

CASE STUDY DISCUSSION GUIDE

Consuela Elena Morales

Effective Communication with Patients who have Limited English Proficiency

PURPOSE

This guide is designed to accompany the Consuela Elena Morales case study and to provide guidance to those responsible for leading discussion groups with residents. The guide includes conceptual frameworks and definitions for culture, cultural competence, and linguistic competence; key takeaways points; content to inform dialogue on the reflection questions; references; and suggested resources. While the guide provides an array of information, the references and resource list offer additional sources to enhance learning and professional development in providing culturally and linguistically competent care to patients who have lupus.



GETTING ON THE SAME PAGE

The following provide a list of key terms and their definitions. Engage the residents in discussion about these concepts and to make sure they are “on the same page” and using terms in the same way.

What do we mean by culture?

Culture is perceived of and defined in many different ways. Have group members discuss their definitions and understanding of culture and how culture impacts both health and health care.

The following is a definition of culture used by the Georgetown University National Center for Cultural Competence:

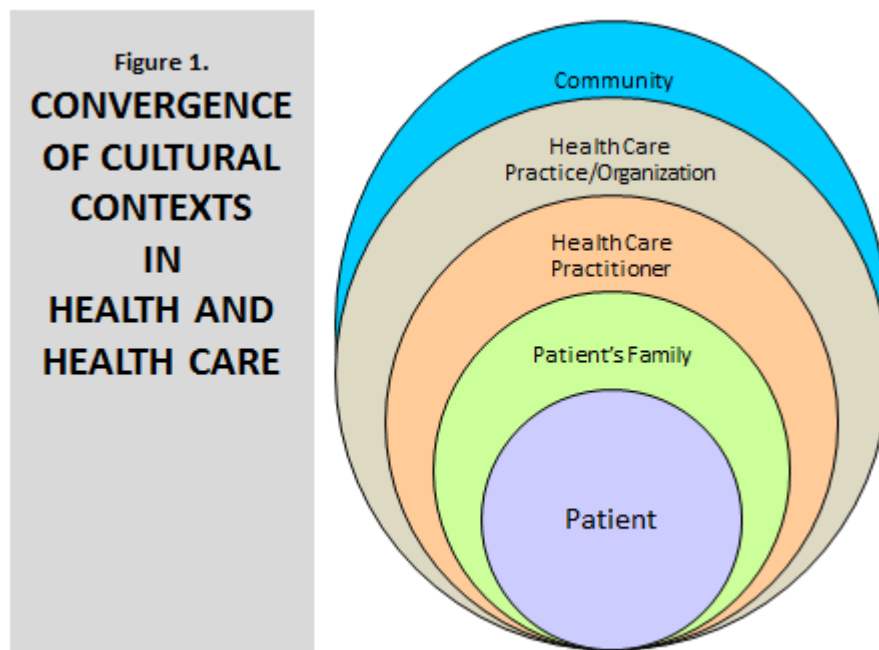
Culture is the learned and shared knowledge that specific groups use to generate their behavior and interpret their experience of the world. It comprises beliefs about reality, how people should interact with each other, what they “know” about the world, and how they should respond to the social and material environments in which they find themselves. It is reflected in their religions, morals, customs, technologies, and survival strategies. It affects how they work, parent, love, marry, and understand health, mental health, wellness, illness, disability, and death.

Culture includes but is not limited to—thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships, and expected behaviors of an ethnic group or social groups whose members are uniquely identifiable by that pattern of human behavior.¹

While the aforementioned definition and conceptualization present culture in terms of the group and group behavior, it is essential to note however, that aspects of culture are manifested differently in each person. A member of a cultural group may neither exhibit nor embrace all of the beliefs, values,

practices, modes of communication, or behaviors attributed to a given group. This understanding of culture recognizes the individuality of human beings and the unique diversity among group members. This may include but is not limited to race, ethnicity, age, gender, gender identity, socioeconomic status, education, profession, country of origin, languages spoken, and the lived experience of chronic illness, disability, or mental illness. Importantly, accepting this understanding of culture minimizes the tendency to stereotype and reminds us that one's cultural identity is influenced by a constellation of interrelated and distinct factors. This conceptualization of culture also acknowledges professional culture, specifically *the culture of medicine* and its impact on one's values, beliefs, and world view.

Lastly, it is important within the health care context to expand our conceptualization of culture beyond individual people and groups to organizations, systems, and the socio-cultural contexts of communities in which patients and their families live. Health care practices, organizations, and systems have their own cultures – norms, rules, language, decision-making processes, approaches to communication, defined roles and responsibilities, ways of interacting with those seeking and receiving care. Figure 1 illustrates this concept by depicting the multiple dimensions of culture that converge and how they are integrally linked in health and health care. Figure 1 asks you to consider the cultures of the patient, his/her family, the health care practitioner, the health care practice/organization, and cultural contexts of the communities that impact health and well-being of patients.



Take away points

The following take away point offer insight about culture within the context of health and health care.

- Understanding another culture is a continuous and not a discreet process.
- It takes experience as well as study to understand the many subtleties of a culture other than your own.
- Culture informs attitudes, beliefs, and practices of individual patients and their families who seek and use health care.
- You are a cultural being and have multiple cultural identities, one of which is your profession – a physician or health care practitioner.
- You view and interpret the world through your own cultural lens which is comprised of both individual and group experiences over time.
- Your world view influences how you deliver health care. This world view may or may not be shared by the patients and families to whom you provide health care.
- You are influenced by the culture of the practice or organizational setting in which you provide health care.

What do we mean by cultural competence?

Encourage the group to discuss their conceptualizations and definitions of cultural competence. This will allow group members to hear how the concept of cultural competence has been taught in medical education and is understood and practiced in residency. Acknowledge that there are many definitions of cultural competence. Some definitions focus on the health care practitioner and others at the system or organizational level. Have the group to discuss the following definition and how it consistent with or different from their understanding of the concept of cultural competence at both levels.

The Georgetown University National Center for Cultural Competence embraces a definition that of cultural competence that requires organizations:

- have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally.
- have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve.
- incorporate the above in all aspects of policy making, administration, practice, service delivery and involve systematically consumers, key stakeholders, and communities.

Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum.²

Cultural competence at the individual level requires the capacity to:

1. *Acknowledge cultural differences* that exist between patients, their families, and health professionals and how such differences impact health care. Demonstrate valuing these differences, for example, in your manner of communication with patients and their families and partnering in medical decision-making.
2. *Understand your own culture*– willingness to reflect upon your own cultural belief systems, including the culture of medicine, and how they influence your interactions with patients and their families.
3. *Engage in self-assessment* – responding to assessment instruments/checklists and taking time for self-reflection to examine one’s own attitudes, values, and biases that may contribute to or compromise positive patient-provider relationships and your approach to health care.
4. *Acquire cultural knowledge and skills* – pursuing formal and informal opportunities to learn about the cultures of your patients, the environments in which they live including the social determinants of health, culture-specific and evidence-based practices and interventions to improve health care outcomes.
5. *View behavior within a cultural context* – even if a behavior seems illogical, seek to understand the beliefs or practices of patients (without judgement) and partner with them to overcome problems that may compromise their health and well-being. This may involve spanning the boundaries or health care to engage with social services and others in the helping professions.³⁻⁵



Take away points

Cultural competence:

- is a developmental process and is enhanced over time, at both the individual and organizational levels.
- must be supported by organizational policy, procedures, practices, and resources.
- is an intentional, evidenced-based practice and involves gaining knowledge and skills in order to provide care that is effective and acceptable to diverse patient populations.
- involves examining one’s own beliefs and attitudes about patient behaviors including one’s biases and stereotypes about patients.

What is linguistic competence?

Linguistic competence is a relatively new term that has gained in credibility, usage, and evidence over the past 15 years. There are many definitions, most which until recently have focused on interpretation and translation services for individuals with limited English proficiency.⁶⁻⁸ The *National Standards for Culturally and Linguistically Services in Health and Health Care*, (commonly referred to as The National CLAS Standards), promulgated by the Office of Minority Health, U.S. Department of Health and Human Services, put forth a broader conceptualization of linguistic competence in its Blueprint which was released in 2013.⁹ Linguistic competence as conceptualized by the Georgetown University National Center for Cultural Competence is consistent with this broader definition and is defined: as the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse groups including persons of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing. Linguistic competency requires organizational and provider capacity to respond effectively to the health and mental health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity.¹⁰



Linguistic competence may include but is not limited to the use of the following:

- bilingual/bicultural or multilingual/multicultural staff;
- cross-cultural communication approaches;
- cultural brokers;
- foreign language interpretation services including distance technologies;
- sign language interpretation services;
- multilingual telecommunication systems;
- videoconferencing and telehealth technologies;
- assistive devices and technologies for individuals who are deaf or hard of hearing;
- print materials in easy to read, low literacy, picture and symbol formats;
- materials in alternative formats (e.g., audiotope, Braille, enlarged print);
- varied approaches to share information with individuals who experience cognitive disabilities;
- materials developed and tested for specific cultural, ethnic, and linguistic groups;
- translation services including those of:
 - legally binding documents (e.g., consent forms, confidentiality and patient rights statements, release of information, applications)
 - signage
 - health education materials
 - public awareness materials and campaigns; and
 - ethnic media in languages other than English (e.g., television, radio, Internet, newspapers, periodicals, social media sites).¹⁰

Take away points

- Linguistic competence involves providing language access services to individuals with limited English proficiency both in spoken and written formats.
- Linguistic competence also involves assessing and addressing the health literacy needs of patients either their language of origin or in English.
- Ensuring effective communication between patients and health practitioners/professionals is critical to providing quality care, assuring the best outcomes for patients, and decreasing health and health care disparities.

“The United States has already established the legal and ethical obligation of health care providers to offer language services to patients with limited English proficiency. We can either pay a small amount up front to ensure that all patients receive equitable, high-quality care, or pay a lot more later or unnecessary tests and procedures, preventable hospitalizations, medical errors and injuries, and expensive lawsuits.”¹¹

Leighton Ku & Glen Flores
Pay Now or Pay Later: Providing Interpreter Services in Health Care
Health Affairs, 2005, p. 442

What is meant by Limited English proficiency and Speaking English Proficiently?

The U.S. Department of Health and Human Services, Office for Civil Rights defines Limited English Proficiency in the following way.

“Limited English Proficiency means persons who are unable to communicate effectively in English because their primary language is not English and they have not developed fluency in the English language. A person with Limited English Proficiency (LEP) may have difficulty speaking or reading English.”¹²

People with limited English proficiency will benefit from an interpreter who can convey what is being stated in the person’s primary language and what is being stated in English. “An LEP person may also need documents written in English translated into his or her primary language so that the person can understand important documents related to health and human services.”¹²



The U.S. Census Bureau also has several definitions related to English language proficiency.¹³ “Speaking English proficiently” or “English proficiency” refers to those who speak only English at home or those who speak a language other than English at home and indicate they speak English “very well,” the highest response category on a four-point scale of English speaking ability. Those who do not speak English proficiently include those who speak a language other than English at home and indicate they do not speak English or indicate they speak English “well” or “not very well.” This information is self-reported in U.S. Census Bureau surveys such as the American Community Survey. A recent study by the Pew Research Center on Hispanic Trends indicates that the English proficiency is on the rise among¹⁴ Latinos.

A "limited English speaking household" is one in which no member 14 years old and over (1) speaks only English or (2) speaks a non-English language and speaks English "very well."¹⁵ In other words, all members 14 years old and over have at least some difficulty with English. Previous Census Bureau data products have referred to these households as "linguistically isolated."

What is the difference between interpretation and translation?

Interpretation is "the process of rendering a message spoken in one language into one or more other languages"¹⁶ or "the oral restating in one language of what has been said in another language."¹⁷ In the health care environment, interpreters facilitate communication between individuals and health care personnel (e.g., clinical, front desk or other staff) who do not speak the same language and those with limited English proficiency. Interpreters also facilitate communication between individuals who are deaf or hard of hearing and the personnel who provide them a service or care at any point of contact. Note that the term "interpretation" is used for processes of oral or sign messages, while the term "translation" is used for written messages. Interpretation and translation require different skill sets.¹⁸⁻¹⁹

What is health literacy?

There are a number of definitions of health literacy that are prevalent in the literature. Most recently we have witnessed a shift from the oneness resting with the individual patient to the responsibility of health care practitioners and professionals. In 2004, the Institute of Medicine provided the following definition of health literacy. "Health literacy is a shared function of social and individual factors. Individuals' health literacy skills and capacities are mediated by their education, culture, and language. Equally important are the communication and assessment skills of the people with whom individuals interact regarding health, as well as the ability of the media, the marketplace, and government agencies to provide health information in a manner appropriate to the audience."²⁰ One of the foremost researchers, Rima Rudd, Ph.D., captures this evolution of the concept of health literacy in the following definitions.²¹



Evolving conceptualizations and definitions of health literacy.

Health literacy is:

the cognitive and social **skills** which determine the motivation **and ability of individuals** to gain access to, understand and use information in ways which promote and maintain good health.

Nutbeam, D., World Health Organization, 1998

the degree to which **individuals have the capacity to obtain, process, and understand** basic health information and services needed to make appropriate health decisions.

U.S. Department of Health and Human Services, 2010

engagement in a wide range of health actions that extend from personal behaviors to social action to address the determinants of health.

Nutbeam, D., 2008



Dr. Rudd pushes us to consider a definition of health literacy that sheds light on the knowledge and responsibility of health care practitioners and professionals and the organizations and settings in which they provide care, services, and supports – ***the capacity of professionals and health institutions*** to provide access to information and support the active engagement of people.²¹

Health Literacy in a Cultural Context

Researchers and practitioners are also placing increased emphasis on the role of culture and health literacy. Guidance to health care practitioners and other professionals focus on the integration of culture and cultural and linguistic competence so that these practices are seen as integral to rather than separate aspects of care. The National Libraries of Medicine states:

“Recognizing that culture plays an important role in communication helps us better understand health literacy. For people from different cultural backgrounds, health literacy is affected by belief systems, communication styles, and understanding and response to health information. Even though culture is only one part of health literacy, it is a very important piece of the complicated topic of health literacy. The U.S. Department of Health and Human Services recognizes that ‘culture affects how people communicate, understand and respond to health information.’ According to the American Medical Association report, [Health Literacy and Patient Safety: Help Patients Understand](#), ‘poor health literacy is a stronger predictor of a person's health than age, income, employment status, education level, and race.’²²



Health Literacy for the Adult Spanish Speaking Patient Populations

There are a number of validated instruments for assessing health literacy for English-speaking populations. For example the Rapid Estimate of Adult Literacy in Medicine (REALM –SF),²³ which is one of the most easily administered test of health literacy and which has been the basis for assessment tools. Assessing health literacy for patient populations who speak languages other than English has been a challenge for clinicians and other health professionals. Researchers documented that Spanish speaking Hispanic/Latino populations that have low health literacy may be more pronounced for adverse effects on their health.²⁴ Two validated instruments have been developed to assess health literacy for the Latino/Hispanic Spanish-speaking adult populations: Short Assessment of Health Literacy–Spanish and English (ASHL-S&E)²⁵ which has 18 items, and the Short Assessment of Health Literacy for Spanish Adults (SAHLSA-50),²⁵ which has 50 items. Using these and other tools are recommended and can be used not only to guide patient-provider communication but also in the design of health information and education materials in languages other than English.

A word about mental health literacy

While there is a movement for integrative care, coordinating and providing behavioral health care in primary care settings, there is still a lack of recognition of the need for such integration in many health care systems and practices. Substantial number of individuals with chronic illness, such as lupus, may also comorbidity of depression or other mental health disorder. The following definition of mental health literacy is offered to



raise awareness of the need to address this among the diverse patient populations. Mental health literacy is defined by the Canadian Mental as the knowledge, beliefs, and abilities that enable the recognition, management or prevention of mental health problems. Enhanced mental health literacy is thought to confer a range of benefits -prevention, early recognition and intervention, and reduction of stigma associated with mental illness.²⁶

Take away points

- Health literacy is an essential component of health care and positively affects patient-provider communication and health outcomes for diverse patient populations.
- There is an abundance of evidence which indicates that when practitioners fail to attend to and address the health literacy needs of their patients, the outcomes can have adverse outcomes on the patient's health and well-being.
- "Health information can overwhelm even persons with advanced literacy skills. Medical science progresses rapidly. What people may have learned about health or biology during their school years often becomes outdated or forgotten, or it is incomplete. Moreover, health information provided in a stressful or unfamiliar situation is unlikely to be retained."²⁷
- Health literacy can be assessed and there are validated instruments both for English speaking populations and for the Spanish-speaking adult population.

What is asylum and how is it different from refugee status for immigration?

Often times the terms immigrant, refugee, and asylee are used interchangeably. They each have legal definitions. The U.S. Citizen and Immigration Services defines asylum seekers or asylees in the following way:

"Every year people come to the United States seeking protection because they have suffered persecution or fear that they will suffer persecution due to:

- Race
- Religion
- Nationality
- Membership in a particular social group
- Political opinion

Refugee status or asylum may be granted to people who have been persecuted or fear they will be persecuted on account of race, religion, nationality, and/or membership in a particular social group or political opinion. Refugee status is a form of protection that may be granted to people who meet the definition of refugee and who are of special humanitarian concern to the United States. Refugees are generally people outside of their country who are unable or unwilling to return home because they fear serious harm. For a legal definition of refugee, see section [101\(a\)\(42\) of the Immigration and Nationality Act \(INA\)](#). You may seek a referral for refugee status only from outside of the United States.

Asylum status is a form of protection available to people who:

- Meet the definition of refugee
- Are already in the United States
- Are seeking admission at a port of entry."²⁸

Discussion of Reflection Questions

How can you create a relationship with patients where they feel safe in sharing the stresses in their lives related to immigration issues?

Learning about the immigration status of a patient and the patient's family are important aspects of a social history. It is not uncommon for families to have mixed status where some members are lawfully present immigrants or even naturalized citizens and other members are not here lawfully present in the United States. A common example is where one or both parents in a family are not lawfully present, but their children who were born in the United States are citizens. These families with mixed status can be reluctant to access public services or advocate for the needs of their children, because they do not want to draw attention from immigration authorities. This situation has been exacerbated recently due to federal, state, and local statutes that require law enforcement to assess immigration status in encounters with individuals, and deportation of parents who are in the United States unlawfully that separate them from their children who are citizens. Thus immigration status can be an important stressor for patients and can impact their choices and actions in ways that will not make sense to health care providers/professionals if they are not aware of the issues. In addition, knowing the patient's status has important implications for their eligibility for health insurance coverage. Under the Affordable Care Act²⁹ only U.S. citizens or lawfully present immigrants can purchase health insurance through the Marketplace. Coverage through Medicaid and Child Health Insurance programs are also related to immigration status.

When inquiring about immigration status it is important to:

- Let patients know why you are asking—to help you better understand their life circumstance, to help them access services and resources for which they may be eligible, and to provide culturally responsive health care.
- Assure patients that it is not the role of the health care provider or setting to report information on immigration status to the federal government immigration authorities
- Explain to patients that the information they provide will not affect their care or services – unless your setting has rules governing eligibility, but this is probably not the role of the health care provider to determine.
- Inform patients that the information about immigration status, like all the information you learn from them, is confidential.

What responsibility does Dr. Wilson have to address Mrs. Morales' limited English skills?

At times in the health care setting, staff, and clinicians assume that because they can easily converse with a patient about day-to-day topics in English, that the patient does not need an interpreter for health care discussions. This level of communication is described in the education literature as basic interpersonal communicative skills (BICS).³⁰ In many instances health care encounters require cognitive academic language proficiency (CALP)³⁰ given the complex nature of health and medicine. It may take English language learners years to develop CALP, the higher level of proficiency needed to deal with technical information, words, and concepts not part of everyday conversation, such as those typically used in health and mental health care.³¹ Thus, it is vital for healthcare providers and settings to make

sure patients understand the information provided to or questions asked of them. There are legal requirements for providing language access services (including interpretation and translation services) to individuals with limited English proficiency. These are based on Title VI of the Civil Rights Act of 1964 - Sec. 601 that ensures –nondiscrimination in Federally Assisted programs and states that “No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”³²

Title VI protects persons of all colors, races, and national origins. Title VI protects against national origin discrimination and are not limited to U.S. citizens. Service providers must take reasonable steps to provide meaningful access to their programs by persons with limited English proficiency (LEP), [68 Fed. Reg. 153 at 47322].³³⁻³⁴

Is Dr. Wilson covered by this law? If he receives federal assistance, (i.e., Medicare, Medicaid, SCHIP) then he is bound by federal requirements. If Dr. Wilson does not receive federal funds, he also should provide language access to patients and their families who do not speak English well enough to participate meaningfully in their health care. In addition, physicians may be working for organizations that receive federal funds through reimbursements or grants and they need to be aware of their statutory responsibilities for language access. Recipients of assistance from the U.S. Department of Health and Human Services (HHS) may include, for example:

- Hospitals, nursing homes, home health agencies, and managed care organizations
- Universities and other entities with health or social service research programs
- State, county, and local health agencies
- State Medicaid agencies
- State, county and local welfare agencies
- Programs for families, youth, and children
- Head Start programs
- Public and private contractors, subcontractors and vendors
- Physicians and other providers who receive Federal financial assistance from HHS

Health care organizations and individual providers are encouraged to seek technical assistance from the HHS Office for Civil Rights or review the “*HHS’ Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons.*”³⁵ This guidance assists health care professionals to assess whether or to what extent language they must provide language access services in order to comply with the Title VI requirement to take reasonable steps to provide meaningful access to their programs by LEP persons.

Thus, Dr. Wilson and his staff have a responsibility to inform patients about the availability of interpretation services, to assess their need for those services, and to assure they are available for health care encounters and in written and verbal communications from the practice setting. Patients themselves are under no obligation to pay for these services, and must be notified of their rights by health care practitioners and practices.

In 2013, the HHS Office of Minority Health published the *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care.*³⁶ The *National CLAS* standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health care organizations. Health care organizations and their providers

should be knowledgeable of these Standards and how they apply to their individual practices and settings. Refer to the *National CLAS* standards listed below. Numerous resources have been developed to assist health care professionals to adopt and implement the standards.

<https://www.thinkculturalhealth.hhs.gov/content/clas.asp>

Principal Standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, orally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create processes for conflict and grievance resolution that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

What role can Dr. Wilson play in helping Mrs. Morales get more support from her family and workplace?

Dr. Wilson is not expected to solve the problems Mrs. Morales is experiencing in her day-to-day responsibilities as a working mother and wife. However Dr. Wilson, as well as other providers, can indeed play an important role by having knowledge of the manifestation of SLE in Latino patients across the life cycle, using history taking approaches that elicit health, mental health, and social concerns that take into account cultural contexts, and knowing where to refer for supportive services that are culturally and linguistically competent. Below find selected examples of providing social supports that may be appropriate for Mrs. Morales.

- ☑ Convene a family meeting. Ask for a time to meet with Mr. & Mrs. Morales and any other family members that the couple believes should have information about SLE in general, and the impact on Mrs. Morales in particular. To the extent possible, offer times that do not interfere with the couple's work schedule. Provide information in "plain talk" and use qualified bilingual staff or a Spanish language interpreter if this is the family's preferred way of receiving information. Help to dispel the notion that Mrs. Morales is simply lazy and address the types of supports she may need.
- ☑ Draw upon faith beliefs and religious affiliations. Explore with Mrs. Morales her faith beliefs, religious affiliations and practices, and the extent to which they are helpful to address concerns about her illness. Explore whether Mrs. Morales is comfortable seeking supportive services from the faith community (e.g., family counseling, child care, prayer or meditation groups, parish nursing, transportation, and meal share programs).
- ☑ La familia puede ayuda. Encourage Mr. & Mrs. Morales to discover what family members, including extended relatives, are willing to help with on days when Mrs. Morales is feeling badly (e.g. meals, child care, brief respite, transportation).
- ☑ Address employer discrimination. Identify resources that address employer discrimination related to SLE and other health conditions. Provide information and materials that Mrs. Morales can share with her employers and connect her to information and support about her legal rights in her employment setting.

What are the roles for family/friends, bilingual staff, and professional interpreters in supporting individuals with limited English proficiency in health care settings?

The National Council on Interpreting in Health Care provides the following information about language access services.

"What is the definition of a qualified interpreter?"

An individual, who has been assessed for professional skills, demonstrates a high level of proficiency in at least two languages and has the appropriate training and experience to interpret with skill and accuracy while adhering to the National Code of Ethics and Standards of Practice published by the National Council on Interpreting in Health Care.

What is the difference between a healthcare interpreter and a bilingual individual?

A bilingual individual is a person who has some degree of proficiency in two languages. A high level of bilingualism is the most basic of the qualifications of a competent interpreter, but by itself does not insure the ability to interpret. A bilingual employee may provide direct services in both languages but, without additional training, is not qualified to serve as an interpreter.

A qualified interpreter is a person who has been assessed for professional skills, demonstrates a high level of proficiency in at least two languages, and has the appropriate training and experience to interpret with skill and accuracy while adhering to the National Code of Ethics and Standards of Practice published by the National Council on Interpreting in Health Care."³⁷

The Georgetown University National Center for Cultural Competence provides the following information in its [Curricula Enhancement Module Series](#)³⁸ about that address the roles of family, friends, and minors in health care encounters with patients with limited English proficiency.

Interpreting in health and mental health care requires the development of special interactive skills and a high degree of proficiency in both languages. For example, the knowledge set required of interpreters is to be familiar with not only a standard use of language, but also the dialectal variations of language used within the community, including colloquialisms and slang. Interpreters also must be aware of confidentiality requirements both as a matter of ethical conduct and as health and mental health care regulations.

The perils of using untrained interpreters³⁸

The use of untrained interpreters is fraught with potential problems for the patient and the health or mental health care organization. A selected list of problems follows.

- *Lack of Translatable Words/Concepts.*
Similar words do not exist in the two languages; the interpreter is not proficient enough in either language to find an accurate substitute.
- *Deletion of Information*
The interpreter cannot keep up with the exchange and paraphrases or leaves out concepts.
- *Modification of Meaning*
The interpreter may not understand what is said, so substitutes what he or she thinks was said, often changing the meaning substantially.
- *Unfamiliar Terminology*
The interpreter is unfamiliar with medical, health, or mental health terminology, perhaps in both languages.
- *Embarrassment*
The interpreter is not clinically trained and may become embarrassed while interpreting discussions of sexual issues, body functions, and other sensitive information.

- *Deliberate Editing of Information*
The interpreter may attempt to control or alter the flow of information from one or both parties for his or her own purposes. This editing occurs through both addition and deletion of words or even whole messages.
- *Emotional Issues*
The interpreter may be too close to the patient or not emotionally equipped to be able to deal with discussions of severe illness or disorders, serious medical situations, or end-of-life concerns.
- *Confidentiality*
The interpreter does not understand the need for confidentiality or is not bound by professional standards.

The case against using family members and friends as interpreters

While family and friends may accompany the patient, they should not serve as the “official” interpreter for the health care organization or practice. Other reasons include:

- Sometimes family members/friends are reluctant to ask questions when they do not understand or when they are embarrassed by the nature of the information stated or sought by health care professionals .
- Family members/friends may lack medical vocabulary in English and their own language.
- Family members/friends are often uncomfortable and will not ask for a more qualified interpreter when the situation gets beyond their abilities.
- Sometimes family members/friends will not give the patient a provider's full and complete explanations. They may be embarrassed to admit they do not understand or embarrassed by the nature of the conversation. They might not agree with the provider. Conversely, they may miscommunicate the patient's message, preferring that the provider hear their version of the situation.

A family member's or friend's emotional involvement often results in a tendency to protect the patient from bad news; therefore, they may be inclined to edit or change information. Additionally, sometimes family members/friends will not share with a provider the patient's full message, again because they are embarrassed, do not have what they judge to be the proper vocabulary, or because they make a decision that the provider doesn't need to know "all this extra information."

Finally, aside from interpretation lapses, confidentiality is also a problem when family members/friends serve as the interpreters. Often, the patient does not want to disclose upsetting private information or secret health issues in front of a relative. The patient may not feel confident that the family member/friend will maintain confidentiality and will not disclose private information to others.

Why minors or children should never be used as interpreters

The Office of Civil Rights, U.S. Department of Health and Human Services, expressly discourages the use of minors in health care interpreting. The following tool provides a selected list for the case against using children as interpreters.

Role Reversal. The child ends up having to process information and provide help and support to the parent or other adult.

Editing. The child may interpret messages to suit his/her personal view of what is appropriate, convenient, or proper to say to spare parents from suffering embarrassment.

Mistakes. It is unlikely that children understand all the intended messages, even when they say (and believe) they do.

Guilt. It is easy for children to feel they are the cause of suffering because they said something painful or made a mistake in conveying a message.

Omissions. Adult patients often omit mentioning important information because they do not want the child to know sensitive aspects of their lives.

Confidentiality. Even when cautioned, children do not understand issues of confidentiality and may inadvertently reveal sensitive material learned during interpreting.

In addition to those reasons cited above, there may be religious, spiritual, and moral prohibitions against engaging minor children in adult situations and discussions (e.g., sexual practices, reproductive health, substance use and abuse, and domestic violence).

Roles for bilingual staff who are not trained as medical interpreters

There are many roles that can be taken by those who are not trained and qualified interpreters. Bilingual staff members can provide important language access services even if they are not qualified and trained as medical interpreters. These include the following but are not limited to the following:

- Answering phones and directing callers
- Setting appointments on the phone or in person
- Greeting patients and helping them navigate to the right office or clinic
- Helping patients fill out forms
- Answering questions about office procedures and billing

All of these roles are important in making the healthcare experience accessible to patients with limited English proficiency.

Roles for family and friends

Family and friends can provide emotional support and can be a second set of “ears” to help the patient remember and process information later. If family and friends are bilingual, they can also help with forms, and with asking questions to find the right office or destination in a health care setting.

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For additional information contact:

Georgetown University National Center for Cultural Competence
Center for Child and Human Development
3300 Whitehaven Street, N.W., Suite 3300
Washington, DC 20007
Voice: 202-687-5387
Fax: 202-687-8899
E-Mail: cultural@georgetown.edu
URL: <http://nccc.georgetown.edu>

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