

Title page

Deconstructing language barriers in healthcare: where are we going wrong?

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Main text

Deconstructing language barriers in healthcare: where are we going wrong?

The COVID-19 pandemic has sharply brought to light the need to address inequalities in health. Language barriers have been demonstrated to be a major determinant in the inequality in healthcare received by BAME and migrant[1-3]. Whilst working in a busy, multicultural London hospital, bridging language barriers have been one of the biggest challenges to delivering healthcare in this setting.

In this short article, we wish to deconstruct what we believe to be the fundamental practical challenges to successfully communicating with Limited-English-Proficient (LEP) patients. We identify that although this is a complex issue, there are several key areas that need to be addressed. Although we do not have a comprehensive solution, we hope that through outlining the major issues we can empower a mandate for change.

The options: availability and choice

At face-value, overcoming language barriers is simple: use a translator. However, the reality is more complicated. The timings of interactions with patients are often unpredictable (e.g. a busy ward round, a medical clerking, an acutely unwell patient), alongside the nature of the barrier (e.g. language spoken, english proficiency) and information that needs conveying. Understanding and accepting these practical difficulties are important and requires a flexible approach. Therefore, in any given scenario there are two dimensions to assess: knowing the options available and making the right selection.

The options:

Currently, there are a number of different modalities with which doctors can use to bridge a language barrier. They are roughly listed as follows:

1. Nil (broken English, hand signals, gestures, written info, pictures)
2. Phone translator apps (eg Google translate, Babel fish)
3. Over the phone translation services (eg Big Word, Language Line)
4. In person translator services
5. Allied health professionals
6. Next-of-kin / relatives

Each modality has its own specific advantages and limitations, both of which are important for the user to understand. For example, phone translator apps are readily accessible and have a multitude of languages however may be difficult to use for more complicated interactions. In contrast, in-person translators have the benefit of being face-to-face, improving rapport which allows more complicated discussions to be had. Unfortunately, they may be difficult to organise, and lack the immediacy that are often required in acute medical settings.

The selection:

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Assessing which form of translation service to use in real world practice can be tricky. This is ultimately determined by three parameters: the patient's English language proficiency, the complexity of English required in the clinical interaction, and the practicalities and timing of that interaction. For scenarios requiring complex spoken language such as breaking bad news, some form of face-to-face formal translator would be ideally required to not only provide the necessary language skills but to also maintain patient dignity and reduce distress. On the other hand, examining a patient may only require limited or simple communication which may be conveyed via a translator app or gestures. Therefore, in order to make an adequate selection one must have a good understanding of, firstly, the complexity of language that needs to be conveyed alongside the language translation capabilities of the translation service itself. This requires careful thought, ideally before starting the consultation! In all cases, the minimum standard must remain that the patient can understand what you are trying to convey and if the patient states they do not understand or you suspect they do not understand, a different method of translation should be used.

We therefore recommend that there are two ways in which this can be improved. Firstly, we must expand the breadth and consistency of translator services and resources available in hospitals[4]. Currently the majority of hospitals will have access to over-the-phone translation services, however accessing in-person translation services may vary. Clearly the number of LEP patients will vary geographically and it would be wise to target resources appropriately. Often Allied Health Professionals (AHPs) are of an ethnic mix representative of the local population served by the hospital and may therefore speak the various languages of patients at the hospital. They therefore provide an invaluable translation resource. Formalising the use of AHPs through provision of training in medical translation would be helpful.

Secondly, doctors must be better equipped with the knowledge of what resources are available alongside how to use them. This is as simple as ensuring language codes and numbers for telephone services are readily available, alongside induction packs explaining how to access in-person translators. Alongside this, we believe teaching on bridging language barriers should be formalised in the medical school curriculum such that junior doctors lie at the heart of driving the use of translator services.

Communication skills

Communicating with LEP patients via translator services has arguably been the most challenging communication skills scenario we have faced since starting work as junior doctors. Communication skills teaching currently forms a major aspect of the medical school curriculum and fundamentally, communicating via a translator involves adapting some of these communication skills frameworks such as history taking or explanation and planning. These core skills have provided many doctors with a strong basis to successfully use translation services. However, there are a number of additional skills that one needs to use. Here are just some examples.

Firstly, how does one assess a patient's proficiency in English? As mentioned above, this provides an important marker for assessing the type of translation service required. Asking a patient at the start of a consultation whether they speak English may not give an accurate answer and risks appearing judgemental. It may take an initial attempt at conversation to get an accurate gauge of what a patient understands and what they do not. This might be helpful prior to jumping into trying to use a form of translator service.

Secondly, one must appreciate the influence of the third party, whether a formal translator, allied health professional or relative. This is particularly important when explaining information to a

patient. One must judge both the patient's baseline understanding and experience alongside that of the translator and adapt communication accordingly. Keeping explanations as simple as possible is usually the safest way to address this. Furthermore, one needs to continually check that both patient and translator understand what you are saying. Alongside this, understanding the bias a translator may have on the information delivered or relayed back is important and warrants consideration. The mere presence of a third party, particularly if a relative, may alter what the patient is willing to share or how they present the information. Weighing up the extent to which one can trust the accuracy of the information given is challenging.

Lastly, awareness regarding how languages are translated, their limitations and how best to overcome this would improve use of translator services. Common English medical terms or phrases such as 'illness', 'stomach', 'cancer', 'get better', 'heart attack', may all translate in very different ways depending on the language. Identifying and deconstructing these specific communication skills is important for developing methods to navigate them that can be formally taught.

Ethics and law

In order to successfully bridge language barriers, one must have a firm understanding of the ethico-legal principles that govern clinical practice. Those of particular relevance include information sharing, valid consent and capacity. Although this is necessary for all clinical practice, from our experience there are specific situations in which greater guidance is needed to ensure these principles are used appropriately.

One of the major challenges when bridging language barriers is ensuring confidentiality is not inappropriately breached when using translators, particularly if this is a relative. Relatives have the potential to provide a valuable, easily accessible route for translation. However, one could argue that it is not possible to consent a patient to share information with their relative, if you have not yet discussed this information with them due to the language barrier. This concept is commonly neglected, although there are few ways in which this can be negated. Firstly, consent to share information might be implied, for example, if the patient chooses to ring their relative to translate. It may even be as simple as a gesture, or nod of the head. In order for this to be valid, this requires that patient to have awareness of what is about to be discussed. In certain situations this may be expected, for example whilst taking a history during a medical clerkship a patient might have an accurate preconceived idea about what the discussion will entail. However, in more complex situations such as explaining investigation results, DNACPR discussions or discussing options for treatment, this might not be the case. In these situations, one must think hard about how to ensure valid consent to share information is gained or whether using a relative to translate is the most appropriate thing to do.

Another major challenge when there is a language barrier includes assessing a patient's capacity to make a decision. Accurately assessing a patients' capacity is heavily reliant on language, whether this is the precise phrasing of what is being said or a person's overall ability to accurately converse. Often translators will summarise what has been said, and not directly translate the patient's exact thinking. This makes it challenging to demonstrate a patient can appropriately weigh up the information being given and relay it back. One might have to request that the translator directly translates everything that is being said to negate this. Equally a patient may be assumed to have capacity to make a decision when instead their delirium is masked by a language barrier. This is something that a translator may be able to unpick quite easily and therefore it is vital that translation services are used in these situations.

These are just some of the ethical-legal considerations that underpin the use of translator services doctors face on a daily basis. Arguably, there is a need for greater guidance on best practice in these situations to protect both patients and doctors.

Concluding remarks:

In conclusion, we believe ensuring quality, holistic patient-centred care for LEP patients is a multifactorial issue which requires several solutions. As a baseline, ensuring there is adequate funding for translation services in hospitals is crucial. This includes both increased numbers of in-person translators alongside easily accessible telephone translator services. We must then take a proactive approach to marketing these resources to all AHPs within hospital trusts, which requires its own budget, manpower and timeline. The next step requires training all medical staff with the communication skills and knowledge to utilise these resources optimally. This begins with training and teaching, starting with medical students. Giving students an understanding of what resources are available and how to navigate difficult consults with LEP patients would mean these future healthcare professionals would feel more comfortable in similar situations. This would not only empower junior doctors with the knowledge and skills to address the current issues we face, but also create long-lasting sustainable growth when it comes to addressing language barriers within the NHS.

We understand that any solution to reduce the impact of language barriers within any healthcare system will take time, skills and resources. A collective effort is needed to ensure change is sustainable. As healthcare professionals it is our duty to ensure that we provide an equal standard of care for all patients. By not attempting to make change, we not only fail to address the issue, but contribute to the perpetuation of inequality in health care. We therefore implore all health professionals to be proactive in bridging language barriers.

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