expensive, service. The interpreter arrives to help with the initial evaluation and explanation of what the diagnostic process will be. However, you anticipate that even if all test results are normal, the patient will be in the ED for at least 6 hours. Having recently been reminded of the federal law applying to providing ED patients with interpreters, you would like the interpreter to stay with the patient the entire time in the ED. You believe the chest pain is probably not due to a serious cause, and, as the nurse manager reminds you, the interpreter's bill is steadily increasing. *Main point: Although it is important for emergency physicians to be stewards of resources in our country's overburdened health care system, in this case, the patient's welfare remains paramount and trumps any cost considerations. If the physician encounters resistance because of cost concerns by the institution, he or she can explain that the decision to maximize patient care is supported by federal law.*

The duty for health care facilities to provide "competent" interpreter services to patients with limited English proficiency was first based on Title VI of the Civil Rights Act.[13] Many states then added a patchwork of legal obligations for health care organizations to provide language access. For instance, Massachusetts requires EDs to have interpreter services available, whereas states such as New Jersey and Rhode Island tie hospital licensure to the provision of language services. Other states have laws focusing on language access around specific medical issues or conditions (eg, reproductive health, cancers, HIV testing, mental health).[14-16]

Previous federal regulations were generally superseded in 2016 by changes to section 1557 of the Patient Protection and Affordable Care Act. This regulation establishes the standards required of language services, clarifies permissibility of ad hoc interpreters, mandates technical quality in tele-interpreting services, and requires notice of language service availability in the 15 most common languages spoken by individuals with limited English proficiency in a given state.[17-20] Health care facilities must now hire interpreters[17] who are not merely competent but also "qualified," meaning those who adhere to interpreter ethics principles, have demonstrated proficiency in speaking and understanding both English and another language, and are able to interpret effectively and impartially to and from English and another language.

Case 2: Ad Hoc Interpreters

When a Spanish-speaking middle-aged man presents with chest pain, you ask one of the Hispanic unit assistants to help interpret. She speaks Spanish at home and says that she is comfortable interpreting. As you are taking the history through the interpreter, a visiting Mexican medical student comes into the room to watch and listen. When you are done, he quietly mentions that most of the "interpretation" was incorrect. *Main point: Speaking limited conversational Spanish at home or with friends does not qualify an individual to be a medical interpreter. Being able to work in that capacity may increase status or pay, so the individual may be reluctant to admit that he or she does not know what is being said either because of a patient's unusual accent or vocabulary.*

This legislation also generally forbids the use of ad hoc interpreters, such as family members or friends accompanying the patient, or unqualified multilingual staff, with 2 exceptions. The first exception is if an individual with limited English proficiency specifically requests that an accompanying adult serve as an interpreter, as long as the accompanying adult agrees, and reliance on his or her interpreting is appropriate to the situation. The second exception allows ad hoc interpreters (including accompanying children) in "an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter…immediately available."[19] One poignant example of this was experienced by one of the authors of this article: a deaf Nepalese patient who communicated with the physician through a professional Nepalese interpreter speaking by telephone to her 7-year-old daughter, who was then using Nepalese sign language with her mother.

Case 3: Making Excuses (No Time): American Sign Language as a Special Case

A 28-year-old profoundly deaf woman arrives alone in the ED with abdominal pain. In the interest of expedience, you communicate with her by writing on a notepad. She demonstrates "pain" and points to her umbilicus. By using the notepad, you ask about symptoms of nausea, vomiting, diarrhea, and constipation. She indicates no, but then gestures that she has been vomiting. Other written questions about her condition generate somewhat contradictory answers. You decide to order a CBC count, comprehensive metabolic panel, lipase test, a pregnancy test, urinalysis, and a computed tomography (CT) scan of the abdomen. During her stay, you determine that she is pregnant and cancel the CT scan. Several hours later, you give her a diagnosis of a viable intrauterine pregnancy at 9 weeks' gestation. You provide referral to an obstetrician and medications to control her nausea. *Main point: Deaf patients use American Sign Language as their first language and English as a second language.*[14] *Many are not proficient in*