The world’s population of refugees and immigrants is growing increasingly large and diverse, and, as a result, the United States is encountering the largest wave of immigration ever. According to the 2000 U.S. Census, over 30 million people, or more than 11 percent of the total U.S. population, are foreign born.1 Currently, about 21 million immigrants and refugees living in the U.S. exhibit limited English proficiency, or LEP. Persons with LEP are defined as those individuals who do not speak English as their primary language and who have a limited ability to speak, understand, read, or write English.1 Nearly 47 million people or 18% of the U.S. population speak a language other than English at home.2 Some of these people are not foreign-born, yet due to their family background and heritage, they do not speak English.

It is critical that the growing number of LEP residents be able to communicate with other members of their community, especially in terms of accessing health care. It is very difficult for LEP individuals to navigate the complex healthcare system. Language and communication barriers present problems for these patients and the healthcare providers working with them. Nonetheless, all people in the U.S., including immigrants and refugees, are protected under federal law as stated in Title VI of the Civil Rights Act of 1964, which declares that, “No person shall on the grounds of race, color, or national origin, be denied the benefits of, or [be] subjected to discrimination under any program or activity receiving Federal financial assistance.”3 The federal Department of Health and Human Services (DHHS) and the courts have applied this statute to protect national origin minorities who do not speak English well. In August 2000, President Clinton signed Executive Order 13166 mandating that federal agencies improve accessibility to their programs for individuals with LEP. In 2001, President Bush reinforced the executive order and instructed federal agencies to republish their LEP guidelines for public awareness and comment. The DHHS Guidance describes various options available for oral language assistance, including the use of bilingual staff, staff interpreters, contracting for interpreters, using telephone interpreter lines, and using community volunteers. The agency stresses that interpreters need to be competent, though not necessarily formally certified.

Physicians and healthcare workers face challenges on many levels when providing comprehensive healthcare to LEP patients. If language barriers exist between staff and patients, compromises may occur in the delivery of health care services as a result of poor exchange of important medical information. Other challenges exist as well, among them: obtaining informed consent adequately through interpretation, understanding important cultural information, understanding patients’ expectations of the medical system, and inability of the patient and physician to share in the decision-making process. Language barriers can result in misunderstanding of physician instructions, decreased adherence with medical regimens, poor appointment attendance, and decreased satisfaction with services. In addition, language barriers
create difficulties for medical staff in diagnosing and treating illnesses or diseases in which they may be unfamiliar and untrained, as well as increased time demands caused by communication obstacles. All of these factors affect how a physician delivers information regarding a disease to the patient and it requires skill, patience, time, and knowledge about cultural practices.\textsuperscript{1,4,5}

One of the most prominent language gaps between healthcare professionals and patients is the staff’s inability to understand the cultural vocabulary of the patients’ language. A prime example is physicians’ experiences with Hmong refugees. There is no word for “cancer,” or even a similar concept in the Hmong language; therefore, inexperienced interpreters have explained the concept of radiation treatment by saying, “we’re going to put a fire in you.” As a result, refugees often refuse treatment or fail to return to the hospital for treatment out of fear and misunderstanding of the medical treatment they need.\textsuperscript{6} Other communication barriers between the physician and patient occur when the doctor does not understand the cultural beliefs of the refugee or immigrant, or when there is misunderstanding of instruction between the physician and the patient, leaving LEP patients uninformed about taking their medications. For example, an oral antibiotic was ordered by a physician to treat a 7-year-old girl’s ear infection; however, the mother of the child, who did not speak any English, misunderstood the instructions and proceeded to pour the medication into her daughter’s ear instead of giving it to her by mouth.\textsuperscript{7}

Using trained interpreters can improve confidentiality, prevent conflict of interest, and ensure that medical terms are interpreted correctly. When family members, friends, or children are used rather than professional interpreters, significant problems can arise. Patients may not understand a diagnosis or treatment, and therefore, suffer direct consequences. One study noted that errors in translation made by untrained interpreters are significantly more likely to have potential clinical consequences than interpretation provided by professional or trained interpreters.\textsuperscript{8}

A significant increase has occurred in the immigrant and refugee populations that have relocated to Central Virginia in the last five years. Over 10,500 refugees have arrived in Virginia during this period of time, yet only 7,800 have been documented to have received health assessments.\textsuperscript{9} The Charlottesville Chapter of the International Rescue Committee (IRC) has relocated over 300 new refugees to the Charlottesville and Albemarle County area from many regions of the world. A high proportion of Central Virginia’s LEP population receive healthcare at the University of Virginia, including various primary care clinics. The International Family Medicine Clinic (IFMC) was established in October of 2002 through the Department of Family Medicine at the University of Virginia Health System for the purpose of providing more comprehensive and coordinated care for patients with limited English proficiency.

This study was developed and conducted at the clinic under the supervision of Dr. Fern R. Hauck from June to November of 2003 for the purpose of determining the number of LEP patients seen and examining whether individuals with LEP who visit the University of Virginia Family Medicine Clinic obtain necessary interpreter services. This research project investigates whether the University of Virginia Health System is providing adequate interpreter services to
LEP patients seen in the Family Medicine Clinic, and whether the University of Virginia Health System is demonstrating effective ways of providing interpretation so that it can serve as a model to be replicated by other hospitals. Thus, the primary research questions were: 1. Is the University of Virginia Medical Center providing adequate interpreting services to LEP patients seen in the Family Medicine Clinic? 2. If so, can the University of Virginia Health System’s interpreting services serve as a model to be replicated by other hospitals?

In order to provide more comprehensive, timely, and culturally sensitive health care to the growing immigrant and refugee population in central Virginia, we designed a quality assessment survey to evaluate a sample of LEP patients seen in the Family Medicine Clinic. The form included a patient’s demographic information, primary language, countries of origin and departure, and specific questions concerning the patient’s English communication skills and interpreter requirements. Random days of the week were selected during the time period from June to November 2003. During those days, 234 patients who attended the Family Medicine Clinic at the University of Virginia were identified as foreign-born patients to be candidates for the study through review of clinic schedules. Data was obtained through discussion with the physician and/or nurses involved in the patients’ care, and missing data was obtained later through review of patients’ medical records. Following the data collection process, information was entered into a computer database using SPSS 11.0 for Windows (Chicago, Illinois). Using the SPSS program, statistics and frequencies on the patients’ gender, status, primary language, country of origin, and communication skills were run both for individual patients and for the entire group. In the analysis, percentages of the types of interpreters present and reasons for their absence were also calculated. Specific cross-tabulations were performed to assess which languages needed interpreting services, and which had the most interpreters present. Differences according to gender were also analyzed in the cross-tabulations. Finally, the numbers and percentages found in the UVA assessment survey were compared with similar results of the studies evaluated from the literature searches performed. Concurrent with the data collection process, literature reviews were performed in order to assess other programs and studies conducted on language barriers and interpreting service access at various hospitals and clinics in the United States. Five specific studies were identified and examined regarding communication services for LEP patients, and whether or not they provided the services necessary for the patients to obtain medical care.

The University of Virginia hospital study consisted of surveys of 234 foreign-born patients seen in the Family Medicine Clinic at UVA’s Primary Care Center. Of the 234 individuals in the study, 148 (63.4%) were females and 86 (36.6%) were males. A total of 25 primary languages were spoken by patients, including Spanish (35.7%), Farsi (17.0%), Serbo-Croatian (8.1%), and Arabic (6.8%). The patients came from a total of 39 different countries, with the top five countries of origin being Mexico (21.3%), Afghanistan (14.9%), Togo (7.2%), Bosnia (5.5%), and Iran (5.5%). The results reveal that of the 234 individuals interviewed, 156 (66.7%) did not speak English proficiently and 78 (33.3%) spoke English adequately to obtain
medical services. Those patients with LEP were questioned by myself or the nursing staff in order to determine if an interpreter was offered to assist them. Of the 156 patients, 134 (85.9%) individuals had an interpreter present; however, 4 (1.7%) of the patients dismissed the professional interpreter for several reasons including the fact that a family member or friend was present instead, and they preferred using him/her. The CyraCom phone, a translation phone service, was used for 9 (5.8%) of the patients who did not speak English, and 13 (8.3%) of the individuals did not have an interpreter present for various reasons. For those individuals who used an interpreter at the time of their appointment, interpreters were obtained from the IRC, the hospital, or patients brought an interpreter with them. Of the 134 interpreters present (combined total of 95 professional and 39 untrained), 95 (60.9%) were professional: 56 (41.8%) certified interpreters came from the hospital, either full-time staff or employees and 37 (27.6%) professional interpreters came from the IRC, and 2 (1.5%) were bilingual clinicians. For the remaining 39 appointments for which interpreters were present, 39 (29.1%) unprofessional interpreters were used, including family members or friends.

The predominant reason, 72.1% of the time, for having no interpreter available was due to a failure by either the patient or clinic to recognize the need for a professional before the appointment. Other reasons that interpreters were unavailable for the remaining patients include: the acute nature of the visit resulting in inadequate lead-time (4.9%); the interpreter was requested, but unavailable (19.7%); or the patient requested an interpreter of the opposite gender than was provided (3.3%). Overall, a high percentage of the medical visits had an interpreter present, implying that the patients with limited English proficiency had adequate communication to obtain medical care. From the 234 patient visits, 217 (92.7%) returned for a second appointment or more. Only 7.26% patients failed to return for another appointment, and the reasons for failure to return are unknown.

The survey suggests that trained interpreters significantly improved communication and medical care for patients with LEP. It is likely that those who had an interpreter present had a more satisfactory setting for treatment and care compared to those without an interpreter. The professional verified that the patient had all of his/her medical problems and concerns addressed, and confirmed that the patient felt comfortable with the medication directions. With the help of a qualified interpreter, the patients’ appointments progressed in a timely, effective manner, with fewer problems in communication between the physician and patient regarding treatment and medication. Having a qualified interpreter from the hospital or IRC resulted in more efficient and timely care compared to using the CyraCom phone.

Although the International Family Medicine Clinic at UVA is providing a high percentage of interpreters necessary for effective medical care, it is working toward having trained interpreters available for all patient visits where needed. More qualified interpreters of various languages need to be hired in order to continue to provide for the spectrum of cultures and languages with whom the hospital has contact. The medical staff meets regularly to discuss the needs and upcoming events the clinic can provide for its LEP patients. The University of
Virginia is currently working on providing better signage for its LEP patients and more translated and understandable pamphlets on its medical care. It is also working towards providing language programs for the healthcare staff in order to better serve the LEP patients who attend the hospital. Having the help of the community and its resources in providing for the refugee and immigrant populations has led the University of Virginia hospital to set a high standard of health care for its LEP patients that other programs can emulate.

References:

4. Early, P. J. in MCW Healthlink (Medical College of Wisconsin, 2003).