COMMENTARIES

Bridging the Communication Gap: Addressing Linguistic Exclusion in Healthcare

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Imagine the experience of grappling with crippling illness. It can be frightening, not knowing what is happing to your body and being unable to stop it. You try to downplay your concerns to your family, as you don't want them to worry, but your condition is overwhelming. As your daily routine breaks down, you decide to seek professional guidance. At the physician's office, you are unable to read the forms presented to you, but you do your best to complete them. The doctor is unable to speak your language, but you both attempt to communicate with hand gestures, linguistic cognates, and transliterations. You go home with the medication prescribed by the physician, although you're not sure about its proper usage and the symptoms are rapidly getting worse. You go to the emergency room, only to beget an all too familiar feeling of isolation. As you progress through the various hospital departments, you communicate with partially bilingual staff members, never really grasping what has happened to you or what will come next. Some of the devices appear positively medieval and by now you're terrified. You can tell by the room surroundings that you are about to enter surgery, and pray you will wake to see your family again.

This is the experience felt by persons with limited English proficiency ("LEP"), who are forced to navigate the American healthcare system without adequate linguistic assistance.[1] LEP is defined as an individual aged over 5 years who speaks English "less than very well", a population which accounts for nearly 10% of the country's demographics.[2] The scope of this problem is astounding, as one study estimates nearly 97% of practitioners come into contact with LEP patients on a regular basis, yet an estimated third to half of all health practitioners are not using adequate translation services.[2] Adequate interpretive services entail using a certified professional and providing these services in a free, timely, private, and consistent manner.[3] One study found a 2% clinically significant error rate for properly trained translator, compared to 20% with no interpreter and 22% with an ad hoc translator. The most common errors by ad hoc translators include word omissions, additions, substitutions, editorial comments, and false fluency.[4] These error-prone communication methods result in misdiagnoses, bodily or mental harm to the patient and their family, low treatment efficacy for the community, and account for 2.5% of all medical malpractice cases often with staggering financial judgments.[1–3]

Access to adequate translation services is required by law, under the authority of nondiscrimination provisions of the Civil Rights Act and subsequent legislation such as the Affordable Care Act.[3] However, enforcement remains low due to the linguistic barriers faced by LEP individuals attempting to file a complaint, along with resource shortages at the agency tasked with assessing compliance.[2] Practitioners should view the furnishing of adequate translation services as a way of improving their medical outreach to the community, in addition to covering potential legal and financial liability. Properly trained interpreters should be certified by either The National Board of Certification for Medical Interpreters or the Certification Commission for Healthcare Interpreters, and can be provided to patients at low cost through remote video conferencing or telephonic means.[3] Many states either reimburse practitioners for interpreters, have a state fund to subsidize these services, or themselves may provide trained medical translators for use within their state.[3] Physicians should proactively assess the linguistic needs of their community, develop a policy to provide adequate access, determine the method of communication services, seek financial support, and finally provide language appropriate resources in their office.[5]

Doctors are the healers of society, fighting for the living in an eternal struggle against the inevitable. In a country with such a diverse cultural tradition, this role can only be satisfied by providing linguistic nondiscriminatory forms of healthcare access. Social determinates of health indicate that disease manifests not only biochemically but also through exclusionary violence. Eliminating gratuitous suffering is entirely within the medical purview, as physicians of tomorrow will be central in treating these harms.

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