

KY Chapter Immigrant Child Health Task Force

March, 2020

TALK TO ME! INTERPRETATION AND LANGUAGE DISCORDANCE

CASE 1: Do I have to use an interpreter?

A previously healthy 12-year-old male is brought to clinic by his grandmother for three days of itching, increasing redness, pain, and swelling of his left leg. His temperature is 37.5 (99.5 F), HR 75, BP 110/75, RR 18. Physical exam reveals excoriations and a sharply demarcated area of erythema and induration on the lateral aspect of his left lower leg. His family immigrated from Rwanda 4 years ago. He speaks English and is doing well in school. His grandmother speaks Kinyarwanda and Swahili.

Do you need to use interpreter services? What if the patient is confident in his ability to explain everything to his grandmother? What if the patient were 15 instead of 12?

CASE 2: Who can interpret for me?

A 6-year-old girl presents to clinic with her family for a Well Child visit. The family immigrated from Guatemala one year ago and do not speak English. You have a bilingual staff member who has offered to interpret for the family.

Is the use of a bilingual staff member to interpret appropriate? What if you had studied Spanish in the past, would you treat the patient in Spanish yourself? What if you were just going to be with the patient for a minute or two?

DISCUSSION:

Case 1:

It is important that the adult responsible for the care of a minor understand what is happening during the encounter. Failure to provide appropriate interpretation for the language discordant families of pediatric patients is known to negatively impact patient outcomes¹. **Interpreter services should be used for the language-discordant caregiver** of any minor patient regardless of the patient's English proficiency². Even if a child or adolescent is confident in their knowledge and ability, they may be overestimating their understanding of the situation and except for exceedingly rare cases do not have the training and qualifications necessary to interpret. Forgoing language services and relying on the patient to communicate with the caregiver to whatever extent they wish introduces potential complications and liabilities, and ignores sociocultural considerations such as reluctance to contradict a provider's power and authority³. Nearly 22,000 households in KY do not have an English-speaking Family member aged 14 or older. Allowing a child to interpret for family members ignores potential conflicts of interest, and using children as interpreters has been shown to be detrimental to their wellbeing⁴.

We recommend using a professional interpreter for the caregiver of any patient you would not see without an adult present. If an English-speaking caregiver would have the option of communicating with the provider interpreter services must be provided, regardless of whether or not the caregiver uses the provided service to communicate with the provider or solely to understand the communication between the patient and provider.

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Case 2:

A bilingual staff member should interpret only if they have been trained to do so⁵. If the care a patient requires falls under the normal job description of a bilingual staff member then it is appropriate to transfer care to that staff member, however if the bilingual staff member ordinarily is not qualified to perform the necessary duties, whether that be patient care activities or interpretation, they should not be tasked with filling those roles⁶.

The benefits of using professional interpreters are numerous: decreased errors, decreased complications, decreased overall costs, improved understanding, increased healthcare utilization, elevated quality of care received by language discordant individuals to a level approaching or equal to that of English-speaking patients, improved patient satisfaction, and improved clinical outcomes^{5,7}.

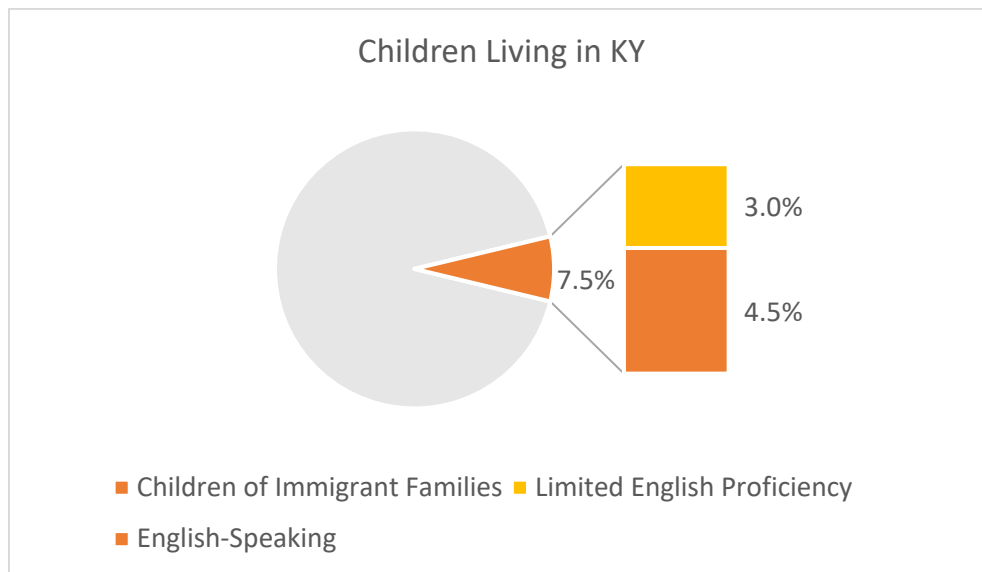
It can be tempting to use non-primary language skills when working with LEP patients, however we recommend caution when considering treating patients in a non-native language. The majority of individuals overestimate their proficiency in languages they have acquired, including individuals who grew up in bilingual households⁸. It is also common for providers to overestimate their patients' English proficiency⁹. An individual's perceived comfort using a language does not indicate mastery of that language. Demonstration of proficiency in the non-English language through formal testing or graduating with a degree from an institution of higher education, with instruction conducted in the non-English language, should be pursued before treating patients in a non-English language; when in doubt with regards to language proficiency of either the provider or the patient it is best to use a medical interpreter^{8,10}. Regardless of the duration of the visit, best practice is to have language services present. Using interpreters in short visits gives language-discordant patients the same opportunity to ask questions that the patient would otherwise have if they spoke the same language as the provider.

Definitions and Explanations:

Language discordance refers to when two individuals do not share the same preferred language. Language discordance affects 8.6% of people living in the US, and 5.6% of individuals living in Kentucky¹¹.

Limited English Proficiency (LEP) refers to a difficulty in communicating effectively in English. The US Government defines LEP as "Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English can be limited English proficient, or "LEP," entitled to language assistance with respect to a particular type of service, benefit, or encounter". [FR Doc. 02-15207 Filed 6-17-02; 8:45 am]

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Data from the Migration Policy Institute, 2017

A **translator** is someone who transcribes a written message from one language to another.

Sight translation refers to the act of reading a message in one language and speaking (or signing) the message in another language.

An **interpreter** is someone who communicates an oral message from one language to another or communicates a message between a spoken language and sign language.

A **Qualified Medical Interpreter** is someone who has completed a minimum of a 40-hour educational course in medical interpretation that is not specific to any particular language.

A **Certified Medical Interpreter** is someone who has studied interpretation beyond the 40-hour minimum and has passed both a written exam in English and an oral exam in English and the language of certification to prove proficiency in both languages.

An **ad-hoc interpreter** is someone who is untrained and not a professional interpreter. An ad-hoc interpreter could be a bilingual staff member or a patient's family member or friend.

Language Access Services include both interpretation and translation.

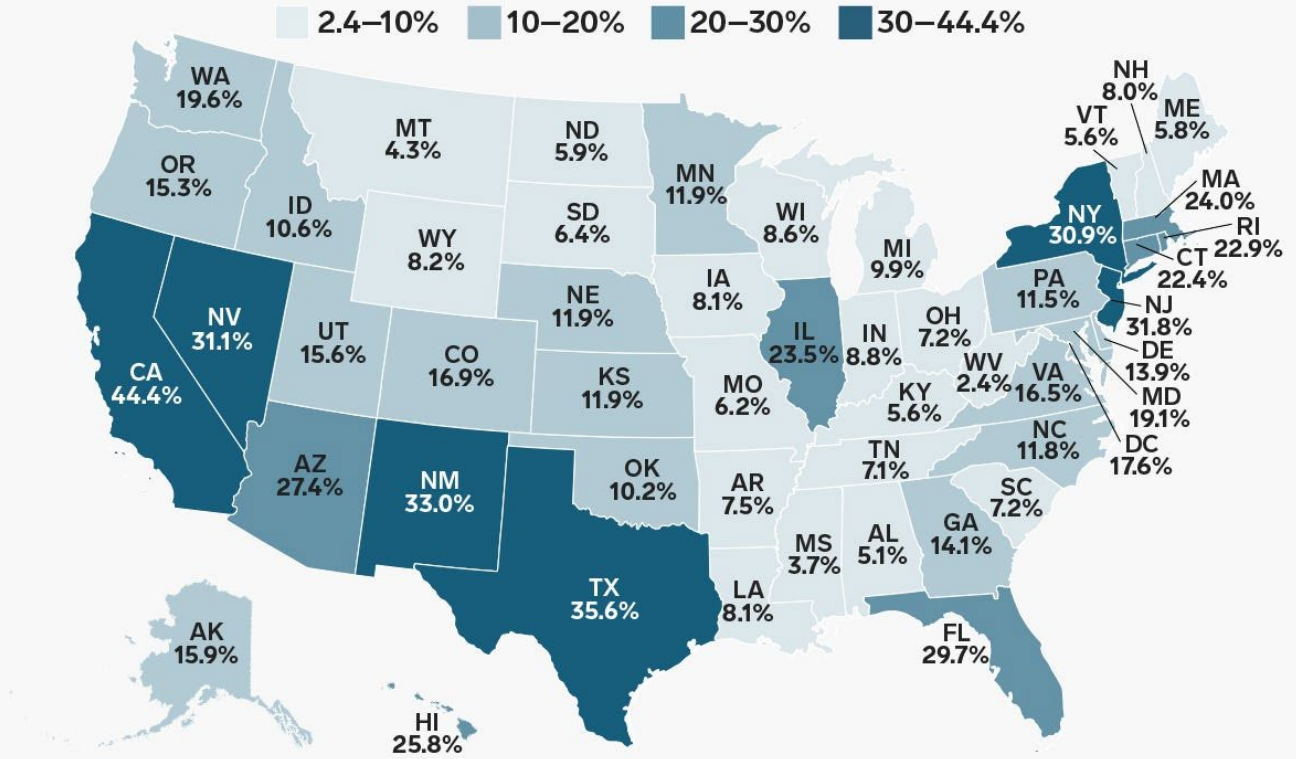
Provision of language access services is a right protected by Title VI of the Civil Rights Act and must be provided without cost to the patient¹².

To earn CME related to Culturally and Linguistically Appropriate Services:

<https://thinkculturalhealth.hhs.gov/education/physicians>

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Speaking a non-English language at home

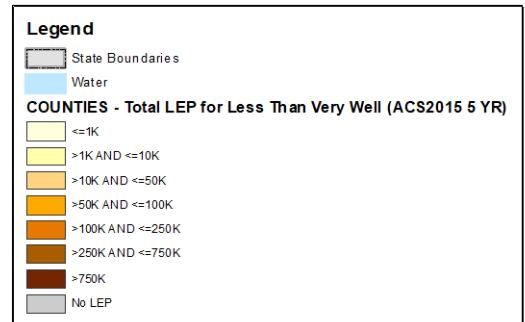
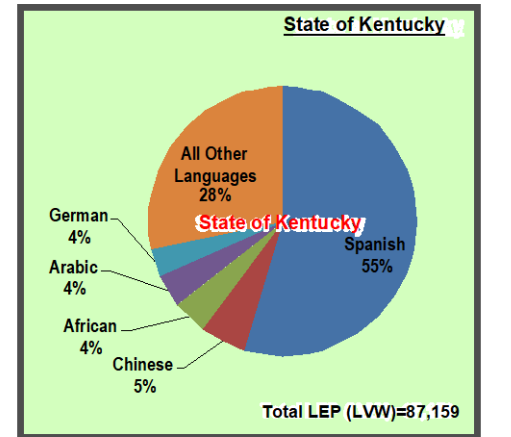
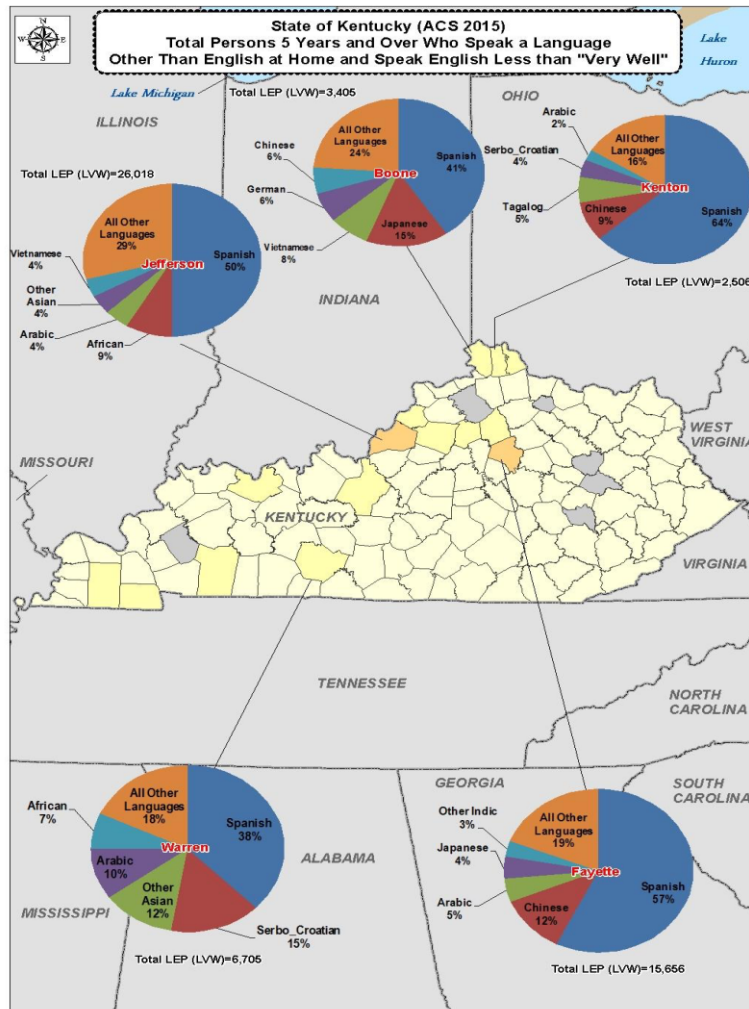


Source: US Census Bureau, 2017 American Community Survey.

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*Pie Charts represent Counties with the highest percent of LEP individuals by languages spoken.



Source: U.S. Census 2011-2015 American Community Survey Data Table B16001
LANGUAGE SPOKEN AT HOME
BY ABILITY TO SPEAK ENGLISH FOR THE POPULATION 5 YEARS AND OVER.
The estimates from the ACS are based on a sample survey and hence are subject to sampling error.

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