

## ETHICS CASE

### **Clinicians' Obligations to Use Qualified Medical Interpreters When Caring for Patients with Limited English Proficiency**

Commentary by Gaurab Basu, MD, MPH, Vonessa Phillips Costa, and Priyank Jain, MD

#### **Abstract**

Access to language services is a required and foundational component of care for patients with limited English proficiency (LEP). National standards for medical interpreting set by the US Department of Health and Human Services and by the National Council on Interpreting in Health Care establish the role of qualified medical interpreters in the provision of care in the United States. In the vignette, the attending physician infringes upon the patient's right to appropriate language services and renders unethical care. Clinicians are obliged to create systems and a culture that ensure quality care for patients with LEP.

#### **Case**

Shiv is a fourth-year medical student hoping to match into dermatology. He knows what program he wants to rank as his top choice and is currently doing a month-long, hospital-based dermatology rotation. He is excited to get additional exposure to a field he genuinely enjoys, and naturally he also feels pressure to do well. One morning while Shiv is rotating with a couple of residents, the attending physician wants to demonstrate some skin findings on a patient, a Haitian woman with an immunologic condition who has limited English proficiency. The attending physician briefly explains, in English, to her and the residents what they will be looking for. As she is giving a hesitant nod to his request, he abruptly pulls down her hospital gown exposing her breasts. She seems to be acutely uncomfortable, her eyes widen, and her arms remain paralyzed at her sides. She doesn't say anything. Having spent a year working on tuberculosis (TB) in Haiti, Shiv happens to speak Haitian Creole and, sensing her discomfort, asks her in Creole if she is OK and explains that it is a teaching session. This seems to calm her somewhat. The attending physician chides Shiv for carrying on a conversation with the patient that the rest of the group can't understand and accuses him of detracting attention from his teaching time. Shiv wonders how to respond.

## Commentary

The Haitian patient in this case has a right to language services. In failing to communicate through a qualified interpreter, the attending physician probably exacerbates the patient's emotional distress from having her breasts abruptly exposed.

We will use a rights-based framework to explore the legal and ethical responsibilities that health care professionals have to their patients with limited English proficiency (LEP). We will then describe national standards for language services established by the United States government and the National Council on Interpreting in Health Care (NCIHC). Analysis of these standards will show that, in this case, a qualified interpreter was required to provide appropriate care to the patient. Shiv, the medical student in this case, is placed in a challenging circumstance and feels compelled to act as an ad hoc interpreter. We detail why use of Shiv as an ad hoc interpreter is inappropriate. Finally, we present systems-based solutions that can help mitigate harm to patients with LEP.

## Patient Care

*A rights-based framework.* Access to health care services is a human right, as defined in numerous international health rights covenants [1-3]. The United Nations Committee on Economic, Social and Cultural Rights' General Comment 14 states, "Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity" [4]. The right to health care should be an organizing principle in our health systems. The use of appropriate language services and the right of a patient with LEP to access health care are inextricably linked. For patients with LEP, the only way to meaningfully access health services is by clearly communicating with health care professionals using their preferred language of care.

In the United States, patients with LEP have a legal right to access health care in their preferred language. The foundation of this right is established in Title VI of the landmark Civil Rights Act of 1964 [5], which prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance. In health care, Title VI—as enforced by Executive Order 13166, entitled "Improving Access to Services for Persons with Limited English Proficiency"—is a cornerstone for the provision of oral interpretation and written translation services to patients with LEP [6, 7].

Health care institutions can provide appropriate language services to their patients with LEP by hiring qualified bilingual staff [8]. However, since it is not always possible to hire qualified bilingual staff in all patients' preferred languages, it is essential to have systems for accessing professional language assistance services in place rather than relying on ad hoc interpreters such as Shiv. One solution is for hospitals to employ qualified medical

interpreters in the major languages of their patient populations and contract with telephonic or videoconference services for access to additional languages on demand.

In this vignette, the Haitian patient's right to access language services was ignored, and the patient experienced unnecessary emotional distress. We believe that some of the patient's emotional distress could have been avoided by trying to more meaningfully and clearly communicate with her via use of a qualified medical interpreter.

*Informed consent.* The American Medical Association's (AMA's) *Code of Medical Ethics* states, "The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention" [9]. The concept of informed consent tends to be referenced mostly in cases of written consent for treatments or procedures. However, performing an invasive examination also requires consent, even if not by a formal written process [10]. In this case, the attending physician needs a qualified interpreter to obtain consent prior to conducting a skin evaluation of the breasts and should certainly be modeling this practice robustly for students (and probably the practice of more gently exposing a patient for examination and teaching purposes). In failing to do so, the attending physician undermines the patient's autonomy and informed decision making. Shiv tries to intervene, but even if he had been interpreting from the beginning of the encounter, the AMA *Code of Medical Ethics* statement on informed consent still would not have been upheld. We've argued here that good informed consent is impossible without the use of a qualified medical interpreter.

### **Medical Interpreting**

*Standards of practice for medical interpreting.* A concern of clinical and ethical importance relates specifically to the risk of errors during a verbal consent process for a patient with LEP that does not involve a qualified medical interpreter [11]. In the United States, the Department of Health and Human Services (HHS) establishes competencies required of a "qualified interpreter" [12]. These competencies include the knowledge of specialized terminology and interpreter ethics and the skills to interpret accurately, effectively, and impartially. HHS requires that hospitals conduct an assessment of individuals claiming to have competencies prior to designating an individual as a qualified interpreter. HHS does not require that hospital staff serving as interpreters possess national certification, which is currently available in just a handful of spoken languages [13]. However, HHS clarifies that "the fact that an individual has above average familiarity with speaking or understanding a language other than English does not suffice to make that individual a qualified interpreter for an individual with limited English proficiency" [14].

The case does not indicate that Shiv has demonstrated the required competencies for a qualified interpreter, so we assume he is acting as an ad hoc interpreter. While current HHS guidelines do allow for the use of an ad hoc interpreter in situations involving an

imminent threat to the safety or welfare of a patient with LEP when no qualified interpreter is immediately available [12], this case does not seem to represent urgent circumstances in which use of an ad hoc interpreter would be endorsed by HHS. Health care professionals should use extreme caution when using ad hoc interpreters. The use of ad hoc interpreters—a broad category that includes a patient’s friends or family members and unqualified bilingual staff—can significantly increase medical errors [11]. Health care professionals face potential civil liability when they fail to provide qualified interpreters, if such failure leads to a tort cause of action, such as lack of informed consent, breach of duty to warn, or improper medical care [15]. In contrast, the use of professional interpreters while providing medical care for patients with LEP improves comprehension, service utilization, clinical outcomes, and patient satisfaction [16].

*Conflict of interest.* The National Council on Interpreting in Health Care has developed standards of practice for interpreters in health care [17]. The standards relevant to this vignette have to do with scope of practice as an interpreter (particularly if one has other roles in a clinical setting), one’s obligation to be impartial, and one’s potential role as an advocate for the patient with LEP. Specifically, an interpreter with an additional role in a clinical setting: (1) must adhere to all interpreting standards of practice while interpreting, (2) should disclose potential conflicts of interest that may hinder patient care and withdraw from assignments when necessary, and (3) may advocate on behalf of a party or group to correct mistreatment or abuse of a patient with LEP.

Shiv finds himself with a complicated [conflict of interest](#) due to his dual roles as a clinician-in-training and possible interpreter. He probably could have prevented some harm to the patient by asking his attending physician to use a qualified medical interpreter at the beginning of the encounter. He did not do this, presumably because such interference could have angered the attending physician, thereby negatively impacting his career ambitions.

It is important to highlight that this dynamic was a direct consequence of the failure of the attending physician as a medical educator. Medical educators have a responsibility to [role model](#) medical professionalism, to teach students about patient rights, and to create a healthy learning environment. The attending physician failed as a medical educator when he did not use a qualified medical interpreter—not to mention when he abruptly disrobed the patient—and then chided Shiv when he attempted to respond to her vulnerability. While Shiv could possibly have done more to intervene, including requesting a qualified medical interpreter, we believe the poor outcome of this encounter is squarely the attending physician’s responsibility.

### **Solutions**

Traditionally, the locus of power in a medical team resides in the attending physician’s capacity for good role modeling and demonstration of collaborative leadership, and we

have examined how he used that authority without regard to legal or ethical standards. We shall now explore how systems-based solutions can check such abuses of power and help create safer environments for patients and students.

We believe that institutions providing health care and training should have processes to prevent transgressions such as those represented in this case. First, patients should be made aware of their rights, and this information should be accessible to patients who are most vulnerable, such as patients with LEP. At our hospital, patients are informed of their rights through programs such as interpreter rounds, in which patients with LEP receive daily visits from an interpreter services representative to verify that the patient's communication needs are being met. Patients with LEP learn how to directly access language services on demand while getting care within our health system, and they are given permission to do so, even if a health care professional does not initiate a request for a qualified interpreter. Second, interpreter services should be easily accessible at all points of care via in-person, telephone, or videoconference technologies, and these services should be advertised to the clinicians and patients. HHS now requires hospitals to include multilingual nondiscrimination notices ("taglines") on significant patient documents and to include information on their websites indicating how patients can access language assistance services [12]. Third, teaching students and providing care to patients with LEP takes significant time and effort. Health care institutions should recognize this and provide employees, particularly clinicians, the resources and time needed to appropriately care for patients with LEP. Fourth, health care delivery systems and financing must reflect the legal and ethical responsibilities health care institutions have to patients with LEP.

The institution should also anticipate its response when the above processes fail. Does the patient have access to an advocate? Are students empowered to report unprofessional behaviors of their supervisors or instructors? Does the attending physician have access to remediation? In our institution, we have a patient advocate and medical students have access to an ombudsperson. Medical students are also given guidance during orientation about how to respond to instances in which patients' or students' rights are violated.

We have argued here that clinicians' responsibilities to patients with LEP extend beyond the walls of a health care institution. The professional societies for medical interpreters should advocate for expanding the access, utilization, and reimbursement for medical interpreters' services. Also, medical education and medical interpreter professional societies should promote interprofessional education that improves attitudes, skills, and collaboration as they relate to the care of patients with LEP. Lastly, we must recruit more underrepresented minorities and professionals who speak languages other than English to serve as clinical staff and faculty and provide them with training in how to request an interpreter or the resources needed to gain competency in interpreting.

## Conclusion

Patients with LEP in the United States have a legal right to access language services, and clinicians have legal and ethical responsibilities to communicate through qualified interpreters when caring for these patients. This case highlights the importance of developing health care delivery and financing systems that honor the rights of patients with LEP and facilitate quality care.

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