Lost in Translation: Current Clinical Issues with Medical Interpretation in Pediatric Nursing

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Although age and education level can prevent children from advocating for themselves in a healthcare setting, the addition of language disparities can compound the risk of pediatric adverse health outcomes in many complex ways. Because English is the predominately spoken language in the United States (U.S.), it is easy to understand how various levels of language differences among pediatric patients, their caregivers, and healthcare providers can cause frustration and miscommunication in carrying out effective treatment plans. Realizing the perceived challenges of limited English proficiency (LEP) among pediatric patients and families seeking health care is an important aspect in identifying areas for improvement in current practice. Further augmenting the importance of advocating for healthcare equity for pediatric patients with LEP are current studies that show biases in healthcare providers’ practices toward this population.

Background

Limited English proficient or limited English proficiency (LEP) are terms coined by the U.S. Census Bureau defining anyone above the age of 5 years who is reported as speaking English less than “very well” (U.S. Census Bureau, 2010). According to data retrieved from the U.S. Census Bureau (2010), it is estimated that as of 2010, 61.6 million individuals, foreign and U.S.-born, spoke a language other than English at home. Even though most of these individuals also spoke English with native fluency or “very well,” about 25.1 million (9% of the total U.S. population) were considered LEP compared to the 14 million (6% of the total U.S. population) in 1990 (U.S. Census Bureau, 1990, 2010). Of additional interest, approximately 2.3 million children between the ages of 5 and 15 years (11% of the total LEP population) were defined as LEP (U.S. Census Bureau, 1990, 2010).

A study conducted by the Pew Research Center indicates that the U.S. population will rise to 438 million by 2050, up from 296 million in 2005, and that 82% of the growth during this time will be attributable to immigrants and their descendants (Passel & Cohn, 2008). “Of the 117 million people added to the population during this period, due to the effect of new immigration, 67 million will be the immigrants themselves, 47 million will be their children and 3 million will be their grandchildren” (Passel & Cohn, 2008). These statistics are a prediction, but should these numbers become a reality, there will be an obvious increased need for linguistically appropriate health care in the U.S.

Issues in Current Practice

Pediatric patients with LEP seeking medical treatment and their caregivers often experience difficulties accessing quality, linguistically appropriate health care in the U.S. Barriers to accessing health care can lead to an increase in emergency department visits, lengthened hospital stays, medication errors, increased readmission rates within 30 days of discharge, and preventable adverse events (Jimenez, Jackson, Zhou, Ayala, & Ebel, 2014; Levass et al., 2014; Levass, Cowden, & Dowd, 2011; Zandieh et al., 2008).

A systematic review of the literature has definitively proven that use of professional interpreters is associated with improved clinical care more than use of ad hoc interpreters, and professional interpreters appear to raise the quality of clinical care for LEP patients to approach or equal...
that for patients without language barriers (Flores, 2005). However, levels of care demonstrating health equality are unfortunately not reason enough to compel healthcare systems and providers to standardize constant access to linguistically appropriate resources for LEP patients and families.

According to Title VI of the Civil Rights Act, meaningful access to language services for LEP patients is a required hospital compliance, and it is enforced through The Joint Commission’s accreditation process (Diamond, Wilson-Stronks, & Jacobs, 2010). However, many hospitals do not meet the standards, even at the risk of losing their accreditation, or do not use language services appropriately (Diamond et al., 2010). Providing consistent access to linguistically appropriate resources can be a financial burden on health systems, and healthcare providers have been shown to knowingly underutilize medical interpretation (López, Rodríguez, Huerta, Soukup, & Hicks, 2015). López et al. (2015) show four recurrent themes when resident physicians were surveyed about their underuse of language services, despite access to excellent medical interpreters:

- Resident physicians recognized they underused professional interpreters, describing this phenomenon as “getting by.”
- Resident physicians made decisions about interpreter use by weighing the perceived value of communication in clinical decision-making against their own time constraints.
- The decision to call an interpreter could be preempted by the convenience of using family members or the resident physician’s use of his or her own second language skills.
- Resident physicians normalized the underuse of professional interpreters, despite recognition that patients with LEP are not receiving equal care (López et al., 2015).

However, resident physicians are not the only healthcare providers who are at fault in knowingly denying meaningful access to language services for LEP caregivers and patients. Attending physicians and nurses were also found to consistently forgo using medical interpreters in their encounters with LEP caregivers and patients for many of the same reasons cited above, adding that institutional provision of adequate medical interpretation was lacking (Michalec, Maiden, Ortiz, Bell, & Ehrenthal, 2014).

Considering the experiences related to the management of language barriers by LEP caregivers of pediatric patients is essential in an overall understanding of potential areas of communication breakdown during medical visits (Steinberg, Valenzuela-Araujo, Zickafoose, Kieffer, & DeCamp, 2016).

Steinberg et al. (2016) conducted a qualitative study including 48 interviews of pediatric health care experiences of LEP Latina mothers in two urban U.S. cities. Six themes were found to be significantly associated to the mothers’ experiences of language barriers in the management of their children’s health care:

1. Preference for bilingual providers as a third party, either in person or telephonically, tended to complicate continuity of understanding between the caregiver and the provider.
2. There was a negative bias toward interpreted encounters when the caregivers did not think the interpreter was expressing their concerns appropriately.
3. There was a tendency to “get by” with limited language skills by using a more English-proficient child or family member to translate, using handheld translator devices, or relying on the limited language skills of the provider for comprehension.

4. There was a fear among caregivers of being a “burden.” They did not want to ask further questions or bother providers, being keenly aware that language differences are taxing and time-consuming.

5/6. Stigma and discrimination were experienced by LEP families. Many caregivers and families felt they were being treated with less respect due to their LEP levels and their ethnicities (Steinberg et al., 2016).

Although strides have been made in the 21st century regarding providing superior health care and culturally competent treatment, current interventions for linguistically appropriate patient care are underutilized and biased.

However, the healthcare community is often reticent about the fact that “excellence without equity looms as the chief human rights dilemma of health care in the 21st century” (Farmer, 2001, p. 210). It is simply unethical to let these prejudiced practices continue when optimal health outcomes are at risk.

**Nursing Implications**

Patient advocacy is a central component of the nursing profession because it is engrained in nursing education, policies, practice standards, and the nursing code of ethics (Gibbons & Jeschke, 2016). The pediatric nursing community has an added appreciation for protecting the vitality of a vulnerable population because children require constant advocacy on their behalf. In a commitment to advocate for pediatric patients, pediatric nurses can be the agents of change in standardizing culturally competent interventions and ensuring quality health care for all patients.

Future studies about the differences in healthcare providers’ practice behaviors when caring for LEP pediatric patients are warranted to understand and overcome barriers that may lead to adverse outcomes. Further investigation of implementing medical interpretation interventions delivered by healthcare providers to LEP pediatric patients and caregivers is also needed to evaluate efficacy.

**References**


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