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Limited English Proficient Patients' Perceptions of When Interpreters Are Needed and How the Decision to Utilize Interpreters Is Made

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Abstract

Our objective was to describe when Hmong- and Spanish-speaking limited English proficient (LEP) patients perceive an interpreter was needed and how they perceive the decision to utilize an interpreter is made in a health care encounter. We interviewed a total of 20 LEP patients. We used a number of strategies to recruit LEP patients including posting language-appropriate flyers at clinics, sending letters to LEP patients and asking our participants to refer their family and friends to participate in our study. Tape-recorded interviews were transcribed, translated, and systematically coded using directed content analysis. Patients identified two factors that influenced LEP Hmong- and Spanish-speaking patients' perception of when interpreters were needed: (1) their self-identified level of English proficiency and (2) the anticipated complexity of the health care communication. They described three factors that they perceived influenced the decision to utilize interpreters: (1) their self-identified level of English proficiency, (2) access to interpreters; and (3) health system automation of interpreter use. The findings show that patients consider a wide variety of factors when determining if an interpreter is necessary and how the decision to utilize interpreters is made. Given that health care decision making is complex, healthcare systems need to do more to help educate LEP patients of the importance of utilizing interpreters in all healthcare encounters. Additionally, future research should to explore how patients conceptualize

the need for and utilization of interpreters in order to provide LEP patients with linguistically appropriate care in ways that are sensitive to their perceptions and needs.

Keywords

Communication; Cross Cultural; Interpreter; Limited English Proficiency; Patient Preference; Qualitative Research; Utilization

Introduction

The importance of providing healthcare to patients in a language they can understand is an increasingly important issue in the United States (US). The 2010 US Census reports over 25 million residents who are limited English proficient (LEP), defined as speaking English less than well or not at all and this group makes up more than 9% of the total US population. Projections indicate that this population will continue to grow over the next 10 years (Pandya, Chhandasi, McHugh, Margie, & Batalova, 2011).

It is well documented that patients with LEP experience health disparities (Cheng, Chen, & Cunningham, 2007). LEP patients have less access to medical care, poorer comprehension of their health encounters, less satisfaction with the system (Jacobs, Chen, Karliner, Agger-Gupta, & Mutha, 2006), and poorer healthcare outcomes (Divi, Koss, Schmaltz, & Loeb, 2007).

To help address some of these inequalities, the US Health and Human Services Office of Minority Health crafted The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS) standards (U.S. Department of Health and Human Services Office of Minority Health, 2016). These standards include detailed strategies that can be used to advance health equity, improve quality and help eliminate health disparities in the healthcare setting for LEP patients. Since the development of the National CLAS standards in 2000, there has been increasing awareness in the healthcare community regarding the importance of providing linguistically and culturally appropriate care to all patients (U.S. Department of Health and Human Services Office of Minority Health, 2011; National Committee for Quality Assurance, 2010; U.S. Department of Health and Human Services Office of Inspector General, 2010).

One way to provide linguistically appropriate care is to use professional interpreters (U.S. Department of Health and Human Services Office of Minority Health, 2016). Professional interpreters have been shown to successfully reduce health disparities among LEP patients. For example, utilizing interpreters has decreased errors in communication, increased comprehension and adherence, and improved medical outcomes for LEP patients (Karliner, Jacobs, Chen, & Mutha, 2007). Current medical guidelines emphasize the provision of linguistically appropriate care as essential in ensuring that LEP patients receive the same quality of care as English-speaking patients (U.S. Department of Health and Human Services Office of Minority Health, 2016).

Nonetheless, professional medical interpreters continue to be underused (Diamond, Schenker, Curry, Bradley, & Fernandez, 2009; E. Hsieh, 2015; López, Rodriguez, Huerta, Soukup, & Hicks, 2015). Several studies have explored how clinicians decide when an interpreter should be used (Baurer, Yonek, Cohen, Restuccia, & Hasnain-Wynia, 2014; Diamond et al., 2009). However, few studies have explored LEP patients' perspective about when an interpreter is needed and how the decision surrounding interpreter utilization is made. One study explored the decision making process of LEP older adults recovering from a stroke. The researchers highlighted that patients' decisions regarding when to use a professional interpreter extend beyond preferences to include complex factors such as perceptions of their own health care providers' language expertise and their trust in interpreters (Fryer, Mackintosh, Stanley, & Crichton, 2013). However, this study took place in an older adult population that had previously experienced a major medical event and so the findings may not be generalizable. It is critical to better understand all LEP patients' perceptions about the need for and their perceptions regarding the decision to use interpreter services in general healthcare encounters. The purpose of this study is to describe the factors that LEP patients say contribute to their perception that interpreters are needed and the factors that contribute to their perceptions regarding the decision to utilize them.

Methods

Participants

The context for the study was to understand the factors contributing to disparities in receipt of preventive cancer screening among LEP primary care patients within a large healthcare system in the US. 10 Hmong-speaking and 10 Spanish-speaking LEP participants were recruited for semi-structured interviews in 2013 for a total of 20 participants. All participants provided verbal consent, and the study was ruled exempt by the Institutional Review Board in February 2013 because all data collected were de-identified.

We used a number of strategies to recruit LEP participants. First, we posted language-appropriate flyers in both Hmong and Spanish at clinics with a large number of LEP patients. Second, we partnered with providers, who have a large number of LEP patients and asked the providers to refer their LEP patients. We sent these LEP patients letters written in Hmong or Spanish to inform them about our study through the US postal service. Third, we asked our participants to refer their family and friends to participate in our study. Interested participants were directed in the flyers and letters to call our study participation line. We had two study participation lines; one in Hmong and the other in Spanish. When interested participants called, they were screened for eligibility by bilingual staff. Eligibility criteria included that participants (1) self-reported speaking English less than well or not at all, (2) Spoke Hmong or Spanish fluently, (3) Were eligible for preventive cancer screening (women 18 and men 50), (4) Never had a previous cancer diagnosis, (5) Visited our healthcare system in the past year, and (6) Were willing to participate in one interview. All participants received \$50 in appreciation of their time.

Data Collection

After a potential participant met our inclusion criteria, they were given the option to choose where they would like to be interviewed. Interviews were done in homes, public libraries and office meeting rooms, using a semi-structured interview guide. The guide was first written in English and then translated into Hmong and Spanish by bilingual study team members based on meaning rather than literal translation (Larson, 1998). For example, one bilingual Hmong researcher, who is a native Hmong speaker, translated the interview guide from English to Hmong. Then another bilingual Hmong student back translated the interview guide written in Hmong to English to ensure that the meaning of the questions was still intact and accurate. Lastly, a group of three Hmong bilingual speakers met to review and discuss if there are any discrepancies in translation. When discrepancies were noted, the group made changes based on group consensus. This process was also done for the translation of the Spanish interview guide.

The semi-structured interview guide was developed based on the personal experiences of healthcare providers and researchers on the study team, and based on the experiences members of the study team have had as LEP patients or children of LEP patients in this system. The interview guide included a series of open-ended questions with supplemental probing questions organized into the following domains: (1) Health care experiences generally; (2) Understanding of what cancer is; (3) Experience or lack of experience with preventive cancer screening; (4) Interpreter services; (5) Receipt of language concordant care; and (6) Recommendations for improvement of provision of care.

At least two bilingual study staff attended all interviews. Hmong interviews were conducted by a bilingual and bicultural Hmong woman and Spanish interviews were conducted by a bilingual white woman. Both interviewers were trained in qualitative research. Interviews were audiotaped and averaged 70 minutes in length.

Transcribed audio files were then translated from Hmong or Spanish into English focusing on meanings rather than literal translation (Larson, 1998). This process of translation was done through group translation process as we did for the interview guide. To maximize accuracy one or two study team members reviewed all translations. We resolved disagreements in translation by meeting as a group and coming to a final consensus.

Coding and Analysis

We used directed content analysis (Graneheim & Lundman, 2004; H.F. Hsieh & Shannon, 2005) to analyze our data. We developed a preliminary codebook based on the domains of our interview questions. Next, each study team member used the preliminary codebook to code the interviews separately. Then the coders met to review their codes and add new codes when necessary. Code definitions were refined and agreed upon by study team members. Our complete codebook contained 269 codes. All transcripts were coded by at least two study team members and they met to review agreement and resolve discrepancies. We then organized the codes into categories, and identified themes from the categories by looking for common meaning. This was done through group consensus as well. We used NVivo10 to code and organize our data.

During the screening process, all participants reported speaking English less than very well or not at all; however, throughout our interviews several participants (1 Hmong-speaking and 5 Spanish-speaking) reported that they spoke some English during healthcare encounters. Because their responses about interpreters were different in regards to determining whether an interpreter was needed and their perceptions regarding the decision to use an interpreter, we defined these participants as those with ‘some self-identified English proficiency.’ Participants who did not report speaking English in the clinic were defined as those with ‘no self-identified English proficiency.’

This paper focuses specifically on themes relating to interpreter services. During the course of the interview, some participants spontaneously discussed their experiences with interpreters. If the participants did not bring up interpreters themselves, we asked them if there were things that the clinic does to make it easier for patients to get care, and we probed on interpreter services by asking questions such as “What have been your experiences with interpreters?”. Participants often described the need for interpreters independently of their perceptions regarding the decision to use interpreters, and we did not ask participants directly to describe the relationship between their perception that an interpreter was needed and whether or not one was used. Therefore, we analyzed patient perceptions regarding whether an interpreter was needed separately from their perceptions about the decision to use interpreters.

Results

Our final sample included 10 LEP Hmong-speaking participants and 10 LEP Spanish-speaking participants. Half of our interviews were with women and half were with men. The average age of the Hmong-speaking participants was 54 (ranging from 34 to 70) and of the Spanish-speaking participants was 53 (ranging from 33 to 75). On average the Hmong-speaking participants had been in the United States for 22 years (ranging from 8 to 33) and the Spanish-speaking participants had been in the United States for 16 years (ranging from 9 to 26). Hmong-speaking participants were born in both Laos (9) and Thailand (1), and Spanish-speaking participants were born in the Dominican Republic (2), Ecuador (1), Mexico (5), Peru (1) and the United States (1).

Participants identified two factors that were important in their perception that an interpreter was needed including: (1) the participant’s self-identified level of English proficiency and (2) the anticipated complexity of the health care communication. They described three factors that they perceived influenced the decision to use interpreters: (1) the participant’s self-identified level of English proficiency, (2) ease of access to interpreters; and (3) health system automation of interpreter use (Figure 1).

Factors that Influence Patients Perception of Interpreter Need

Self-identified level of English proficiency—Many Hmong- and Spanish-speaking participants stated that an interpreter was needed when they had no English proficiency. One Hmong-speaking man who identified himself as having no English proficiency said, “I don’t know the language too well either so for example, when you go for a visit to the clinic, there

has to be an interpreter.” Many participants described scenarios similar to this one where the interpreter was needed in order for the patient to understand the provider.

Alternatively, participants who identified as having some English proficiency did not always think an interpreter was needed due to the fact that they could speak some English. One Spanish-speaking woman stated that “...well they put an interpreter on [the phone] and then well the nurse talks and she talks and I feel like...it isn’t necessary.”

Anticipated complexity of communication—In contrast, participants who identified as having some English proficiency thought an interpreter was needed if they anticipated complex communication during the healthcare encounter. This included unfamiliar medical terminology or the anticipation that a large quantity of information would be discussed. One Spanish-speaking man said, “we did want an interpreter because the level of understanding-things were more difficult, terminology more advanced that I didn’t understand.” Another Hmong-speaking man said, “...during the times that you are going in and there’s more information to discuss then they have to call an interpreter to translate.”

In contrast, participants who identified as having some English proficiency shared that when they perceived communication to be straightforward and easy to understand then they did not think an interpreter was needed. One Spanish-speaking woman described an interpreter as not needed during a straightforward encounter, “And with my nurse, the one that treated me for diabetes, well they were basic things and I was able to communicate well with her. And also with my primary care doctor, umm well it was also the basics.”

Factors Patients Perceive Influence the Decision to Utilize Interpreters

Level of English proficiency—Participants who stated that they did not speak English described how interpreters were utilized because of their lack of English proficiency. For example, one Spanish-speaking male with no self-identified English proficiency said, “I have had translators because I unfortunately cannot speak English.” Both Hmong- and Spanish-speaking participants discussed their own English proficiency as a factor in the decision to use interpreters.

Access to interpreters—Both Hmong- and Spanish-speaking participants described situations where the decision to use interpreters was determined by whether or not interpreters were accessible. Most participants described having an experience where an interpreter was either late to an appointment or left early for another appointment. One Spanish-speaking man with no English proficiency described a time when an interpreter left in the middle of his appointment. “In some cases in the middle of an interview with the doctor [the interpreters] excuse themselves because ... they have to meet with another, with another appointment.” Participants described difficulty accessing interpreters as one factor that contributed to interpreters not being utilized when they perceived them as necessary.

Automated decision by system—Participants with some self-identified English proficiency abilities described scenarios where interpreters were utilized because the system provided them with an interpreter automatically even though they themselves did not think an interpreter was necessary. One Hmong-speaking man said, “even if we know the

language, they still send an interpreter to come.” Similarly, one Spanish-speaking woman described a situation where a telephone interpreter was automatically provided to her even though she believed an interpreter was not necessary. Some participants with self-identified English proficiency spoke about the utilization of interpreters as out of their control because they were automatically determined by the healthcare system. These participants were somewhat indifferent about interpreters being provided to them when they weren’t needed, but there were one or two participants who expressed frustration with automatically being provided with an interpreter when one wasn’t needed. A Spanish-speaking man expressed his frustration in the following terms, “But, that’s why I said that [the interpreters] waste their time. There are people that really don’t understand anything.”

Discussion

We found that both Hmong- and Spanish-speaking LEP participants did not always consider interpreters to be needed in healthcare encounters. Factors they considered when thinking about whether an interpreter was needed included their perceived level of English proficiency and the anticipated complexity of the communication. Hmong- and Spanish-speaking participants also identified several factors that influenced their perceptions of the decision to utilize an interpreter such as the patient’s level of English proficiency, the accessibility of interpreters and whether or not the decision was automated by the system.

Interestingly, although all of our participants reported that they spoke English not well or not at all and were thus classified as LEP, six of the participants we interviewed also believed that their English was good enough to communicate with their providers in some healthcare encounters without an interpreter present. These participants also indicated that they often had different perceptions of the need for an interpreter than the health system where they received care. In our healthcare system, patients’ LEP status is documented in the electronic health record (EHR). If they say yes to the question, “Would you like an interpreter at your healthcare visits?” at their first visit or are unable to answer in English; the patient is subsequently flagged as needing an interpreter for all future healthcare visits. This field can only be changed to “English-speaking” by the director of interpreter services based on an interpreter’s evaluation of a patient’s English ability. If an in-person interpreter is not scheduled with the patient’s visit, then the Medical Assistant will call an interpreter on the telephone while they check in the patient. Although the healthcare system classifies all of these patients as LEP so that they receive an interpreter and can communicate in a language they understand, this system does not take into account that LEP patients have a range of language skills and their ability to speak English may change over time. Our system errs on the side of patients who overestimate their ability to understand English or may underestimate the complexity of the communication even when they have some degree of English proficiency.

The patients in our study described how this automatic system often left them feeling frustrated and unclear as to why an interpreter was present. In some cases, the participants actually preferred not using an interpreter even though they self-identify as LEP. The frustration these participants experienced in relation to receiving an interpreter could extend to other areas of their future care seeking behavior. Previous literature has shown that patient

dissatisfaction with healthcare broadly can lead patients to avoid or delay seeking future healthcare (Peek, Sayad, & Markwardt, 2008) and can lead to distrust or suspicion of the healthcare system (Eriksson & Svedlund, 2007; Ware & Davies, 1983). Therefore, it is important that LEP patients and providers discuss how and why interpreters are brought into the encounter. If patients truly feel that they do not need an interpreter, then they could go through the evaluation process to get the flag removed from their EHR. Additionally, the EHR could be programmed to confirm that a patient continues to need an interpreter every 5 years.

One option to decreasing patient frustration regarding interpreter utilization could be to allow patients to determine when interpreters are utilized. However, the interviews highlighted that patients determine whether or not an interpreter is necessary based on their own health beliefs regarding the expected complexity of the communication during the encounter. It is known that there are many situations where patients seek care from a provider for something that they perceive is not serious or complicated when, in reality, it is. Therefore, we believe health systems and providers should provide interpreters for all LEP patient encounters. In our system we can assuage patient frustration regarding interpreter utilization by reassuring patients that there are plenty of interpreters for all LEP patients—either in person, on the phone or via video, and that if they use one they are not taking one away from someone else. Easy access to interpreters may not exist in every system, however, this does not negate the import of access to interpreters for all LEP patients. Therefore, systems that do not have access to interpreters for their LEP patients might consider investing resources in telephone interpreter systems, or hiring in-person interpreters at the clinics that see the highest volume of LEP patients. We believe health systems and providers should provide interpreters for all LEP patient encounters because in the United States, the Federal Government mandates it and it is essential to ensure the LEP patients receive healthcare in a language they can understand.

Another way to assuage patient frustration could be for the provider, the interpreter and the patient to discuss the role that they want the interpreter to play in the encounter. Previous literature shows, that interpreters are often asked to be more than a simple language conduit in healthcare encounters (E. Hsieh & Hong, 2010). It is reasonable for interpreters to play a different role with patients who have some English language proficiency compared with patients who have none. If a patient has some English proficiency, an interpreter could be present during the encounter but only participates when they observe a misunderstanding or when asked to participate by either the provider or the patient.

This study has several limitations. While the results raise important questions for further investigation, they may not be generalizable. Additionally, our recruitment strategy was an opt-in system, and it is possible that patients who were already informed and interested in language in healthcare were the participants in the study. As stated previously, we did not ask participants directly to describe the relationship between their perception that an interpreter was needed and whether or not one was used. Therefore, the data are not directly connected. This study also had strengths. First, this study was conducted in two distinct LEP populations. This is strength because we were able to note similarities and differences across groups. Secondly, this study was conducted in a system that has high quality interpreter

services. Conducting a study like this in a healthcare system with high quality interpreters is a strength because it highlights areas where even high-quality interpreter services can be improved.

Conclusions

The findings show that patients consider different types of conditions when determining if an interpreter is necessary and when thinking about interpreter utilization. Additionally, these interviews highlight that patients and healthcare systems do not always agree as to when an interpreter is necessary and should be utilized. Therefore patients, providers and interpreters need to work together to agree on the role that the interpreter should play in the encounter especially when the patient has some English proficiency. Finally, this study highlights the need for future qualitative research to explore how patients conceptualize the need for and utilization of interpreters with the end goal of providing LEP patients with linguistically appropriate care in ways that are sensitive to their perceptions and needs.

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FIGURE 1.

Factors that Patients in Our Sample Say Influence whether an Interpreter is Needed or Utilized