

Concept Paper: Language Access Services In Nursing

Prepared by Charlene Pope, Ph.D., M.P.H., C.N.M.
School of Nursing, Medical University of South Carolina

Purpose: To provide input to National Project Advisory Committee (NPAC) for the design and definition of curriculum modules on culturally competent care for nurses based on the corresponding subset of National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards, and to contribute to a better understanding of cultural and linguistic competence.

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National Project Advisory Committee For Culturally Competent Nursing Modules Language Access Services

Statement of Purpose:

This paper summarizes issues of language access that concern nurses involved in the promotion of cultural competency for the profession, supported by the American Institutes for Research and the Office of Minority Health. A systematic review of multidisciplinary literature first reviews the needs, current legal requirements, recommendations, and resources concerning language access, language services, language use, and language barriers. First, language access is defined according to the Office of Civil Rights (Department of Justice 2000a), the Centers for Medicare and Medicaid (CMS), the National Standards for Culturally and Linguistically Appropriate Services for Health Care (CLAS) (Office of Minority Health 2001), and as part of the pattern of disparities demonstrated in the Institute of Medicine report, *Unequal Treatment* (Smedley, Stith, and Nelson 2003). The four CLAS Standards that concern language access are used to identify priorities for action and areas that remain to be addressed. As part of these priorities and gaps, a multidisciplinary review introduces additional concepts and relationships between language use and social inequalities necessary to promote linguistic, social, cultural, and communication competence in health services. A model that promotes language access and equity in care is reviewed. Specific areas of concern are proposed to promote language access and more effective communication in health services with patients with limited English proficiency. Based on the literature review, the final summary proposes a number of concrete suggestions for nursing that provide for language access and the monitoring of care for social biases and inequality.

Extent of Need for Language Access

Currently, 11.5% of people in the United States are foreign-born, of whom over half come from Latin America, making Spanish the most common second language (Schmidley, 2003). Of those foreign-born, a Commonwealth survey reports 65% have lived in the U.S. more than 10 years and over half of Hispanics (53%) report English as their primary language spoken at home (Doty and Ives, 2002). According to the U.S. Census Bureau (Shin and Bruno, 2003), nearly 18% (47 million) of people in the U.S. speak a language other than English at home. Of the estimated 300 or more languages spoken in the United States, over half of those with English as a second language (ESL) speak Spanish (28 million) with the next most frequent group speaking Asian and Pacific Island languages (7 million) (Shin and Bruno, 2003). According to the National Adult Literacy Survey (NALS) (US Department of Education, 2001), those who immigrated before the age of 12 are more likely to be as fluent and literate in English as those native born, with over 65% reporting having English spoken at home before immigration.

About 3% of all people in the U.S. are neither fluent nor literate in English (US Department of Education, 2002). As a related component of language access, the NALS reported about 90 million people in the U.S. as having inadequate (Level 1: 21-23% or 40 million) or limited (Level 2: 25-25% or 50 million) literacy skills, only 25% of whom were of limited English proficiency (LEP) (Kirsch, Jungeblut, Jenkins, and Kolstad, 2002). Hahn and Cella (2003) observe that though the majority of those with low literacy are White, ethnic and linguistic minorities exceed their proportion representation in the population. The disadvantages of language status and literacy increase in particular social groupings. Difficulties associated with LEP and literacy status cluster in the elderly, where 34% of English speakers and 54% of Spanish speakers reported inadequate or marginal literacy on a survey of 3260 Medicare patients in managed care (Gazmararian, et al., 1999). Though well-documented as a social determinant of health (AMA, 1999), health literacy as a language access challenge for native-born Americans is beyond the scope of this paper, but should be included in the development of social, cultural, and

communication competence in health care. The focus of this paper will be on LEP status and language access in health services.

Increasingly, anecdotal reports (Dye, 2001), reviews (Maltby, 1999), recommendations and commentary (Villarruel, Portillo, and Kane, 1999; Lange, 2002) address language access in nursing. However, the majority of nursing research concerning persons with LEP has concentrated culturally specific behaviors or perceptions of patients or nurses, ethnicity-attributed health or disease states (Naranjo and Dirksen, 1998; Clark, 2002; Flaskerud, et al., 2002), or the development and adaptation of measurement scales (Lee et al., 2002; Wu and Yu, 2003; Hendrickson, 2003; Goulet et al., 2003). Other than those who explore nurse perceptions or the perceptions of LEP clients (Blackford, 2002; Cioffi, 2003), few nursing investigations focus directly on the effect of LEP status on nurse or other health provider behaviors during access encounters and provider-patient interactions in relation to health outcomes.

Consequently, the few studies identified regarding nurses, language access, and LEP patients tend to appear outside the discipline (Elderkin, Silver, and Waitzkin, 2001; Labun, 1999; Adair, Nwaneri, and Barnes, 1999) or in other countries. In qualitative studies, nurses caring for language minority patients in the United Kingdom report finding it more difficult to form relationships and withdrawing into more restricted physically oriented tasks when language plays a role in health encounters (Murphy and Clark, 1994; Gerrish, 2001). In the same type of nursing situations, patients report feeling isolated, lonely, and excluded, often not aware they have the right to ask for an interpreter (Vydelingum, 2000). Efforts to develop effective evidence-based continuing education for nurses require more systematic investigation of LEP and language access in future, since cultural competency efforts alone have not been shown to decrease health status or health service disparities (Brach and Fraserirector, 2000).

The health impact of limited English proficiency (LEP) often is not well documented, since investigations may not separate ethnicity from language status, as noted in literature reviews examining Latino health issues (Timmins, 2002). As complicating factors, the consequences of LEP are often associated with other social determinants of health in a number of related ways. As observed regarding the challenges of LEP students in the education system (Zygouris-Coe, 2001), LEP patients are likely to experience more segregation and isolation from the mainstream than other minorities related to race, ethnicity, and socioeconomic status, a source as stress as well as material disadvantage. As a subset of LEP persons, immigrants are more likely to be uninsured (60%) than those native-born in the U.S. (28%), increasing their problems of health service access (Kaiser Commission, 2003), less likely to receive essential services such as cancer screening (Swan, et al., 2003) and more likely to need a higher or lower intensity of specific services. For example, women born outside the U.S. make up 20% of all births and were more likely to begin prenatal care late, a sign of access problems (Anonymous, 2002), while at the same time being at higher risk for domestic violence (Raj and Silverman, 2003). To further complicate matters, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) restricts institutions from providing health services to those without legal status (Kullgren, 2003), limiting entry into services beyond issues of language access. As a dimension of language access difficulties, undocumented immigrants make up 26% of those foreign born or 9.3 million people in the U.S. (State of California 2004).

In summary, language barriers play a significant role on overall reports of quality of care, as demonstrated in an analysis of pediatric services using the National Consumer Assessment of Health Plans (CAHPS) (Weech-Maldonado, et al., 2001). With similar socioeconomic status and health system access, mothers of Hispanic children not identified by language status report less feelings of affiliation and poorer relationships with their physicians (Stevens and Shi, 2002).

Language barriers may contribute to more diagnostic studies and increased emergency department (ED) visits (Hampers et al., 1999), less follow-up after ED visits (Sarver and Baker, 2000), more hospitalizations for preventable conditions (Laditka, Ladika, and Mastraduno, 2003), and fewer non-urgent regular physician visits (Derose and Baker, 2000). Even in managed care plans with similar access and services, Hispanic patients of whom a portion are LEP are less likely to be seen by specialists or to have a regular health provider (Hargraves, Cunningham, and Hughes, 2001). Looking at Hispanic patients as a partial measure of the experience of those with LEP, Hispanics experience differences in access to services (Jones, Cason, and Bond, 2002; Elixhauser, Machlin, and Zodet, 2002). Reflecting the role of LEP to worsen disparities, Hispanic patients who speak Spanish primarily also receive poorer quality of care and less satisfaction with providers than Hispanics who speak English and non-Hispanic Whites (Morales, et al., 1999). Tools commonly used with English speaking patients may not have been developed or tested in the LEP patients' language or cultural models and demonstrate variations when investigated, as seen with differential analysis of components of the Beck Depression Inventory (Axocar, Arian, Miranda, and Miroz, 2001). Even taken for granted medical interviewing practices such as self-reports may not be meaningful within the culture involved or may involve stigmatized behavior or ways of asking questions perceived as offensive, beyond the content of what was asked (Hunt and Bhopal, 2003).

Identification of Limited English Proficiency (LEP)

A variety of approaches can be used to determine language status. For the purposes of this paper, LEP refers to those who identify their first language as other than English and their capacity in English as limited English proficiency (LEP), according to the U.S. Census two-sentence screen (U.S. Census Bureau, 2000). Since nurses and institutional admission services may not systematically identify language status or use a variety of methods, the U.S. Census screen provides a uniform approach to determine language status for health services. LEP status includes a limited ability to read, write, speak, or understand English (USDHHS, 2003). The Census document uses a two-sentence screen, which offers a model for people to self-rate their language ability. [*"Do you speak a language other than English at home?"* If yes, then *"How well do you speak English?"*, is self-rated from *"very well," "well," "not well,"* to *"not at all."*]. The U.S. Census Bureau advises that all respondents who answer below *"Very well"* will benefit from both interpreters and the use of their preferred language to overcome LEP and address language access for effective services. Though not without limitations, the two-sentence screen identifies fluency in a uniform way, rather than the traditional nurse recommendation to generally inquire (Spector 1996, p.375). This screening approach concurs with the concept of patient self-assessment of need (Derose and Baker, 2000) more likely to reflect the needs of the particular LEP community, rather than needs of the institution and professionals who are either monolingual or prefer the dominant majority language.

Definition of Language Access in Health Services

As part of the legacy of the Civil Rights Act of 1964 (USDOJ, 2000) and its mandate to not discriminate or deny services, the term *language access* refers to the legally guaranteed right of all persons who self-identify as limited English proficiency (LEP) to the provision of accessible, equal, and meaningful services by institutions or individuals regulated by federal agencies, within federal agencies, or when supported by federal funds. Though this legislation was meant to prevent racial discrimination, its intent supports the rights of LEP persons who seek health services. Particular Titles under the Civil Rights Act of 1964 provide instructions to this end in differing ways, contributing to later mandates about language access. As a basis for other nondiscrimination statutes, Title VI advises:

“...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 (USDOJ, 2001a).”

Federal assistance includes state and local money that comes from the federal government, services that use federal personnel in any way, contracts or grants related to the federal government, and direct money or services, paving requirements for health institutions and health services in a variety of environments. Though issues of deaf patients are vital in the development of culturally competent care (Steinberg et al., 2002), they are not included in this dimension of language access. **Legal Guidelines that Contribute to the Definition:**

Since 1946, the Hill-Burton Act that supported federal money for public hospital construction mandated an obligation to open and unrestricted community services on the part of those institutions that accept federal funds (Perkins, 2003). Following the Civil Rights Act of 1964, a number of laws and forms of legislation paved the way for language access rulings. In 1998, President Clinton called for a commitment to eliminate racial and ethnic disparities in the six categories of health status that the Department of Health and Human Services would later establish as priorities for intervention (Perot and Youdelman, 2001). On August 11, 2000 and building on recent civil rights cases of persons with LEP, President Clinton signed into law Executive Order 13166, *Improving Access to Services for Persons with Limited English Proficiency* (LEP) (Interagency Working Group on Limited English Proficiency, 2004). This mandate requires health and human services make every effort possible to enhance admission to and the use of services for those with differing primary language status other than English that receive federal funds or are conducted by the federal government. The Executive Order also mandated the Department of Justice monitor compliance, as part of nondiscrimination under Title VI of the Civil Rights Act of 1964. Part of that compliance includes an audit of existing services and a strategic plan for change to reach the legal goals.

In December 2001 (Boyd, 2001), the Assistant Attorney General for Civil Rights convened the Federal Interagency Working Group on Limited English Proficiency to raise public awareness of LEP issues and develop or identify tools or technical assistance that would assist government agencies and those supported by the government to increase language access. Maintained by the Interagency Working Group on LEP, a URL site entitled *Meaningful Access for People who are Limited English Proficient (LEP)*, (<http://lep.gov.govt.html>), identifies many of these source documents and resources. The Office of Civil Rights (OCR) also issued policy guidance entitled *Title VI Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency (LEP)* to make rights and responsibilities more explicit (US Department of Justice, 2002c). OCR pointed out that other related laws, such as the Emergency Medical Treatment and Active Labor Act (EMTALA) (CMS, 2003), institutional regulations (JCAHO, 2004), and specific managed care or health care contracts also support language access.

The Title VI requirements stress that language access must be meaningful (USDOJ, 2002c), tailored to the needs and capacities of institutions and situations, and measured by whether the funded health service party previously taken steps to ensure its programs and services serve LEP persons adequately. The factors to meet the intent of the law are defined later in this discussion. After public comments and concerns about cost, enforcement, and other issues to the OCR guidance in the *Federal Register* (USDOJ, 2002), what had been previously read as a mandate now appears as guidance and was last open to review until January, 2004 (USDHHS, 2003). The feedback prompted clarification of key aspects of policy around issues of compliance, minimal standards, what constitutes a language assistance plan, use of informal translators or interpreters,

cost, and the 'safe harbor' provision that vital written documents be available in translation with so many languages involved and when some LEP persons cannot read in their native language. Subsequently, the United States Department of Health and Human Services (USDHHS) released additional policy guidance in the *Federal Register* in 2003, currently in place (USDHHS, 2003), further defining LEP persons, recipient provider and institutional obligations, the use of the OCR four factor analysis described below, means of selecting language assistance and translation services, and the elements for an effective language assistance plan. Political resistance prompted the USDHHS admission that compliance was voluntary, technical assistance was available as complaints under investigation that would likely take time, and, though loss of federal funds was a possibility, intermediate steps would be accepted in good faith.

A number of public forces presented resistance to LEP policy. A few health providers and institutions claim language access too costly and enlisted the political group ProEnglish as advocates who filed a lawsuit against the Bush Administration in March, 2002 (Ao and Lai, 2003) and others posed a Supreme Court challenge. Though Title VI and the Executive Order mark a significant advance in the care of LEP persons, the United States Supreme Court decided against LEP rights in the case *Alexander v. Sandoval*, a challenge by a Mexican immigrant to the Alabama Department of Safety concerning language access. The court case ruled that only intentional discrimination would be grounds for legal action, a move that removed considerable power to enforce the law (Perkins, 2003). Unfortunately, most modern discrimination appears to be seen as taken for granted or covert (McConahay, 1986), socially constructed (Pope-Davis and Liu, 1998), or invoked by cultural stereotypes when people have high levels of prejudice (Kawakani, Dion, and Dovidio, 1998). Whether as individuals or within the policies of institutions, many people from the majority deny seeing or believing discrimination occurs in human services or view it as unintentional (Neville, Worthington, and Spanierman, 2001), though real in its consequences. Just as White physicians are less likely than Black or Hispanic physicians to believe discrimination occurs in health services (Kaiser Family Foundation 1999), those who speak only English may not realize or acknowledge the problems with access or discrimination LEP patients face.

A number of recommendations grow out of these laws, federal guidance, and other related initiatives of the government, professional organizations in the health and human services, and consumer advocacy organizations, some of which differ in focus. The second goal of the national recommendations *Healthy People 2010* proposes the elimination of health disparities among those disadvantaged by race, ethnicity, and socioeconomic status (USDHHS, 2000). Indirectly, those disadvantaged include people identified as limited English proficiency who face risk for disparities as part of their racial/ethnic identity and national origin as well as their LEP status. The second *Healthy People 2010* priority appears in Objective 11-2 *Health Communication*, that urges the improvement of health literacy for all persons, including those with LEP more indirectly, but does not make recommendations about health services. Rather than a structural barrier as civil rights legislation envisions, *Healthy People 2010* conceives of language as part of a personal barrier of access to health services and as an individual's experience or responsibility that serves as part of the contribution of their social environment more indirectly co-contributing to health status (USDHHS, 2000). As an extensive recommendation to a considerable segment of the LEP population, the Centers for Medicare and Medicaid Services (CMS) commissioned guides on culturally and linguistically appropriate care developed by the Agency for Healthcare Research and Quality (AHRQ) (AHRQ, 2003). Many of those with LEP receive public funds. This manual defines the following essential terms:

- **Linguistic competence:** The provision of easily available, culturally appropriate oral and written language services to LEP patients through trained interpreters, qualified translators, and

available bilingual/bicultural staff. Notice that this definition does not include how language is used or how providers use interpreters, though an important component of meaning and understanding.

- **Cultural competence:** As defined by Cross et al. (1998), a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective interactions in a cross-cultural framework.
- **Cultural and linguistic competence:** As defined by the Office of Minority Health (USDHHS, 2000), the ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by the patient to the encounter. As guidelines to be considered and applied, the CMS manual recommends the use of the

Office of Civil Rights four factor analysis concerning LEP to determine discrimination under Title 6 of the Civil Rights Act of 1964 (USDOJ, 2001b), defined in more detail by USDHHS (2003). When health institutions address the needs of limited English proficiency clients, the law requires they consider: 1) the proportion of LEP persons in their eligible service population, 2) the frequency LEP individuals come in contact with the program, 3) the importance of the service provided by the program, and 4) the resources available to the recipient. The OCR encourages organizations that receive public funds to follow these five steps within their institutions:

1. Identify the number and type of persons who need language assistance (*Assessment*)
2. Describe what language services are available, publicize how their staff should access and use these services for LEP patients, and how they will measure and insure the competency of interpreter staff or services (*Development of Written Policy on Language Access*)
3. Provide training regarding how staff should use and work with in-person interpreters and telephone interpretation services (*Training of Staff*)
4. Provide public notice to LEP persons through multiple channels, such as in-house signage, community outreach, telephone menus, and non-English media (*Community Outreach*)
5. Monitor and update the plan while considering on-going changes in demographics over time, needs for particular services, and other factors (*Vigilant Monitoring*).

The CLAS Standards

(National Standards for Culturally and Linguistically Appropriate Services in Health Care)

The explanations that accompany these Standards are meant to define key issues for nurses. As further guidance, the United States Department of Health and Human Services (USDHHS) Office of Minority Health began a three year process in 1998 with national representatives to review, compare, and propose standards for cultural and linguistic competence, culminating in the National Standards for Culturally and Linguistically Appropriate Services in Health Care, known as the CLAS Standards (Office of Minority Health, 2001). Their website lists the 30 policy documents they reviewed prior to the development of standards, public comment, and revision, resulting in the 14 Standards finally published in 2001. Four of the CLAS Standards directly address the needs of LEP persons and are duplicated below for discussion. Rather than simply list the CLAS standard and move on, each language access standard receives attention for nurses to consider definitions, potential issues for application, and areas of difficulty identified in other human and social sciences, such as counseling, education, and linguistics.

Standard 4: *Qualified Language Assistance Services Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.*

LEP patient/consumers include not only those seeking health and health related services, but also any persons who come into contact with the public health system, parents and guardians of minors eligible for services, and community members trying to participate in health promotion activities (USDHHS, 2003). Smaller federal fund recipients who have smaller budgets are not expected to provide language assistance services on the same scale as large institutions, but are not excused from the obligation of an effective plan suited to their scale. Two types of language assistance are expected: 1) interpretation, defined as “the oral re-stating in one language of what has been said in another language,” and 2) translation, “the written conversion of written materials from one language to another” (Goode, Sockalingam, Brown, and Jones, 2001). According to the National Council on Interpreting in Health Care (2001), health care or medical interpretation that takes place in health or community settings takes a number of forms, such as:

- **Consecutive interpreting**, in which the interpreter converts the speaker or signer’s message into the second language after pauses that have a particular social context
- **Simultaneous interpreting**, in which the interpreter converts the message while the speaker is speaking; *first-person interpreting*, in which the interpreter uses the first person for both of the principal speakers as if they were the voice of the person, such as “When did your headache start?” My headache started at...”
- **Relay interpreting**, in which two people communicate through two interpreters, each of whom speaks one of the two target or source languages plus another third language held in common
- **Remote interpreting**, the use of an interpreter who is not present but accessed by video conference, two-way radio, or telephone
- **Summary interpreting**, a limited interpretation that excludes details and concentrates on only on what the interpreter considers the most important points, falling short of full interpretation.
- **Cultural brokering**, often not included part of professional interpretation unless requested, this aspect of communication includes additional cultural information the interpreter acquires or shares that adds to the linguistic meaning of the messages or their significance to participants.

Beyond literal words and messages, health providers may be unaware of cultural roles or responsibilities that occur with social contexts, sources of embarrassment or resistance (Robinson and Gilmartin, 2002), the weight of particular silences (Jaworski, 1993), or the significance of particular rituals or inattention to narrative forms, explanations or apologies (Benoit, 1995). Even the translation or adaptation of documents with careful backward validation runs into difficulties translating concepts across languages and cultures, as seen in the adaptation of the European Quality of Life scale into Xhosa in South Africa where ideas of mobility or gendered constructions proved difficult (Mkoka, et al., 2003).

Any successful language access program must include all points of contact, with professional interpreters, during entire stays or multiple ambulatory encounters, and at all times, not only during the admission process or a clinic visit to the exclusion of lab and pharmacy services (Keers-Sanchez, 2003). Hospitals have been slow to publicize the mandate for language access and subsequent federal guidance to encourage change or explain how the quality of care suffers with lesser levels of language access. In a survey of 40 pediatric medical residents, 75% reported never or only sometimes requesting an interpreter, though 68% acknowledge they were not fluent in

Spanish and 53% reported they used inadequate communication skills with LEP patients often or every day (O'Leary, Federico, and Hampers, 2003). Similarly, Baker and colleagues (1996) conducted a survey of 63 English speaking Hispanics and 467 Spanish-only speaking Hispanics, some of whom had interpreters and some of whom needed them but did not get them called. They found that over a third of LEP patients received no interpreter and only 12% of those needing interpretation received professional interpreters, with most interpreted by physicians, nurses or other staff. Those who needed interpreters but did not have them called were the least satisfied with care.

A number of models of language assistance services provide a variety of approaches offered institutions that can be found at: <http://www.diversityrx.org/HTML/MODELS.htm> and http://www.ncihc.org/NCIHC_PDF/MODELS%20for%20the%20Provision%20of%20Language%20Access%20in%20health%20Care%20Settings.pdf.

According to the National Council on Interpreting in Health Care (Downing and Roat, 2002), these models include:

Bilingual provider models can use either: a) native language speakers as health providers speaking the both the source and target language fluently, or b) native English language speakers who speak the target language fluently. This model may include difficulties of dialect, non-ethnic congruence, social class differences that intimidate, or power differentials invested in cultural beliefs about appropriate conduct with health providers. In a survey of Hispanics receiving care in a Hispanic clinic with bilingual staff, patients perceived more needs to be addressed and better access to their health care providers, but reported more difficulties managing medications and related care (Diaz, et al., 2001), suggesting that linguistically congruent or culturally specific care may not mediate all provider-patient communication difficulties or health disparities.

Bilingual patient models that involve strategies to promote English speaking among LEP persons. This model still leaves the short-term problem of language access unaddressed, may miss social or cultural inferences, or make patients feel negatively received or judged when wanting to discuss culturally specific beliefs, as demonstrated in focus group discussions with Chinese-American and Vietnamese American patients (Ngo-Metzger, et al., 2003).

Interpreter models come in a number of forms.

○ **a) Ad hoc interpreter models** include:

- i. The bilingual clinical staff model uses those working at the professional level in the setting who may or may not be involved with this particular patient's care, who may or may not be familiar with medical or folk terminology or conceptual models used by the patient. Requests pull people from their assignments, lower productivity, and increase expenses by using those with higher salaries for interpreter duties that pay less. LEP persons interacting with bilingual physicians have similar rates or resource use as English speaking patients (Hampers and McNulty, 2002), compared to those with professional interpreters who received less tests but had longer visits, and those without interpreters or bilingual physicians who had the highest costs, tests, and admissions.
- ii. The bilingual non-clinical staff model uses non-professional ancillary staff based on availability and also decreases productivity, is usually unpaid, uses less educated people who are untrained as interpreters or bound by the same code of conduct, and may be unfamiliar with medical terminology.
- iii. The community service or agency staff model uses bilingual staff from other human service agencies that may accompany the client for short periods of

time, such as in the case of refugees. These interpreters may also be untrained and unfamiliar with medical terminology or have an advocacy orientation that affects the literal interpretation of intended remarks.

- iv. The family or friends model uses those who accompany the patient and are untrained, but who are known to the patient and within the culture and social network. The patient may prefer ad hoc family/friends interpreters because of trust, privacy, support and advocacy during the visit, and the sense that their interpreters will help problem solving about the problem beyond institutional walls (Kuo and Fagan, 1999). Unfortunately, family and friends as interpreters are associated with poor quality of care (Rhodes and Nocon, 2003), conflicts of interest or mixed agendas, and higher rates of interpreter errors with more severe clinical consequences (Flores et al., 2003).

Dedicated interpreter models include all the means of providing professional interpreters in language access, including:

- The staff interpreter model, in which health organizations have a professional certified interpreter on staff, either full or part-time depending on demand. The use of this type of interpreter is associated with increases in clinical service use including office visits and prescriptions, and the use of preventive health services, as seen in increased rates of immunization and screening (Jacobs et al., 2001) and evaluations of higher LEP patient satisfaction, provider friendliness, concern for the patient, and time spent (Baker, Hayes, and Fortier, 1998). The model becomes less expensive over time than improvised or temporarily hired alternatives, but reaches fewer languages and may be inconvenient at all points of contact, if the interpreters must cover large numbers of clients, or meet needs for hospitalized patients that require explanations over periods of the day. Jacobs and colleagues (2001) describe the most effective model as including sufficient staffing with trained interpreters, simultaneous appointing of physicians and interpreters for LEP patients with flags for staff attention, and 24 hour availability at all points of contact within the system.
- The contract interpreter model hires professional interpreters on a per-need basis, so can also be bound by institutional standards and monitoring. This system depends on the availability of qualified people and the identification of a department in the hospital to be responsible for screening, monitoring, coordinating, and paying.
- The agency interpreter model hires an agency with language assistance for the health institution or provider, but may not monitor quality with the same criteria for excellence, may be more subject to cancellations, and is the most expensive.
- The volunteer interpreter model uses community volunteers who are not paid and may not necessarily be trained or certified. The turnover and dependability of volunteers may vary more than the other models.
- The face to face interpreter model was covered above in 1-4 of this section, but telephone and video conferencing models are increasingly used. Considered remote interpreting, reputable telephone interpretation services have the highest availability, the widest variety of languages, and certified interpreters. Acquired by AT&T in 1989 and bought out by a private provider 10 years later, the best known service, Language Line Services, offers 150 languages, 24 hour services, certified interpreters, and specializes in health care (Language Line Services, 2004). Providers use either of three types of service and billing options:
 - Subscription services that are 24 hour, 365 day a year constant availability with volume discounts for large institutions or large volume needs;

- Membership interpretation that would be intermittent or infrequent; usually involving a setup fee and monthly minimum;
- Personal interpretation that is fee-for-service when requested and paid by credit card. Estimated by using the Language Line Services number, costs for such services vary from \$2.50/per minute with a minimum fee and no volume discount until over \$3000/month for subscription services to \$4.50/minute for personal interpretation with no other fees or minimums.

Other telephone services offer similar services though health care focus, availability or costs may vary, but most have been criticized for the lack of non-verbal feedback, difficulty of access in exam rooms, and expense (Jacobs, 2001). As a means of using a professional interpreter off-site at a distance with a room computer and adaptive equipment in the health provider's office, video conferencing continues to develop as an alternative to reach affordability for health institutions and shows beginning results of acceptability in clinical trials (Paras et al., 2002). Costs for equipment for each room without other relay fees, monthly costs, or programs currently reach \$5000 and beyond. When Spanish-speaking LEP patients who had seen Spanish speaking providers were compared with English speaking patients, family/friend/adhoc interpreters and use of a telephone interpretation service, satisfaction with care was comparable for LEP patients with same language providers and the telephone interpretation line, but patients with untrained interpreters were less satisfied (Lee et al., 2002).

To consider encounters with or without interpreters, LEP patients with English speaking physicians receive a differing process of care than English speaking patients with language concordant physicians, contributing to disparities in outcomes. Building on the medical communication research demonstrating the worth of patient-centered interviewing and participation, Rivadeneyra and colleagues (2000), compared 19 matched monolingual and bilingual encounters with Spanish speaking patients. In examining the distribution of questions as ignored, close-ended, open-ended, or facilitating further discussion, investigators (Rivadeneyra et al., 2000) found that the Spanish speaking patients were less likely to receive the facilitating prompts from English speaking physicians, receive close ended questions, and more likely to have their comments ignored, potentially contributing to later poor compliance.

Continuing as a reproduction from the CLAS Standards (Office of Minority Health, 2001):
Standard 5: Notices to patients/consumers of the right to language assistance services.

Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

The right to free language assistance must be offered in the LEP person's preferred language and at no cost at all points of contact. Just as race and ethnicity data must be collected, CLAS Standard 5 requires that language status be documented for all patients for on-going monitoring of need and service provision. Some institutions post tear-off language cards, some community and advocacy organizations distribute wallet cards with a person's preferred language, but all require a documented outreach effort to make the language entry into services more accessible. In multivariate analysis of the effects of race/ethnicity, language, access factors, and patients' perceptions of primary care, Seid and colleagues (2003) found that language access and material access issues such as insurance status and a regular provider both independently affected perceptions of care and when present reduced the health disparities of Latinos and Chinese patients, reinforcing the need to promote the availability of language assistance.

Standard 6: Qualifications for bilingual and interpreter services.

Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

The recruitment and retention of bilingual staff is preferred and promoted under CLAS Standard 4 and this Standard as well, but the presence of those who speak the same language in other health professional roles does not necessarily guarantee ethnic or social congruence or understanding. When bilingual physicians and nurses who have not been trained as interpreters are used, a qualitative observational study of 21 Spanish speaking patients and their providers showed miscommunication in half the visits, in which the provider misunderstood the problem, had contending agendas, slanted explanations to undermine the patient's account in the institution's interest, or missed a cultural metaphor or context (Elderkin-Thompson, Silver, and Waitzkin, 2001). When language concordance was measured by the presence of an interpreter, whether they were trained, and the nurse's proficiency in the target language, assessments of 723 encounters revealed that nurses used professional interpreters only 8% of the time and patients less often reported traumatic events, intimate details, and psychosocial conflicts when low language concordance was present (Bischoff, et al., 2003). In a comparison of Hispanic LEP patients with monolingual English and bilingual Spanish speaking physicians, numbers of questions asked by patients as participation and recall was higher for those with bilingual physicians though the amount of information transmitted for both groups was similar, suggesting provider strategies differ and could be modified for monolinguals.

The quality of interpretation varies as does the quality of health care. Though interpreters for LEP persons are mandated by law (Keers-Sanchez, 2003), professional interpreters are only recommended by recent federal guidance (USDHHS, 2003) over the use of informal interpreters such as family, friends, or incidental staff such as cafeteria workers or security guards who happen to speak the same language (also referred to as *ad hoc interpreters*, NCIHC, 2001). Professional interpreters have received training and been held to professional standards of experience to ensure consistency, accuracy, confidentiality, and a code of ethics (NCIHC, 2001). Some interpreters considered professional because of limited training or an institution's screening test are not considered certified professional interpreters who have been deemed competent by a professional organization with strict standards, recommendations for on-going evaluation, and testing (NCIHC, 2002). In an observational study of Spanish-speaking families and their interpreters without professional certification in a pediatric setting, 66% of reviewed portions of transcripts of interviews contained errors or omissions and interpreters interjected discussion or social observations not related to the interpretation 30% of the time, practices that increased with longer interchanges and when discouraged by professionals.

The CLAS Standards recommend that interpreters demonstrate bilingual proficiency and some medical interpretation training, suggesting the NCIHC 40 hour standard but not requiring it. Federal guidance to apply the CLAS Standards and meet the OCR Title VI LEP regulations advises that the competency of an interpreter requires more than fluency as a bilingual (USDHHS, 2003), at the same time recommending but not requiring that interpreters be trained and certified and stepping away from previous more stringent requirements. For compliance in these guidelines, participating providers or institutions need only demonstrate they have taken reasonable steps left undefined to assess that interpreters have met proficiency standards, use appropriate methods, understand medical terminology, observe confidentiality and ethics, and refrain from acting as a counselor or in roles other than direct interpretation. Within the federal guidelines, the standards for quality and accuracy vary widely with an acknowledgement that quality could understandably differ by type of

service if not urgent if necessary. Timeliness is not considered a part of competence if it seems an undue burden (p. 47316). Efforts to train nurses in linguistic and cultural competence demand higher and more consistent standards than those currently promulgated.

A second independent translator is recommended for review of written documents, but the most recent federal guidance on Title VI and LEP persons does not include specific recommendation for monitoring the quality and competence of translators or delineate the highest qualifications to be used (professional trained and certified translators of text sources). Though studies of errors in medical interpretation in health care such as Flores and colleagues (2003) are fairly recent and demand attention to interpreter qualification, sociolinguistic analysis of miscommunication with non-native speakers of languages extends over the last three decades (Gass and Varonis, 1991) and should be considered when using untrained interpreters, translators, or health providers who do not request interpreters, categories that raise the rate of errors. The finding that untrained, ad hoc interpreters have the highest rate of medical errors with the potential for the most severe clinical consequences (Flores et al, 2003) should concern all health providers who accept less than professional interpreters in qualifications.

Standard 7: Translated materials.

Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

As previously discussed, OCR guidelines require that translated materials be freely available in languages that are commonly encountered in particular health service areas. This admonishment means that institutions must demonstrate how they document the need for translated materials and their sources and how they collect data on race, ethnicity, and language on all admissions and update it over time (Perot and Youdelman, 2001). Of more immediate issue to LEP persons entering the health system or service, non-English signs in the more frequently encountered language or languages are encouraged for development. The development of accurate and effective materials for LEP persons requires back-translating and validation to make sure of acceptability and understandability with audiences as well as attention to cultural and ethnic variability in supposed monolithic categories such as Asian or Hispanic. In linguistic anthropology investigation of multilingual media campaigns in Zambia, beliefs, intentions and motives are seen to be invested in the content and presentation of public media campaigns, suggesting that signage is not a neutral issue with meanings that may differ within ethnic groups seen by outsiders as homogenous (Spitulnik, 1998). Both patient written materials and institutional signage benefits from focus group feedback and community participation in planning from the onset of change, as demonstrated in participation action research to reduce diabetes in the Chicago Southeast Diabetes Community Action Coalition (Giachello et al., 2003).

Language Use with LEP Persons and Communication Competence :

Language access consists of three parts, two of which have been discussed and are covered within the 4 CLAS Standards: language admission or entry into the system, which includes assessment of LEP, and language assistance services, which include the availability and selection of interpreters and the organizational practices and rules that support services. Language use constitutes the third dimension, less directly identified within law, regulation, federal guidance, or recommendations. Though the CLAS Standards mandate that care be effective, respectful, acceptable, and meaningful to the LEP person, how the providers speak with patients when language differs currently receives less formal or systematic attention. The components of language use need operationalization for further study as well as for the development of evidence-based cultural competence education.

From a perspective of clinical skill, most health professional curriculums do not train providers to work with interpreters, though some multilingual societies include such recommendations as part of suggested professional behavior (Office of Multicultural Affairs of Queensland, Australia, 2003). Working with interpreters should be a part of cultural competence education and includes preparation prior to the session, conduct and interaction during the center, and subsequent evaluation of services and monitoring of outcomes (Enslein, 2002). The dimension of language use that requires more multidisciplinary perspectives includes the more subtle social dynamics of speaking differing languages with differing narrative forms and how the use of accented English affects the health encounter beyond health content or nursing intentions.

Same language speech partners recognize unsaid messages about contexts, intents, motives and one another's identities in a spoken encounter, as the disciplines of social psychology (Holtgraves, 2002), sociolinguistics (Lippi-Green, 1997), and linguistic anthropology (Hymes, 1996) describe. Similarly, the ways LEP patients and their nurses speak to one another (language use) can be as or more meaningful than what is said (content). Though beyond the capacity of this consensus paper to discuss thoroughly, essential elements from the social sciences cited above affect encounters with LEP persons as they do all provider-patient communication, can expand cultural competence training, and are offered here for consideration.

Stewart and colleagues refer to the interpersonal process of care as a vital construct in working with diverse populations in which speaker style, decision-making, and patterns of communication affect both clinical content and the consequences of the encounter (Stewart et al., 1999). As part of style, Holtgraves (2002) summarizes the cultural variations in politeness theory in talk, in which participants work while speaking to negotiate and preserve a positive face with one another to avoid stigma and embarrassment as well as transmit messages. Health providers may not give the LEP patient a place on the conversational floor to ask a question, but at the same time the LEP patient may believe posing the question without invitation offends the listener or jeopardizes acceptance by the health provider. As Urciuoli (1996) portrays in ethnography of Puerto Ricans, second language status embeds issues of power, control, and symbolic capital that participants may leave unsaid, beyond the subject of health encounters.

Even within the same language, a pitch, change of tone or rhythm change can signal shifts in meaning or what is considered appropriate or acceptable. Language differences add additional variation (Wolfram, Adger, and Christian, 1999), not always captured by interpreters presenting only what was said. Linguistic anthropology describes talk as a non-material tool that speech partners use to negotiate for time, attention, and material goals (Duranti, 1997). Patterns of speaking are not subject to interpretation. Using speakers from Korea, Hawaii, and the mainland United States in non-health care situations, Kim and colleagues (1998) compare preferred forms of requests, clarifications, and silence that affect interactions as communication strategies. In health encounters with Hispanic patients and English speaking physicians, Reichman (1997) found communication strategies may vary within and between the ways patients use language, a component of language access beyond intercultural decision-making or cultural models of thought and models of health and illness. Sociolinguistic comparisons of monolingual and bilingual encounters result in descriptions of both similarities and differences that contribute to failed communication in intercultural situations that need consideration in health care.

During the real-time interchange of speaking, people categorize, process information and make inferences while the speech partner does likewise simultaneously, in the moment, beyond conscious acknowledgement of cultural beliefs. The anthropologist Bourdieu (1972/1995) refers to long conditioned and learned social and cultural expectations and patterns of behavior as *habitus*.

The taken for granted process of *habitus* underlies social practice in talk, unintentionally and unknowingly affecting clinical practice through inferences (Ross, 1997) beyond interpretation in second language encounters. Since most cultural competence education relies on appeals to conscious thought and acknowledged belief systems, linguistic *habitus* would not be addressed. Though Van Ryn and Burke (2000) removed LEP patients from their sample, their comparison of provider and patient survey data two weeks after angiograms observed that race and social class affected physician inferences as perceived differences during visits. In observations of unintentional discrimination related to language in non-health situations, Urcioli (1995) describes how speakers shift their identities, establish or fail to establish boundaries during spoken encounters, privilege the interpreter's version over the client's, react based on accent or impatience, or change patterns of speaking that occur in similar monolingual encounters, such as close-ended questions versus open-ended invitations. Most nurses request brief narratives from patients in taking a history or conducting an assessment, but narrative forms differ linguistically from culture to culture and with social contexts (Hymes, 1996), leaving vital nuances behind in interpretation that excludes inferences. An English-speaking nurse may label a patient a poor historian or not identify the central theme correctly, when faced with an indirect narrative with elaborate detail expected for someone of higher social status in a particular culture.

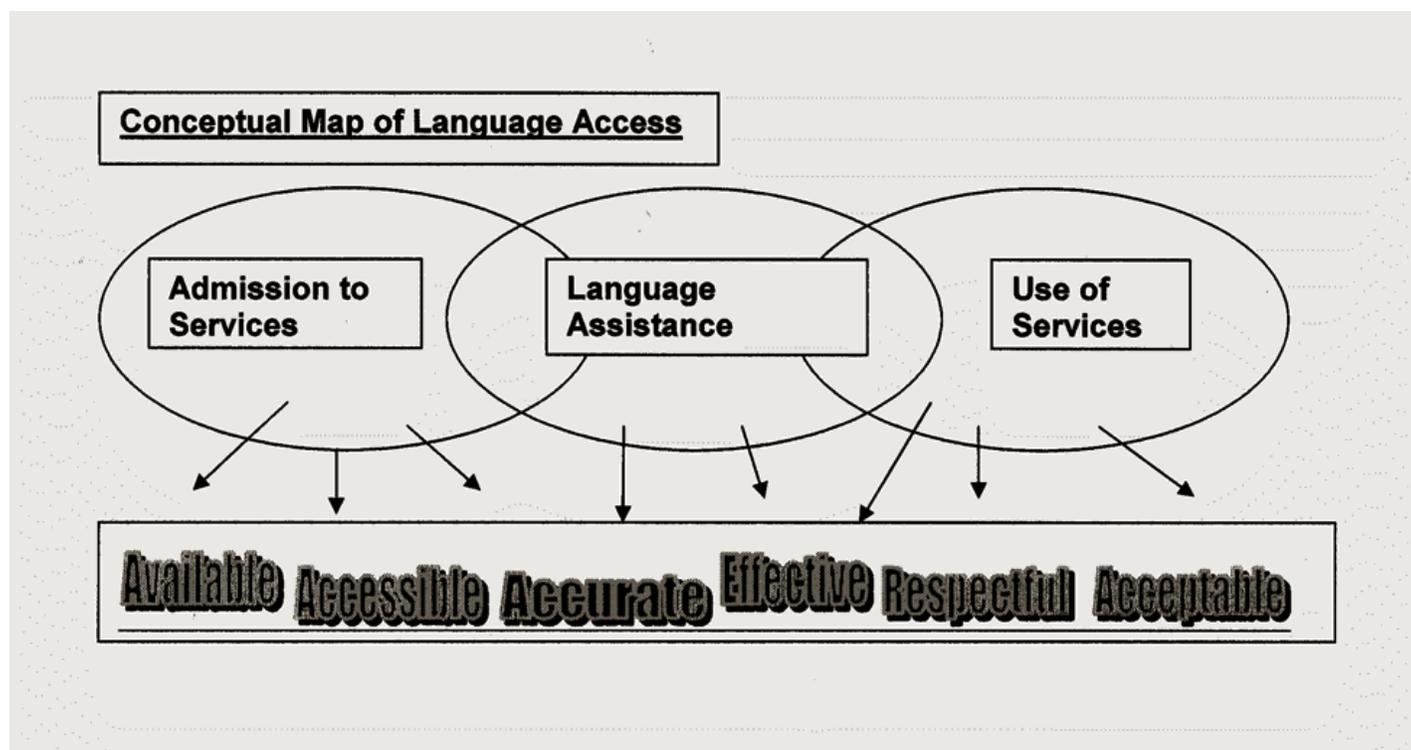
Finally, regarding language use, attitudes that speakers hold towards people who do not speak the same language affect care in a number of ways. In a study comparing Japanese speakers in monolingual and bilingual circumstances, Itakura (2001) noted that tendencies to control the topics under discussion and the structure of the conversation appeared more often in those with limited language encounters. Even with interpreters as Davidson describes (1998), topic shift, uptake, and the organizing of health encounters changes LEP persons and their English-speaking physicians talk and may partially explain clinical disparities in information and participation noted, a source of variation that deserves further study.

In education, a comparison of Hispanic and English speaking elementary students with their teachers (Masten et al., 1999) found significant differences in attributed motivation and ability to learn related to the teacher's evaluation of acculturation, an aspect of language attitude. For the LEP person, second language encounters are an independent source of stress beyond the institutional or clinical reason that brings the patient to the provider, as demonstrated in comparisons of English and French speaking Canadian university students (Clement, Noels, and Deneault, 2001). LEP patients demonstrate a favorable bias toward health professionals in situations they perceive as participatory and satisfactory while health professionals demonstrate a desire for a level of control of interactions beyond that with same language speakers making participation less likely (Watson and Gallois, 2002). Beyond the interpretation of a professional or ad hoc interpreter, the process of language use transmits beliefs, attributions, and strategies of capacity or supposed problem solving (Cargile et al., 1994) as communication behaviors and evaluations that affect the consequences of clinical practice and health care.

To identify this dimension of language access for cultural competence requires a model of access that applies specifically to health disparities. As part of a design to eliminate racial and ethnic disparities, Cooper, Hill, and Powe (2002) modify the Institute of Medicine (IOM) model of access to health services to include language and literacy as one interrelated factor among the personal barriers that patients face along with structural and financial barriers. In an expansion of the IOM framework, Cooper and colleagues (2002) include mediating factors involving health provider attitudes, biases, cultural competence and communication behaviors, as well as patient adherence, use of services, and outcomes.

In considering the role of race and ethnicity on provider-patient communication, the IOM report (Cooper and Roter, 2003, p. 555) proposes three strategies: to provide language assistance as direct interpreters and translated materials, to increase culturally congruent staff, and to promote an institution's capacity to accommodate second language clients, especially by increasing the staff's ability to interact with the client's culture. Though a valuable foundation for change, the needs of LEP persons or the sources of the discrimination they face when interacting remain to be identified in institutional and professional strategies specific to multilingual situations as well as cultural beliefs. Cooper and Roter (2003) review the substantial evidence of provider-patient differences related to gender, socioeconomic class, and health literacy, noting that even when English speaking patients speak with English speaking physicians they often have difficulty understanding what was said without sufficient power in the ritual to ask for clarification. These differences magnify for LEP persons and should be factored into the development of cultural competence education for health providers. Based on this briefly reviewed literature and the models of interpretation, nurse recommendations must identify the specific areas in the language access process that require recommendations and on-going monitoring for improvements.

The Figure below, the *Conceptual Map of Language Access*, details these components.



NURSE RECOMMENDATIONS:

1. Admission to Services

a. Language Availability.

Developed with both community and nursing participation, a social marketing plan must make the availability of language access services visible to members of the language minority communities within institutions. A nursing representative should be available to Cultural and Linguistic Competence groups within these institutions as a conduit of information in both directions. As staff training, nursing orientations and continuing education should include comprehensive orientation to the CLAS standards and their institutional responsibilities to meet these linguistic commitments. Access to multilingual services should

be identifiable to individual members of nursing staffs, similar to JCAHO inquiries during accreditation.

b. Language Screening - Accessibility.

All patients should be formally asked if English was their primary/first language and to rate their fluency using the U.S. Census two-question screen.

*“Do you speak a language other than English at Home?”
” If yes, then “How well do they/you speak English?,”
self-rated from “very well,” “well,” “not well,” to “not at all.”*

Advise all patients who say less than “*very well*” that they are entitled to have a certified interpreter and with the client’s agreement contact that person, whether on staff or by remote service. Ideally, scheduled visits should have interpreters planned before the patient arrives. If a patient chooses to have a family member or friend, advise that their privacy and accuracy will not meet the safest level for health care and they still have the right to a trained interpreter by phone or through the institution. If they prefer a family member or friend, document the offer, refusal, and person interpreting. Though patients speak some English, recognize that they may falter when trying to describe intimate situations, function in situations of stress or urgency, or provide significant details. Identify other social or cultural barriers to language assistance that exist, such as age, gender, ethnic or national identity or other forms of status that preclude direct communication. For example, a Somali pregnant patient in her 30’s had assigned to her a female 19-year old Kenyan-born interpreter who was of Somali descent who had never been married or pregnant. The patient continually denied symptoms while she bled since she would not speak with the interpreter about reproductive issues because of her unmarried and young state. The patient later pointed to conduct while talking she considered demeaning, as a less educated person.

c. All points of contact.

Identify all points of contact in the health service that the patient or family will encounter that will need interpretation and whether the current chosen form of interpretation will be sufficient. Make alternative plans as necessary, if necessary with beyond the institutional walls case management or community based services.

2. Language Assistance.

a. Preparing for the encounter.

The relationship of the interpreter to the patient, nurse, and situation needs discussion first. Interpreters need to be oriented to the provider’s expectations and providers need to be aware how an interpreter sees the process of interpretation. If the nurse or provider desires information about meanings, cultural appropriateness or significance, and information about capacity or understanding as well as accuracy in medical content, then those wishes need to be identified and agreed upon. Later after building rapport, the client’s social history should be reviewed with the client not the interpreter, especially since how the patient arrived in the U.S. may contribute to fear and willingness to participate or be forthcoming. A survivor of a refugee camp may have been raped or a client working in the U.S. may be undocumented. To increase cultural competence, nurses need to police their assumptions and expectations, since the language speaker may be a PhD in their native land or a commuter and U.S. citizen in Puerto Rico up for their annual grandchild visit or a secluded wife whose culture isolates her at home without opportunity to learn English. Ask the interpreter what health content may need extra attention for this particular patient or for themselves. Invite questions, clarification, and identify the provider’s preference for seeking validation and feedback. Nurses should

identify the shared commitment to accuracy with the interpreter and any additional information needed.

b. Working with an interpreter.

The standard instructions of how to work with an interpreter are covered in the Environmental Scan and elsewhere (Enslein and others, 2002), so are not presented here in detail. The process starts as all visits should, as the nurse introduces themselves and their intents to the patient and asks what brings the patient to the encounter. Speak directly to the patient, using “I” and “you.” The preferred positioning is the nurse facing and watching the LEP speaker for both verbal and non-verbal cues, bearing in mind that not all non-verbal behavior is culturally congruent and may mean something else. The interpreter sits to one side. A patient’s smile may mean embarrassment not amusement and what would be perceived as a frown in Anglo culture a show of appropriate seriousness. Where an English speaker may interpret refusal to make eye contact with speech as guilt, the speaker may consider it deference. The nurse should avoid idioms, metaphors, and down-home expressions (“happy as a clam”) and ask for clarification and expansion when unfamiliar phrases are translated. Ask for direct interpretation with as little paraphrasing as possible and no interjections, understanding that word for word interpretation may need expansion, explaining, and clarifying that the interpreter may still not be able to do. Use repetition, visual aids, and allow for extra time, since these encounters take two to three times longer.

3. Use of Language Services.

a. The Interpersonal Process of Care.

Stewart and colleagues (1999) propose the concept of the interpersonal process of care (IPC) as a unit of analysis that would be useful in the study of cultural competence and language access. As we consider the three elements of language access (admission, assistance, and use), the IPC idea provides a means to monitor the quality of care and equity in the use of services, when comparing those patients and providers whose primary language is English with providers speaking to LEP patients and families. According to Stewart and team (1999), the interpersonal process of care includes three parts: communication, decision-making, and style. Communication involves more than a supposed neutral information giving or exchange, but includes elements of patient-centered orientation, relationship-building, interpersonal sensitivity, the types of narratives used to describe and persuade, and the behaviors one uses when activating attention and processing information, motives, and expectations (Street, 2003). The interpersonal process of care involves both similar issues of communication competence expected of same language speakers as well as issues unique to bilingual communication and intercultural communication competence. Beyond information exchange and embedded in how speakers use either language, Hajek and Giles (2003) propose that the process of intercultural communication includes attention to:

- i. the social perspectives of speakers (long or short-term migrants or immigrants, age, gender, ethnicity, nationality, sources of status, advantage or stigma),
- ii. their cultural orientation (belief system, acculturation, cultural habits or ways of speaking, collective versus individual focus), and,
- iii. their cognitive preparedness to engage with one another (motivations, attitudes, prejudices or fears, history, and their balance between stereotypes and ability to see one another as individuals).

As an example of decision-making, a patient may use an indirect way of speaking with a great deal of framing and explaining of an event like stomach pain, but the nurse may interrupt the interpreter telling him to “Tell her to get to the point.” The interruption ignores the differences in life circumstances the patient wishes to add or as a means of introducing barriers to care she believes the nurse does not know, but may also represent a cultural way of speaking considered the polite form, rather than asking direct questions considered less respectful.

b. Evaluation and quality of care.

The use of communication skills tools to assess the quality of communication can add equity to LEP language use situations. For example, the Calgary-Cambridge Observation Guide (CCOG) (Kurtz, Silverman, and Draper, 1998) identifies overall functional components of provider-patient interaction, such as establishing rapport, gathering information, structuring the agenda for the encounter, building the relationship, explaining and planning, and closing the session, originally developed for same language speakers. With twenty-five years of use and a Spanish language version available, the CCOG can be used to compare and monitor monolingual and bilingual encounters to evaluate if content and quality of care differs, whether an interpreter is present or is not. On a nursing service that conducts peer audits for quality of care, colleagues could sit and observe a few encounters a year as part of their in-service reviews, comparing nurse encounters that are with a same language and differing language partner but with similar case content and clinical indications. The nurse can request feedback from the interpreter for suggestions to improve their technique. With a patient’s permission, audiotaping can be conducted for a second interpreter evaluation. Case studies of particular situations can be used for in-service review to highlight best practices, discourage what did not work, and continue more positive inter-language development. Nurses in leadership positions should monitor for selective assignments and “cherry-picking” when LEP patients are assigned, the latter practice observed in emergency rooms where hospital residents sort through charts to avoid such patients. Records should be kept of the percentage of other language speakers in particular health sites for pro-active planning. In a transitional time as institutions gear up to meet CLAS Standards, exit interviews with LEP patients and their families can determine what they needed and did not need, barriers, and what worked and what still needs to be done for most effective care. Where outcomes management services are in place, hospital data should monitor the services LEP patients receive for parity in diagnostic testing, pain management, follow-up and referrals, and broken appointments, as suggested for health systems in Canada (Bowen, 2000).

c. Miscommunication.

Among those who teach English to speakers of other languages, mistakes in language use in bilingual situations arise from four sources (Brown, 1991). First, in the native language, a speaker applies original constructions, idioms or frames of reference that the second language person will not recognize. For example, an English-speaking nurse with long-ago rusty high school French tries to translate for a Haitian patient and substitutes a word that makes no sense to the patient in Creole or French, but the patient answers in the affirmative trying to not be perceived as a trouble-maker. As second source of error, a speaker using a second language may not recognize an unfamiliar concept, particular inferences, or how a particular tone of voice changes meaning. As an example, a Thai patient in an emergency room stood on an injured foot and was asked by the doctor, “Wouldn’t you like a chair?” Acting as an interpreter, his young son said, “It must be bad. They want to put you in a wheelchair.” As a third source of error, the social context of either speaker’s situation may invoke or miss social biases and contain assumptions and taken for granted that are not

shared or accurate. For example, a Spanish-speaking interpreter in a prenatal clinic who was originally a professor from Spain explained pregnancy risks to a sixteen-year old pregnant Mexican migrant worker, but left out details about breastfeeding. When asked later why she did not explain breastfeeding, she commented, "Those people all know about breastfeeding." Finally, the strategies that each speaker employs while working in either their primary language or the second language may produce inaccuracy or misinterpretation, such as a gesture that means one thing in Colombia and quite another in Puerto Rico or pointing in a Chinese-American dictionary to a word with an ambiguous meaning.

Many of the means of identifying communication style and miscommunication in nursing and health care have been by self-report, a limitation in perspective. Since most miscommunication may be covert, unintentional, and undetected by either or both speech partners (Tzanne, 2000), nurses and their health systems need to develop more descriptive, qualitative and non-traditional ways of monitoring the interpersonal process of care with LEP patients and with all patients. As an introduction to more diverse ways of working with LEP patients, Robinson (2002) summarizes over 120 studies and interventions in the United Kingdom and elsewhere that characterize approaches to LEP in health systems, an emerging frontier in health service research.

Conclusion:

The national commitment to eliminating health disparities requires a definition of cultural competence that includes social inequalities and a definition of linguistic competence that includes not only language entry and assistance but the use of language services. Advances in provider-patient communication such as the CCOG offer nursing an opportunity to improve services to all patients, but especially LEP patients. In each practice site, nursing should play an active role in cultural and linguistic competence planning, monitoring, and clinical research. Every effort should be made to involve language communities with LEP members in the planning and process of change, through nurse advocates in community outreach. This paper summarizes the legal and conceptual background that shapes policy, practice, and programs surrounding language access, with special attention to the roots of language access legislation offering nursing symbolic capital in negotiation with their institutions. The model, the evidence that produced it, and the dimensions described can contribute to a more comprehensive approach to language access issues in nursing curriculum, practice, and research.

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