When I walked into the room to see Mr. X, I noticed two things instantly – his labored breathing and his swollen ankles. He had been discharged from the hospital one week earlier after a nine-day hospitalization for a heart failure exacerbation. Mr. X now came to see me for follow-up, and clearly, the nine days outside of the hospital had not been kind to him.

Before walking in to see my patient, I knew two other things about him. I knew he was non-English-speaking. And I knew, based only on chart documentation revolving around frequent emergency room and hospital visits, that he had been labeled as a patient with “poor compliance.”

Mr. X was accompanied to the office by his daughter, who spoke adequate – but far from perfect – English. The daughter typically served as an interpreter for his health care encounters. In our discussion, I learned that, when he was last in the hospital, his heart failure treatments were never discussed with him via the use of a trained medical interpreter, that he was not provided printed language-appropriate discharge instructions related to medications and diet recommendations, and that neither he nor the daughter could ever recall an interpreter-mediated conversation with a dietician regarding the importance of limiting sodium intake.

Typically, the daughter told me, Mr. X gets admitted every time he goes to the emergency room.

Teachable moment

This case presents an opportunity to consider the challenges facing both physicians and patients in encounters involving language and comprehension barriers, an issue that is becoming increasingly relevant in the diverse populations we serve. Patients with limited English proficiency (LEP) represent a growing proportion of patients encountered by health care providers – with the American Community Survey (2005-2009) reporting that 24 million Americans have LEP [1].

Anecdotally, these patients present a myriad of challenges – ranging from cultural differences related to medical care to appropriate comprehension of discharge instructions and follow-up care. Many of these challenges have been formally examined as well. For example, one study showed that no interpreter was used in 46% of emergency department cases involving LEP patients [2], while another study
of 106 patients, about half of whom were non-English speaking, showed that comprehension was the only factor significantly related to future compliance [3].

Certainly, there are inherent dangers to poor communication between physicians and patients, and these dangers can be amplified when there is a language barrier, especially in situations where family members – who have their own cultural differences and ability to comprehend medical information – serve as interpreters rather than trained professionals.

Recognizing these challenges, and their potential consequences, there are laws and guidelines that should inform physicians and caretakers. In 2000, President Clinton issued an executive order (13166) that in part states that any LEP patient is entitled to receive language assistance (oral or written translation) for medical treatment, a rite that seems self-evident but that in experience often does not occur, with barriers including limited time and/or limited resources for rare languages. President Clinton’s executive order does state that healthcare providers are required to “take reasonable steps to ensure meaningful access” to their translation services [4]. In addition, the U.S. Department of Health and Human Service’s Office of Civil Rights – guided by Title VI of the Civil Rights Act of 1964 – requires physicians to inform LEP patients that he or she has the option of having an interpreter provided free of charge and furthermore states that a family member or friend should not be required to serve as an interpreter [5].

Why does all of this matter? Extensive research has shown that LEP patients who are provided with trained professional interpreters make it to more of their outpatient visits, have higher satisfaction with care, and fill more of their prescriptions [6]. It is possible these improvements could lead to lower healthcare costs as well.

Mr. X had been labeled as “poorly compliant” despite the fact that, based on chart review and discussion with him and his daughter, full efforts to involve a trained interpreter, to educate him on the ongoing care of his chronic disease, and to provide appropriate discharge had rarely, if ever, been met in his many healthcare encounters. As a result, he was seeing me again with a heart failure exacerbation, an outcome that could have been avoided with simple steps that involve one of the basic tenets of medicine: developing a more personal connection with patients like Mr. X and thereby focusing on prevention.

Note: Mr. X is not the patient’s actual name.

References


