Policy of Current Hospital Translation Services and Recommendations for Future Adjustments for Spanish-Speaking Patients

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Preface

It is a seldom-discussed fact that English-speakers in America enjoy a quality of health care that is not necessarily afforded to non-native speakers receiving care at the same facilities. Policy regarding what is required of health institutions in terms of translation services is exceedingly vague, and implementation of this policy is inconsistent. This lack of guidance makes it possible for many patients needing interpreters to fall through the cracks. This project will examine current policy guiding interpretive services in the U.S., and will recommend more specific guidelines that would improve quality of care for limited English proficiency individuals. This project will also include an ethical analysis of the necessity to provide high-quality interpretation services, as they are essential to ensuring that informed consent is obtained.

Though this project focuses largely on the Spanish language, as Spanish is the second-most widely spoken language in the United States besides English, and Spanish-speakers make up over a tenth of the U.S. population, its aim is to lay the foundation for a standard that serves non-English speakers of any other language. If hospitals claim to offer excellence in health care for all, they must uphold this responsibility, which is precisely what this project and resulting policy recommendations seek to ensure.

Introduction

This project addresses a hindrance to access in healthcare that affects the Spanish-speaking population in America, and extends to all LEP (limited English proficiency) patients seeking healthcare in Tennessee hospitals. LEP persons are defined by the National Resources Conservation Service as “individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English.” In 2011, 25.2 out of 311.7 million Americans were classified as LEP individuals by the Migration Policy Institute,

with 174,000 living in Tennessee. This translates to "about one in five [U.S.] residents [being] non-English speakers, an increase from about one in seven a decade earlier [than 2000], and that almost a quarter of these non-English speakers could not speak English well or at all" (Locatis et al.) Furthermore, Tennessee was ranked fifth highest among all states in LEP population growth between 1990 and 2000, which means that these numbers are only on the rise (Migration Policy Institute). Again, the most common non-English language in America is Spanish, spoken by an estimated 13% of the population (Pew Hispanic Center). As immigration policies change, the number of Spanish speakers is growing, and thus, the treatment of LEP individuals in the U.S. warrants discussion. How are we to treat these individuals who make up such a large portion of our country? How should we best deliver them health care services?

As a child, I watched as my mother, a bilingual Colombian-American, accompanied LEP family members and friends to doctors' appointments and hospital visits. She was an ad-hoc interpreter without formal training, recognized by her community as the answer to a seemingly insurmountable problem. Truly, before the passage of the Patient Protection and Affordable Care Act in March 2010, which includes a small clause on the importance of non-discrimination against patients, there were few institutionally/legally mandated avenues for these patients to receive care they understood—i.e., interpretation services were not widely available. Fast-forward to the Department of Health and Human Services' explanatory guidelines for the PPACA's Section 1557 on non-discrimination, and the country now has (somewhat) clearer guidance for treatment of LEP patients. However, these recommendations are not specific enough. Too often, hospitals with few resources ignore the interpretation crisis as a low-priority problem, deferring funding to other projects and leaving LEP individuals to fend for themselves. A better set of recommendations backed by a strong ethical argument for the necessity of

offering specific interpretation services to LEP patients will improve LEP patient outcomes during their hospital visits. To this end, I will discuss the problem that inadequate interpretation services create by prohibiting patients from providing their fully informed consent. This is a great ethical issue: it is wrong to treat a patient without his or her knowledge of how his/her body is being manipulated, regardless of the integrity of the purpose. Adequately informed consent is essential to ethical medical practice, and warrants great effort towards securing it—the kind of effort involved in crafting improved policies. Even problems with interpretation that seem slight can be detrimental to a patient's ability to choose for themselves, and consequently, their health, so it is imperative that adequate interpretation can be ensured.

Furthermore, I do acknowledge that this is a complicated problem without a simple solution. The same guidelines that will work for interpretation services in the middle of diverse and urban Knoxville, Tennessee will not apply in the middle of rural, predominantly white Pickett County, Tennessee. With this in mind, I attempt to clarify the different methods that should be employed in different hospital settings, considering small/rural and large/urban as two major hospital types. Finally, though this project is somewhat limited in scope to Tennessee and focuses primarily on the Spanish language, it is worth noting that this is a starting point, not an end, to the work that needs to be done. Spanish interpretation is the first problem to fix, as it is the most widely spoken of all non-English languages in the United States, but it is not the only language to consider. The standards set for Spanish interpretation should become models for all other languages, and in the same way, these policy recommendations crafted for Tennessee should serve as models for other states as well. No patient, regardless of his or her geographic location, primary language, or economic status, should ever receive treatment without being able to give his or her properly informed consent.

Part 1—Informed Consent: Ethical Implications

Informed consent, as it will be discussed here, is defined as "patient-reported understanding of the (1) reasons for and (2) risks of the procedure and (3) having had all questions answered" (Lee et. al). This expanded definition marks a shift in health care, largely over the last two decades, which moves from a paternalistic model to more autonomous, patient-based decision-making. The paternalistic doctor-patient relationship is best characterized as one in which the physician "clearly sees him or herself as being in a superior position… [and] feels justified in overriding the patient's wishes [and] may subscribe to the view that patients do not have sufficient knowledge to make good decisions or that they are they are less capable of this" (McKinstry 340-341). This paternalistic relationship has been rightly criticized for facilitating doctors in making medical decisions that they "know the patients would object [to] if they were properly informed" (McKinstry 341). A paternalistic physician might exaggerate the benefits of a treatment he prefers administering (for any reason, however justified or arbitrary) or downplay potential harms of a treatment that he knows would give a patient pause. Whatever a physician's reasoning behind doing so, any manipulation of pure fact, I argue, is a form of disrespect for a patient's autonomy as human being capable of making his/her choices about his/her own physical health. When a doctor obscures or otherwise twists information presented to a patient, however slightly, he/she treats the patient as lesser than himself, and thereby demeans the value of human life, disregarding the fact that all humans are equal. Furthermore, when a doctor's paternalistic decision produces negative results for a patient, the doctor must bear the full burden of the blame. However, it is not the doctor that must live with the implications of a wrong choice—"it is the patient that will suffer" (McKinstry 342).

This negative view of the paternalistic model has become more widely accepted in recent years, and a newer movement in medical ethics advocates for the right of the patient to express his or her autonomy. Jukka Varelius defines autonomy in bioethics as "self-government" which "is, at minimum, self-rule that is free from both controlling interference by others and from limitations, such as inadequate understanding, that prevent meaningful choice." Most often, the importance of autonomy is defended by the idea that it is an "individual's right to make his/her own decisions…the individual has the final say because the body/mind in question is their own" (Belden). Autonomy must be protected carefully, as it can be easily diminished or lost without the patient's knowledge. The most important aspect in guaranteeing autonomy, I argue, is ensuring a patient's access to all relevant information. As Varelius states, "if a person's beliefs concerning some matter are false, inconsistent with each other, or she is uninformed about that matter without her realizing this, then she is not autonomous with respect to that matter." It is in this latter scenario, that of the uninformed patient, that the connection between autonomy, informed consent, and medical interpretation services becomes clear—herein lies the greater argument comprising the ethical basis for the policy recommendations found in the last section.

The transition from paternalistic medicine to autonomous decision making is paralleled by a transition from simple to complex informed consent. Whereas simple informed consent involved little more than a physician stating the general nature of the treatment he/she was about to administer to a patient and a patient agreeing with the physician's choice, complex informed consent involves ensuring that a patient is fully aware of all details of a medical treatment, all possible alternatives, all of the most probable outcomes and/or side effects, etc. Of course, it is difficult to provide specific criteria for complex informed consent, as the extent of information given to a patient is entirely situation-dependent—obviously, there is a far greater amount of

information to make a cancer patient aware of when discussing treatment options than there is in the case of a simpler treatment, such as suturing a minor laceration. However, the concept remains the same across all cases: a patient should be provided with as much information as possible, in a *way they understand*, to be able to make a fully informed decision that upholds their autonomy as their own primary medical decision-maker. In the medical field, a physician is in charge of physically manipulating a patient's body, an act that cannot be justifiable done without the patient's consent. The following quote presents a depiction of medical treatment that we often may not consider, accurately describing the gravity of the situation: "No one has the right to even touch, let alone treat another person. Any such act, done without permission, is classified as 'battery'- physical assault and is punishable. Hence, obtaining consent is a must for anything other than a routine physical examination" (Satyanarayana Rao).

A useful legal guideline for ensuring complex informed consent corresponds to this model, taken from a study on informed consent in medicine by Berg et. al: "1) consent must be given before a patient receives a treatment and 2) physicians must report all information that will enable patients to participate in knowledgeable decision-making." This applies to all patients, but is certainly more difficult in the case of LEP individuals. The simple model of informed consent, which is undoubtedly faster and easier to translate, will *not* suffice. So, it is of the utmost importance that hospitals provide the resources to ensure that LEP individuals fully understand all aspects of the care they are receiving. And, even before this can happen, it means ensuring that all aspects of an LEP patient's medical condition are fully understood by the health care provider, so that the proper course of treatment can be determined. An LEP individual cannot give his or her genuinely informed consent if an interpreter has not accurately and fully relayed all details of the treatment to him or her, and correctly mediated the discussion of treatment

options between the patient and physician. Thus, inadequate interpretation services preclude a patient's ability to give informed consent, and function to undermine his or her autonomy.

The connection between interpretive services and informed consent has been proven in several studies, such as in the 2017 Lee et al. study published by the Journal of General Internal Medicine. The study interviewed 152 LEP (Spanish and Chinese-speaking) individuals as well as 86 English speakers undergoing invasive procedures in a hospital, measuring their self-reported levels of "understanding of the (1) reasons for and (2) risks of the procedure and (3) having had all questions answered"—a response of 'very well' or anything beyond this was considered 'adequate' informed consent, per study design (Lee et al.) The results showed that before an over-the-phone bedside interpretive service was offered (with a certified interpreter on the line), when patients used either ad-hoc interpreters or other unreliable means of interpretation, only 29% of LEP individuals met the criteria for adequately informed consent (Lee et al.) After the OTI services were implemented, this number increased to 54% (Lee et al.) Additionally, 99% of LEP individuals with access to the OTI service reported adequately informed consent, while only 89% met the criteria before the service was made available (Lee et al.) Unfortunately, even though the 54% of LEP patients meeting informed consent criteria with the OTI service is an improvement over the 29% in absence of this service, English speakers far exceeded these numbers; 74% of English speakers met the criteria for adequately informed consent (Lee et al.) Though this is only one study, it is representative of the fact that speaking English automatically places a patient at an advantage for being able to give adequately informed consent. It also indicates that offering interpretation services improves LEP individuals' ability to give adequately informed consent significantly, but that the quality of these services should be evaluated so that a greater percentage (ideally: all) of LEP individuals are able to give it.

Part 2—Current Legislation on Healthcare Equality

What does the law say?

Interpretive services offered in hospitals are typically regulated on a small scale, following hospital-specific policies. However, these stem from guidelines set in place by federal law, which I will now take this section to review. The history of policy guiding medical interpretation is brief (hence, the motivation for this project), but it is marked by one significant shift. Namely, the Patient Protection and Affordable Care Act (the PPACA) passed by President Barack Obama on March 23rd, 2010, included an important clause protecting patients against discrimination in healthcare based on race/language spoken, among other things. This act, along with a follow-up set of recommendations from the Department of Health and Human Services that guide its use in medical settings, is the only form of federal guidance for interpretive services. This next section will first briefly review the policy that guided medical interpretation in America before the passage of the PPACA, then will cover relevant details of the PPACA as it pertains to interpretive services.

Pre-Patient Protection and Affordable Care Act

One of the first pieces of legislation demanding equal treatment in healthcare was the Hill-Burton Act, passed into law in 1946. The law is also known as the Hospital Survey and Construction Act, and emerged as a response to then-president Harry S. Truman's call for improved healthcare for Americans made possible by federal grants and subsidies. The Hill-Burton Act is especially significant considering the state of public health insurance in America at the time of its passage. In 1946, Medicare and Medicaid had not yet been launched, and the majority of Americans were either covered under employer or private insurance, with the rest

being either uninsured or relying on the few available government subsidies. At this time, state-level health insurance was the norm; it was not until the late 1950's-early 1960's that full-fledged federal insurance and assistance programs for health care were available, beginning with the Kerr-Mills Act passage in 1960, and then the incorporation of Medicare and Medicaid into the Social Security Act in 1965. I may appear to digress, but this legislation is included to underscore the fact that the Hill-Burton Act was novel and instrumental in guiding health care practice on a *national* level—something that state-level health policy stemming from state-level health insurance was clearly not in a position to do.

Under Titles VI and XVI of the Hill-Burton Act, public and non-profit facilities received financial assistance—these facilities include acute care general hospitals, special hospitals, nursing homes, public health centers, and rehabilitation facilities (Department of Health & Human Services). The act is lengthy and will not be duplicated here in its entirely, but it is worth highlighting a few key clauses, as they laid the foundation for the current legislation that guides interpretation services today. One such clause states that hospitals/other health care centers receiving Hill-Burton funding must "give each person living in its service area non-emergency medical treatment at the facility no matter their race, color, national origin, creed, or any other factor unrelated to a person's ability to pay for a needed service and the facility's ability to provide the needed service," which was one of the first non-discrimination stipulations passed into legislation in this country (Department of Health & Human Services). The act also requires covered facilities to "post [their] community service obligations in English and Spanish, and any other language spoken by 10 percent or more of the households in the service area" (Department of Health & Human Services). Clearly, the Hill-Burton act displays a sensitivity for LEP

individuals, but it does not provide directives beyond this, and does not call for specific services facilitating accessibility of healthcare for LEP patients.

The Civil Rights Act of 1964 was next to contribute to this genre of literature on non-discrimination in healthcare, most notably in Title VI, entitled "Non-Discrimination in Federally-Assisted Programs." The section promotes goals quite similar to those of the Hill-Burton act, namely, to "protect persons from discrimination based on their race, color, or national origin in programs and activities that receive federal financial assistance" (Department of Health & Human Services). This act applies to a much wider variety of services and institutions than does the Hill-Burton Act, but is relevant because all hospitals are federally funded to at least some extent (even if only indirectly by accepting Medicare, Medicaid or other governmental health plans as forms of insurance), which means they all fall under the act's jurisdiction. The act prohibits (federally funded institutions including) hospitals from either denying service to or providing different and/or lower quality healthcare services to any patient based on his or her race, color, or national origin. A positive directive of the act requires hospitals to provide free language assistance to LEP patients, to post notice of these services in (at least) Spanish and English, and to provide consent forms in most commonly spoken languages in the institution's area (Department of Health & Human Services). The guidelines also mention that discrimination against LEP individuals is viewed by the Supreme Court as discrimination against national origin, which is protected against under this law. Title VI of the Civil Rights Act was certainly headed in the right direction with all of these guidelines. However, as it provides no detailed guidance on exactly *how* LEP individuals should be provided with language assistance, it is relatively unhelpful in the context of this project, and still leaves us with the task at hand, to recommend a more specific policy. Nevertheless, the Civil Rights Act of 1964 was significant in

decreasing societal discrimination and establishing systematic protections against it, and was instrumental in the creation of the Patient Protection and Affordable Care Act.

This review of legislation loosely tied to interpretive services (more accurately: to non-discrimination) in hospitals is brief, and is not entirely comprehensive. However, this section's shorter length is partially reflective of the fact that this is an area of policy which leaves much to be desired. Certainly, federal law displayed a sensitivity to the problem of discrimination in health care before the turn of the century and the passage of the PPACA. Though other literature exists regarding the implementation of these policies, the selections presented here illustrate the greater point that health care policy up until the time of the PPACA did *not* specifically seek to ensure the equal treatment of LEP individuals by suggesting any specific mechanisms for communicating with them. The legislation is essentially a compilation of vague statements of purpose, which boil down to encouragement against discrimination, but little else. Detailed guidelines are needed. In the next section, I will discuss the (marginal) progress the PPACA makes towards this end.

Post-Patient Protection and Affordable Care Act

As stated, the passage of the Patient Protection and Affordable Care Act in 2010 outlined a better standard for non-discrimination against racial minorities, a category which inevitably includes many LEP individuals. The text of the PPACA on non-discrimination is brief, but is important for health care providers to be aware of. The official text of the relevant section of the PPACA, Section 1557, is as follows:

> (a) IN GENERAL.—Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age

> Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection.
>
> (b) CONTINUED APPLICATION OF LAWS.—Nothing in this title (or an amendment made by this title) shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or the Age Discrimination Act of 1975 (42 U.S.C. 611 et seq.), or to supersede State laws that provide additional protections against discrimination on any basis described in subsection (a).
>
> (c) REGULATIONS.—The Secretary may promulgate regulations to implement this section.

Section 1557 calls for the equal treatment of all persons seeking medical care. Interestingly enough, however, the text of the act does not specifically mention the LEP, which does not fall cleanly under the umbrella of race, color, or national origin that the prior legislation protects. LEP individuals may be of any race, color, national origin, etc. So, a minority group that makes up around 8% of the population is not considered by the PPACA, despite the fact that its treatment in a medical setting has been shown to be strikingly sub-par, indicating that these patients are subject to a form of discrimination (Migration Policy Institute.) Furthermore, the text of section 1557 is quite vague, and as such, is vulnerable to misuse and abuse. Under the text of

the act, it is *not* specified that LEP individuals should be accommodated by a medical interpreter who speaks their language, which can be detrimental.

In order to provide clarity to the vagueness that is Section 1557, the Health and Human Services Department published a set of guidelines for medical providers to follow when treating any person that might fall under the protection that the Section is meant to guarantee. This "Final Rule" was not made public until July 18th, 2016, and was published with the aim of "clarif[ying] and codif[ying] existing nondiscrimination requirements and set[ting] forth new standards to implement Section 1557" (Federal Register). The guidelines manifested themselves in the form of an almost 200-page document, which is (again) too long to replicate here, but is available for public reference on the Office of the Federal Register's website. A few key points that appear in this Final Rule are especially relevant to this paper, namely, the first official definition of an LEP individual, which is as follows:

> We proposed that the term "individual with limited English proficiency" codify the Department's longstanding definition reflected in guidance interpreting Title VI's prohibition of national origin discrimination, entitled Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons [49] (HHS LEP Guidance). Under the proposed definition, an individual whose primary language for communication is not English is considered an individual with limited English proficiency if the individual has a limited ability to read, write, speak or understand English. Accordingly, we proposed that an individual whose primary language for communication is not English, even if he or she has some ability to speak English, is an individual with limited English proficiency if the individual has a limited ability to read, write, speak or understand English.

The Final Rule also provides a stronger definition and stricter qualifications for medical interpreters. The text states that a "'qualified interpreter' means an individual who has the characteristics and skills necessary to interpret for an individual with a disability, for an individual with limited English proficiency, or for both" (Federal Register). Importantly, the Final Rule notes that simple knowledge of a second language other than English is not sufficient for qualification as an interpreter—a point I will revisit in the later discussion of ad-hoc interpreters. The Final Rule makes it clear that qualified interpreters must possess other skills as well, including training in interpreter ethics, competency, confidentiality, and tact in determining potential conflicts of interest. For example, "a qualified bilingual/multilingual nurse who is competent to communicate in Spanish directly with Spanish-speaking individuals may not be a qualified interpreter for an individual with limited English proficiency if serving as an interpreter would pose a conflict of interest with the nurse's treatment of the patient" (Federal Register). Thus, the Final Rule calls for the use of in-person interpreters first, but stipulates that in their absence, either a video or telephonic interpreter must be available as back-up. The Final Rule also guarantees a patient's right to decline the use of interpretive services, but requires the provider to document the patient's refusal of these services.

Types of Interpretation Services

Many options exist for translation in hospitals. In this section, I will give an overview of the most widely used services, considering 'pros and cons' of each.

<u>In-Person Interpreter</u>

It is important to keep in mind throughout this section that reference to an in-person interpreter does *not* include the ad-hoc, unofficial interpreters that will be discussed at the end.

An in-person interpreter will only specialize in a small number of languages (usually, one). For the purposes of this project I will only consider those trained in Spanish interpretation. In-person interpretation is the most traditional option for medical interpretation, and is fairly self-explanatory, but it is a nuanced service. Though there is not a law (federal or state) mandating the certification of medical interpreters by an accredited service, nearly all interpreters employed part- or full-time by hospitals are certified by some organization or another. The largest and most well-known option for certification in medical interpretation is through the National Board of Certification for Medical Interpreters, or the CMI. Note that in this project, when an "in-person interpreter" is referenced, it assumes an interpreter certified either by the CMI or another comparable service. The CMI offers certification in Spanish, Russian, Mandarin, Cantonese, Korean, and Vietnamese, and hopes to expand this repertoire with time—the organization only recently received accreditation by the NCCA (National Commission for Culture and Arts) in 2010. To receive CMI certification, a prospective interpreter must be at least 18 years old, have the equivalent of at least a high-school level education, have taken at least 40 hours of an approved medical interpretation training course as well as at least 3 hours of medical interpretation coursework, and have a certain level of 'oral proficiency' in Spanish (Martinez-Morales). Once these requirements are met, candidates take both a written and an oral exam which "test adequate knowledge of the medical interpreting profession, including ethics, standards of practice, role boundaries and medical terminology, among other important competencies" (Martinez-Morales). The CMI is a model program for certification in medical interpretation, and a CMI certification lasts for 5 years. Beyond this, an interpreter should be trained in hospital-specific protocol (as is required of any employee) including a basic course in medical ethics. In-person interpreters should also assist a physician in the interpretation of the

protocol; for example, the interpreter should instruct the physician to address the patient when speaking and to speak in small segments so that the interpreter does not forget to relay any part of the medical interview or conversation. Knowledge of such protocol is part of training for the interpreter certification—however, the importance of applying of this knowledge must not be overlooked.

Errors that arise in interpretation usually are associated with omission of details, a 2015 NIH study found (Nápoles et. al). Among certified interpreters (both in-person and through a video), the study found "27 errors on average per encounter, only 7% of these were moderately or highly clinically significant" (Nápoles et. al). This number may seem high, but is actually only half, on average, of the number of mistakes made by over-the-phone interpretive services—and this is not to mention interpretation done by untrained individuals (Nápoles et. al). The in-person interpreter has the greatest ability to relay non-verbal communication from the physician to the patient, and is best able to interpret tone.

There are no downsides to the in-person interpreter, from both the physician and patient perspective. This is the best of the options, and is preferred by patients and physicians alike. However, most hospitals do not staff either full or part-time interpreters because it can be cost-prohibitive. For some hospitals, adding in even a part-time salary is out of the question, or perhaps better stated, out of the budget. In light of this, the argument for hiring in-person interpreters may need to shift from the ethical to the pragmatic for the sole sake of motivating economically-minded hospital board members. The cost of a medical malpractice lawsuit due to interpretation-related misunderstanding is non-negligible, and *far* outweighs the burden of shifting a budget around to have it include one more staff member. And, returning to the ethical

consideration, there is *no* price tag too high for securing a patient's access to informed consent, and thus, their dignity.

Telephonic Interpreter

Though several options for over-the-phone translation services exist, I will focus on the most widely used, which is the CyraCom Over the Phone Interpretation service, also known as the OPI. This company, which was started in 1995, has been approved by the federal government as a General Services Administration vendor, and is used by sectors of the federal government for interpretation purposes. CyraCom has also been endorsed by the American Hospital Association. Hospitals using the CyraCom OPI will purchase several phones throughout the premises specifically for phone-in translation. 76 different languages are offered for OPI translation. A medical provider simply picks up the designated phone and either says the desired language or inputs it onto the phone screen, and the conversation begins.

Interpreters for CyraCom are extensively trained. To be certified for medical interpretation, a candidate must go through "120 hours of initial standardized, in-person training, including written and oral certification tests; [this is] three times longer than is typical in the language service industry" (CyraCom). Interpreters are available 24/7, 365 days a year. Each phone call is priced by the minute, and CyraCom boasts low per-minute prices. At the "basic" rate, which is recommended for those who expect to use the translation service very little, CyraCom charges $2.98 per minute. At the "basic plus" rate, intended for hospitals and other settings which expect to use the service frequently, the price is $1.98. The price drops further with other plans available for hospitals who believe they will use the service more than five times per day.

CyraCom is useful in that it is always available when needed. It provides immediate access to all major languages, and then some—including dialectic variations on some of the more common languages, such as Eastern and Western Armenian, which can be extremely important in the health care setting. CyraCom interpreters are trained well and taught cultural competency skills. Plus, the cost of using the OPI service is relatively low (in comparison to per-minute rates of other companies offering comparable services). For some hospitals, services like CyraCom's may seem to be the best option. However, I would be remiss not to include findings from several studies that have detailed the downside(s) of the OPI service (from both CyraCom and other related companies).

The value of physically *seeing* a medical interpreter cannot be overstated. According to a 2010 NIH study evaluating the relative effectiveness of various interpretive services, "non-verbal communication generally constitutes a significant part of any medical encounter, and…is already lost when an interpreter is involved, because pausing for translation necessarily adds a time-delay from the time communication leaves the provider's mouth to the time it reaches the patient in a manner they understand" (Locatis et. al). This study also found that medical interview lengths were shorter when over-the-phone services were employed, which "raise[s] questions about the prospects of miscommunication in telephonic interpretation, given the absence of a visual channel" (Locatis et. al). What exactly is being left out in a medical interview when the non-verbal component is missing? This is a difficult answer to pinpoint, but it is entirely reasonable to believe that whatever is missing has significant (negative) implications for the patient's total understanding—and thus, his/her informed consent.

Video Translation

CyraCom also offers the option of video-mediated interpretation using an iPad or other comparable tablet as its interface. The cost of this service is also per-minute, and rates are negligibly higher than those for OPI. Though essentially everything about this service is the same as OPI services, video interpretation bears the great advantage of the interpreter being visible to the patient and physician, and vice versa (barring improper iPad placement in the hospital room). The video, of course, could be subject to technical malfunctions, such as slow internet; however, this is a concern with OPI services as well (though to a lesser extent). Video interpreters are certified to the same extent that OPI interpreters must be (at least in reference to the prototype of CyraCom that is our working example). In absence of a certified in-person interpreter, the video interpreter is the next best option, as it retains more features of an in-person interpreter than any of the other options do.

Ad-hoc Interpreters

Sometimes, an LEP individual will bring a family member or friend along to facilitate the hospital visit. This family member or friend will be referred to as an 'ad-hoc' interpreter, a nod to his/her lack of certification and professional status. While it is possible that the patient *might* be bringing a certified individual to his/her hospital visit, this is most often not the case. (In the event of this happening, the interpreter should show proof of certification in medical interpretation such as that required of staffed interpreters or employees of CyraCom, for example, before being allowed to proceed.) The ad-hoc interpreter situation can be an ethically complicated one. Usually, the patient feels most comfortable with the ad-hoc interpreter facilitating the visit, and will decline the offer of an alternative (approved) method of interpretation. This is completely logical, as patients tend to prefer interacting with a trusted loved one over a stranger, whether in person or on a phone or iPad. However, it is the duty of the

physician to determine the capability of the ad-hoc interpreter to properly and thoroughly convey all relevant information to the patient, and likewise, report correctly and fully all details of the patient's medical history to the physician. Despite the fact that ad-hoc interpreters are used quite frequently, they are almost never properly qualified to take on the task of interpreting a medical encounter. There are several reasons for this, but perhaps the first and foremost is the knowledge of a second language, such as bilingualism in English and Spanish, does *not* guarantee proficiency in medical terminology. Just as fluency in English does not perforce qualify a person to pass a medical terminology exam, knowing Spanish (or any other language) indicates *nothing* about an individual's competence with using medical terms in that language. Furthermore, since this is a discussion of hospital settings rather than primary care doctors' offices, it is even more likely that more complicated medical terms will be used, as hospitals generally treat more complex ailments which often have correspondingly complex names.

Despite this, physicians often allow the ad-hoc interpreter to facilitate interactions because it is simply *easier* than doing the right thing and using a trained, qualified interpreter. It is difficult to tell a patient that their loved one is inadequate for the task at hand, even in this professional context, and many physicians choose not to. The problem with this is that even the best ad-hoc interpreters must rely on their layman's understanding of various physical conditions and even body parts and functions, breaking these down into more common terms they are comfortable with using and translating back and forth. When this happens, the patient receives medical information about his or her own body in a severely crude and detail-lacking manner. As you can imagine, in the context of a hospital in which a patient might be learning for the first time of his or her contraction of a rare disease, or attempting to explain a complicated medical

history, the details are everything, and their absence severely compromises the quality of health care the patient is able to receive.

Furthermore, the ad-hoc interpreter is usually a close friend, relative, or at least prior acquaintance of the patient he/she accompanies. This poses another problem; that is, that a patient may be reluctant to share some sensitive health information with the ad-hoc interpreter. This can lead to omission of crucial details that could likely affect the patient's treatment, as the physician would not be fully informed of the nature of the medical situation he/she means to treat. On the other hand, it is easy to imagine some scenarios in which the physician needs to relay sensitive medical information to the patient that he/she can guess the patient would *not* want the ad-hoc interpreter to know. For instance, a physician would be in a sticky situation if he needed to relay the news of a positive pregnancy test to a pre-teen LEP girl, if the ad-hoc interpreter was her father, or some other individual who might be disturbed by the news. This is just one example, but is alone is sufficient to demonstrate why a neutral third-party certified interpreter should yield much better outcomes.

Thus, the ad-hoc interpreter should *not* be used except under the most extreme circumstances, such as when a patient vehemently refuses the alternatives and cannot be convinced otherwise, or when he/she is in an emergent situation in which the time it would take to access a certified interpreter would be detrimental to the patient's health. In the event that the patient strongly refuses alternatives to their ad-hoc interpreter, physicians must realize that this represents a liability for malpractice. It is almost inevitable that some part of the physician-patient encounter will be left out due to the interpreter's incompetence, and/or that some piece of information will be translated incorrectly so that the patient has an incorrect understanding of his/her ailment. This could easily manifest itself into a lawsuit down the road. Though the

possibility of heavy legal repercussion does not motivate this next part, it should not be ignored. If a patient insists on using an ad-hoc interpreter, he/she should be given a waiver to sign that absolves all responsibility from the physician in the event that an error in interpretation leads to a negative health outcome for the patient. This does have the added bonus of protecting the physician (and hospital) from legal trouble, but it is also a welcome hindrance that should make it more difficult for the patient to use the ad-hoc interpreter. For, as soon as the ad-hoc interpreter incorrectly relays a piece of medical information to either the patient or the physician, the patient is robbed of the robust version of informed consent to which he/she is entitled. The risk of this happening is too great, so use of the ad-hoc interpreter should be severely restricted to only those times when it seems absolutely necessary. This is in the best interest of the patient, the physician, the interpreter him/herself, and the hospital.

Part 3—Recommendations for Change

I will preface this by restating that there is no 'one-size-fits-all' model that we can appeal to in crafting these recommendations. Each hospital has a different population demographic, geographic location, probability of treating LEP patients of different national origin and language, and finally, budget. The state of Tennessee as a prototype for creating these recommendations is actually rather ideal, as it has areas of wealth and homogeny as well as those of poverty and diversity (and varying combinations of all of these.) Tennessee also has a relatively large immigrant population (an estimated 5% of total state population) which usually comprises a large percentage of the LEP population (American Immigration Council.) So, a singular policy will not be able to best fit the needs of this diverse demographic. In an effort to ensure that LEP individuals in all settings are best guaranteed their own informed consent, we

must tailor policies to the characteristics of the hospitals in which they are treated. This section will discuss how different hospital characteristics ought to influence policies guiding interpretive services at each hospital.

Hospital characteristics affecting the treatment of LEP individuals include (as previously stated): size (measured in number of hospital beds), hospital budget, population demographic of the area the hospital serves, geographic location (urban vs. rural), and probability of seeing LEP individuals of different nationalities/ethnic origins. Each of these can influence the quality of interpretive services a hospital is capable of offering. I will begin by describing the ideal policy that would fit a large, urban hospital with a large budget that is most likely to treat Hispanic patients. This kind of hospital and the corresponding policy recommendation is loosely based around my observations at the East Tennessee Children's Hospital, which fits these descriptors, and is an exemplary model.

Large, Urban, Big-Budget Hospitals

If it was not already made clear in the previous section on various interpretation methods, the In-Person Interpreter should always be a hospital's first choice. A 2017 NIH study found that Spanish-speaking LEP individuals reported greatest satisfaction rates with face-to-face interpretation (analogous to our In-Person Interpreters) over telephonic interpretation (Anttila et al.) The study also reported higher satisfaction rates for video-mediated interpretation, suggesting that the most important element affecting patient satisfaction is the ability to see the interpreter's face.

At the East Tennessee Children's Hospital, an 11-person staff of Spanish interpreters is available around the clock. There are typically 4-5 working at any given time, and they are nearly always all busy facilitating patient visits. In a large hospital, (ETCH has 152 beds) it is

important to have a staff of interpreters at least this big—one is not enough. A good rule of thumb in areas dense with Spanish-speakers is to determine the percentage of LEP Spanish-speakers in the area and then use this to find the number of patients likely to fall into this category. The number of Spanish interpreters should slightly exceed the number of LEP Spanish-speaking patients expected based on this percentage, which in Knoxville, was 0.6% in 2008 (Knoxville Transit). When Spanish is not the most widely spoken language other than English, this same method can be applied for certified interpreters of that language. ETCH accomplishes this goal, because if even only 4 interpreters are working at a given time, they are able to cover 2.6% of patients—which is greater than the percentage of LEP Spanish-speaking individuals, and should ensure their adequate coverage. Interpreters should coordinate which patients to see using a pager system, which is common practice in most hospitals, and makes the process more efficient.

East Tennessee Children's setting in a city with a large population of immigrants and Spanish-speakers justifies the use of the hospital budget to employ the interpreters. For those LEP individuals who speak languages other than Spanish, access to over-the-phone interpretation is available, and language cards are used to identify which language a patient needs when this is difficult to discern at the beginning. Good examples of such cards can be found on websites like the Washington D.C.-based Office of Human Rights. Finally, as discussed in Part II, occasionally a family member of friend will be adamant about serving as an ad-hoc interpreter for a patient. Though this option should be used with extreme caution, at the discretion of the physician, it is important that all hospitals (large or small, urban or rural, well-endowed or resource-limited) keep on hand a set of liability waivers to be signed by both the LEP individual

and the physician in the event that this alternative is used. These can be drafted at the discretion of the individual hospital.

The scenario at East Tennessee Children's Hospital is ideal—neither geographic concerns nor budget restrictions pose significant limitations, and Spanish is the most common language for LEP individuals to speak (there are more Spanish medical interpreters available for hire than any other language). When hospitals do not face any of the above constraints, a similar setup should be implemented. The next section will consider best practices in other contexts which are less-than-ideal.

Small, Rural, Resource-Limited Hospitals

There is never any difference in the quality of interpretive service deserved by an LEP individual: each deserves an interpreter that will facilitate his/her ability to give fully informed consent. However, staffing full-time in-person interpreters is not always fiscally possible, and in some cases, is not justified by the population demographic in which the hospital is located. For example, the Byrdstown Medical Center of rural Pickett County, Tennessee, serves a population that is 98.8% Caucasian (Index Mundi). It is thus far less likely that this hospital will run into LEP patients on a daily basis. However, they must be prepared to offer these individuals the proper interpretation services in the inevitable—albeit less likely—event that they show up needing medical treatment. In this case, it is acceptable, and financially prudent, to forego staffing full-time interpreters, provided that they supplement this absence with a ready supply of video-mediated interpretive services, such as through CyraCom. A smaller number of iPads or tablets equipped with access to such services is preferable to a larger number of phones equipped with OTI—refer back to section II and the discussion of the value of seeing an interpreter's face. In no situation should financial constraints be an excuse for a hospital neglecting to provide any

sort of interpretive services, relying instead on ad-hoc interpreters. Again, as in the case with larger hospitals, smaller hospitals must have liability waivers available in the rare event that ad-hoc interpreter use is permitted.

General Notes

The purpose of these recommendations is to ensure the informed consent of LEP individuals, which must be at least *adequate* in order to be ethically justified. The first 'large hospital' guidelines are intended for any hospital with over 100 beds and a significant portion of LEP individuals in the greater population. The same percentage-ratios discussed in that section guiding number of interpreters on staff should be used for any hospital greater than this size. These hospitals should also have at least 3 (again, determined by percentages) iPads or tablets equipped with video interpretation access (though CyraCom or a similarly reliable service). Small hospitals must at least provide an adequate number of video-mediated interpretive services.

In either scenario, there are some things every hospital staff should do to ensure these resources are used properly, once they are implemented. Physicians (as well as any hospital employee who may use interpretive services) should be trained on proper interpretation etiquette. This includes addressing the patient directly, not the interpreter, and speaking in small segments so that the interpreter can remember every detail of the segment of speech to be translated. Additionally, hospitals should implement mandatory trainings in cultural sensitivity, so that no LEP individual is ever made to feel at a disadvantage, or discriminated against, for his/her lack of fluent English.

Finally, it is important to remember that there are occasionally emergent situations which will either preclude or significantly complicate a hospital staff's ability to follow all of the above

guidelines. For example, it is possible that an LEP individual may come into the emergency department with a time-sensitive medical problem, such as a stroke or seizure, and there is not time to either page an on-staff interpreter or call one over the video service. In this case, hospital staff may need to ask questions of an ad-hoc interpreter, or even use medical interventions without communicating with the patient initially. These situations exemplify *erring on the side of life*, and apply to English-speakers as well: when a choice must be made between securing full-fledge informed consent and saving a patient's life, the former may be sacrificed to keep the patient alive. Of course, the relevant guidelines must be properly followed once the patient has been stabilized.

Part 4—Conclusions

As health care moves from the traditional paternalistic conception of the doctor-patient relationship to one that emphasizes more the role of patient autonomy, we see a shift from the simple to a more complex model of informed consent. All patients, regardless of race, ethnicity, gender, age, sexual orientation, level of proficiency in English, etc. have the right to be fully informed of the medical treatments they are to receive in hospitals. Patients should be informed of all aspects of their care, and should be involved in the decision-making process when alternative treatment options are available. Clearly, for limited-English-proficiency patients, accurately relaying all of the information necessary to ensure this informed consent is obtained proves more challenging.

Federal regulations in the spirit of promoting equality in health care abound, including the Title VI of the Civil Rights Act of 1964, the Hill-Burton Act, and others. These policies direct federally subsidized or otherwise funded health care providers to enforce non-

discrimination in the delivery of their services, but they do not speak specifically to the unique situation of LEP individuals. The Patient Protection and Affordable Care act passed in 2010 does come much closer to achieving this end, especially thanks to the Final Rule created by the Department of Health and Human Services after the passage of the PPACA. The Final Rule provides further guidelines for the use of interpretive services in hospitals, but these guidelines are insufficient to ensuring LEP individuals are able to provide their fully informed consent. LEP individuals, therefore, are not guaranteed an equal quality of healthcare until these guidelines are improved.

I recommend that legal policy guiding interpretive services in hospitals be strengthened so that it is both more specific and better suited to the types of hospitals it guides. Two major hospital types, large/urban and small/rural are considered. The large/urban hospitals should always employ a staff of in-person interpreters for the most widely spoken non-English language of the area's population (this will usually be Spanish), with additional video-interpretation services available for non-Spanish-speaking LEP individuals. The smaller/rural hospitals may not have a need for a full-time interpretive staff, but should always provide patients with access to certified interpreters via video-mediated services (such as those provided by CyraCom). In either case, one common goal is to reduce the use of uncertified ad-hoc interpreters, who often cannot properly facilitate doctor-patient hospital encounters and thus make it quite difficult for LEP individuals to provide their fully informed consent.

Though the guidelines recommended in this project are still only a start, and each hospital is tasked with drafting its own policy that meets the requirements established, this project marks a significant step forwards. Too often, LEP individuals fall through the cracks as hospital staff take the 'easy route' instead of going the extra mile to ensure they receive the best quality of

care. This situation cannot be allowed to continue. Without even considering the potential legal ramifications, we have enough ethical justification that tells us this is unacceptable—not providing LEP individuals with the proper interpretation services precludes their ability to provide informed consent, which ultimately undermines their autonomy as human beings, which is absolutely unacceptable.

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