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Perspective

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Language Barriers to Health Care in the United States

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A 12-year-old Latino boy arrived at a Boston emergency department with dizziness and a headache. The patient, whom I'll call Raul, had limited proficiency in English; his mother spoke no English, and the attending physician spoke little Spanish. No medical interpreter was available, so Raul acted as his own interpreter. His mother described his symptoms:

"*La semana pasada a el le dio mucho mareo y no tenía fiebre ni nada, y la familia por parte de papá todos padecen de diabetes.*" (Last week, he had a lot of dizziness, and he didn't have fever or anything, and his dad's family all suffer from diabetes.)

"Uh hum," replied the physician.

The mother went on. "*A mí me da miedo porque el lo que estaba mareado, mareado, mareado y no tenía fiebre ni nada.*" (I'm scared because he's dizzy, dizzy, dizzy, and he didn't have fever or anything.)

Turning to Raul, the physician asked, "OK, so she's saying you look kind of yellow, is that what she's saying?"

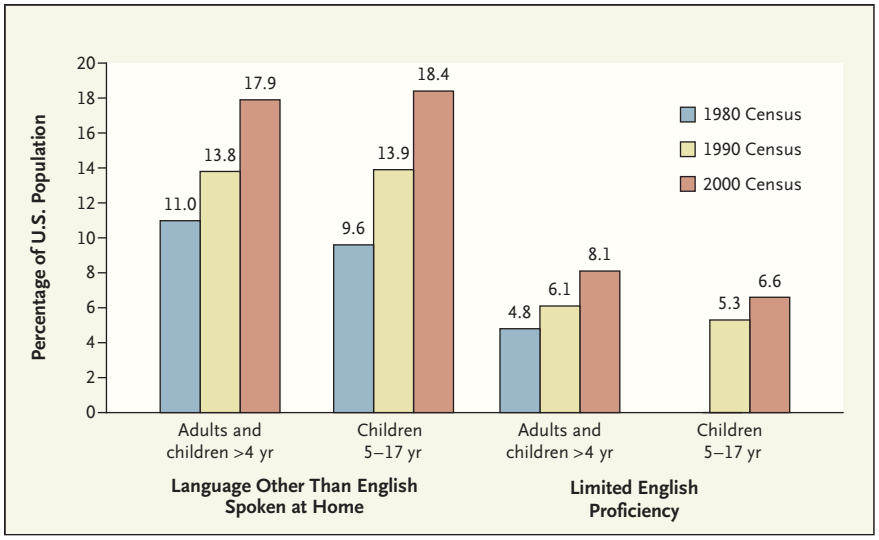
Raul interpreted for his mother: "*Es que si me vi amarillo?*" (Is it that I looked yellow?)

"*Estaba como mareado, como pálido*" (You were like dizzy, like pale), his mother replied.

Raul turned back to the doctor. "Like I was like paralyzed, something like that," he said.

If Raul received inappropriate care owing to his misinterpretation, he would not be alone. One interpreter, mistranslating for a nurse practitioner, told the mother of a seven-year-old girl with otitis media to put (oral) amoxicillin "in the ears."[1] In another case, a Spanish-speaking woman told a resident that her two-year-old had "hit herself" when she fell off her tricycle; the resident misinterpreted two words, understood the fracture to have resulted from abuse, and contacted the Department of Social Services (DSS). DSS sent a worker who, without an interpreter present, had the mother sign over custody of her two children.[2] Clearly, catastrophes can and do result from such miscommunication.

Some 49.6 million Americans (18.7 percent of U.S. residents) speak a language other than English at home; 22.3 million (8.4 percent) have limited English proficiency, speaking English less than "very well," according to self-ratings. Between 1990 and 2000, the number of Americans who spoke a language other than English at home grew by 15.1 million (a 47 percent increase), and the number with limited English



Percentages of Americans Who Speak a Language Other Than English at Home or Who Have Limited English Proficiency.

Data are from the U.S. Census Bureau, which examines language proficiency in school-age children but not in those under five years of age. Data on the proportion of children with limited English proficiency were not collected in the 1980 Census.

proficiency grew by 7.3 million (a 53 percent increase, see graph). The numbers are particularly high in some places: in 2000, 40 percent of Californians and 75 percent of Miami residents spoke a language other than English at home, and 20 percent of Californians and 47 percent of Miami residents had limited English proficiency.

Yet many patients who need medical interpreters have no access to them. According to one study, no interpreter was used in 46 percent of emergency department cases involving patients with limited English proficiency.[3] Few clinicians receive training in working with interpreters; only 23 percent of U.S. teaching hospitals provide any such training, and most of these make it optional.[1] Data collection on patients' primary language and English proficiency is frequently inadequate or nonexistent. Although no federal statutes require the collection of such information, no statute prohibits it, either.[4]

Language barriers can have deleterious effects.[1,5] Patients who face such barriers are less likely than others to have a usual source of medical care; they receive preventive services at reduced rates; and they have an increased risk of nonadherence to medication. Among patients with psychiatric conditions, those who encounter language barriers are more likely than others to receive a diagnosis of severe psychopathology — but are also more likely to leave the hospital against medical advice. Among children with asthma, those who confront language barriers have an increased risk of intubation. Such patients are less likely than others to return for follow-up appointments after visits to the emergency room, and they have higher rates of hospitalization and drug complications. Greater resources are used in their care, but they have lower levels of patient satisfaction.

Inadequate communication can have tragic consequences: in one case, the misinterpretation of a single word led to a patient's delayed care and preventable quadriplegia.[1] A Spanish-speaking 18-year-old had stumbled into his girlfriend's home, told her he was "intoxicado," and collapsed. When the girlfriend and her mother repeated the term, the non–Spanish-speaking paramedics took it to mean "intoxicated"; the intended meaning was "nauseated." After more than 36 hours in the hospital being worked up for a drug overdose, the comatose patient was reevaluated and given a diagnosis of intracerebellar hematoma with brain-stem compression and a subdural hematoma secondary to a ruptured artery. (The hospital ended up paying a $71 million malpractice settlement.)

In 1998, the Office for Civil Rights of the Department of Health and Human Services issued a memorandum regarding the prohibition, under Title VI of the Civil Rights Act of 1964, against discrimination on the basis of national origin — which affects persons with limited English proficiency. This memorandum states that the denial or delay of medical care because of language barriers constitutes discrimination and requires that recipients of Medicaid or Medicare funds provide adequate language assistance to patients with limited English proficiency. In 2000, a presidential executive order was issued on improving such persons' access to services. Thirteen states currently provide third-party reimbursement (through Medicaid and the State Children's Health Insurance Program) for interpreter services. Unfortunately, most of the states containing the largest numbers of patients with limited English proficiency have not followed suit, sometimes citing concerns about costs. Al-

though the Office for Civil Rights issued guidelines in 2003 that seem to allow health care facilities to opt out of providing language services if their costs are too burdensome, Title VI provides no such exemption.

Ad hoc interpreters, including family members, friends, untrained members of the support staff, and strangers found in waiting rooms or on the street, are commonly used in clinical encounters. But such interpreters are considerably more likely than professional interpreters to commit errors that may have adverse clinical consequences.[1,5] Ad hoc interpreters are also unlikely to have had training in medical terminology and confidentiality; their priorities sometimes conflict with those of patients; and their presence may inhibit discussions regarding sensitive issues such as domestic violence, substance abuse, psychiatric illness, and sexually transmitted diseases.[5] It is especially risky to have children interpret, since they are unlikely to have a full command of two languages or of medical terminology; they frequently make errors of clinical consequence; and they are particularly likely to avoid sensitive issues.[1,5] Given the documented risks associated with the use of ad hoc interpreters, it is of concern that the 2003 guidance from the Office for Civil Rights states that such use "may be appropriate."

Later this year, the California legislature will consider a bill prohibiting state-funded organizations from using children younger than 15 years of age as medical interpreters. Leland Yee, the California speaker pro tempore, proposed the bill, prompted by his experiences interpreting for his mother and, later, as a child psychologist. The bill requires organizations receiving state funding to establish a procedure for "providing competent interpretation services that does not involve the use of children."

Although this legislation may emerge as a state model, as an unfunded mandate, it will have limited power to improve care. Perhaps the time has come for payers to be required to reimburse providers for interpreter services. The provision of adequate language services results in optimal communication, patient satisfaction, outcomes, resource use, and patient safety.[1,5] A 2002 report from the Office of Management and Budget estimated that it would cost, on average, only $4.04 (0.5 percent) more per physician visit to provide all U.S. patients who have limited English proficiency with appropriate language services for emergency-department, inpatient, outpatient, and dental visits. This seems like a small price to pay to ensure safe, high-quality health care for 49.6 million Americans.

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Taking Heart — Cardiac Transplantation Past, Present, and Future

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Heart transplantation hit the international news with a splash in December 1967, when the first human-to-human transplantation was performed in South Africa by Christiaan Barnard, and the first transplantation in the United States, performed by Norman Shumway at Stanford University, followed a month later. Initial enthusiasm for the procedure was quickly curbed, however, when it became evident that survival rates were usually measured in days or weeks. This poor survival was due not to poor surgical technique, but to an inadequate understanding of the type of postoperative complications one should anticipate and a lack of tools for addressing these complications when they were recognized.

A 1971 cover story in *Life* magazine, entitled "A New and Disquieting Look at Transplants,"[1] reflected the public perception of