INTERPRETER SERVICES IN CRITICAL CARE:
CREATING A PARADIGM SHIFT

By

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INTERPRETER SERVICES IN CRITICAL CARE:
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Abstract

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There is a two fold nursing problem that lies central to the successful utilization of interpreter services in the acute/critical care setting for persons with limited English Proficiency (LEP). The first problem that exists is the absence of a specific guideline or a clinical algorithm for healthcare providers to follow when deciding which mode of interpreter services is appropriate for a LEP encounter and second, the inconsistency of reimbursement for interpreter services nationwide, which can affect provider attitude when caring for persons with LEP. In this article, it will discuss the indications for the algorithm development; in addition, explore current barriers that affect interpreter services utilization. A comprehensive literature review was completed, in order, to discover the potential benefits of the critical care interpreter services algorithm. Through an evidence-based approach, algorithm guidelines will emphasize the basic precepts of Maslow’s Hierarchy of Needs, so that a healthcare provider will be able to implement critical decision making skill, that are needed, to assist in the choice of an appropriate interpreter service mode for any given LEP healthcare communication encounter. Recognizing that administrative issues such as cost containment, healthcare outcomes, and patient satisfaction are significant to the discussion of interpreter services, a case will be made, in light of these points, for the use of this critical care interpreter services algorithm in the acute care setting.
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There is one significant theme found in a variety of research studies about persons with Limited English Proficiency (LEP) (John-Baptiste, Nagile, Tomlinson, Alibha, Etchells, Cheung, Kapral, Gold, Abrams, Baccus, & Krahn, 2004; Lehna, 2005). This theme is best expressed by Jacobs, Shepard, Suaya and Stone (2004) when they state: “... [they] are less likely to have a regular source of primary care and are less likely to receive preventative care. They also are less satisfied with the care that they do receive, and more likely to report overall problems with care, and may be at increased risk of experiencing medical errors” (p. 866). Anecdotally, these negative experiences appear to have occurred to persons with LEP in numerous situations within the healthcare settings. Many providers may be able to reflect upon an encounter with a person with LEP and confirm this reality. Upon reflection of these encounters, what is important to note from these situations is that our attitudes, as providers, impact persons with LEP care. Lehna (2005) found that when physicians cared for Spanish speaking patients, not only were limited comments made, these patients were less likely to be acknowledged by the provider when compared to an English speaking patient. Consciously or unconsciously many providers may have demonstrated behaviors similar to those of the physicians in this study.

In the United States (US) the population is growing rapidly. This growth is not only attributable to native English speaking citizens, but also to non-English speaking immigrants. According to the United States Department of Homeland Security 2006 Yearbook of Immigration Statistics, a combination of Legal Permanent Residents (LPR), refugees and asylees alone totaled 1,333,527, and the total number of deportable aliens—not US citizens—in 2006, was 1,206,457 (Chertoff, Baker, & Hoefar, 2007). Illegal immigrants make up a portion of the deportable
aliens. To expand on this profound reality of growth, the 2000 Census reports that of the 47 million people that speak a language other than English in the United States within the home, only half of them claim to speak the other language very well (Karliner, Jacobs, Chen, and Mutha, 2007). These facts have a profound impact on the delivery of healthcare to persons with LEP in the United States.

There are two current nursing problems that are central to the successful utilization of interpreter services in the acute/critical care setting for persons with LEP. The first problem that exists is the absence of a specific guideline or a clinical algorithm for healthcare providers to follow when deciding which mode of interpreter services is appropriate for a LEP encounter and second, the inconsistency of reimbursement for interpreter services nationwide, which can affect provider attitude when caring for persons with LEP. These problems have been brought to our attention since the enactment of, Title VI of the Civil Rights Act of 1964, requiring federally funded facilities/recipients to provide medical professional interpreters to persons with LEP (Karliner et al., 2007). According to Flores, Abreu, Schwartz, & Hill (2000), minorities have received a lower quality of care, and this lower quality of care is reflective in limited interventions in the following areas: procedures, preventative care, analgesia and prescriptions. Although the literature does not directly indicate that poor care occurred because interpreter services were not accessed, one can conclude that these outcomes could possibly occur if there was a language barrier in addition to other possible issues. This has been an unfortunate reality in my own work—compromised quality of care due to a language barrier. In the Post Anesthesia Care Unit (PACU) setting, a patient’s altered level of consciousness (LOC) or inability to directly ask for pain medication due a language barrier could result in less analgesia. As a safety mechanism, nurses avoid overmedicating to prevent a compromised airway in all post anesthetic
patients. It should be noted, however, when there are outward indicators of pain, which do not require the use of language—such as, facial grimace, frequent movement on the bed, tachycardia, or hypertension—patients are medicated. This example highlights the significance of language barrier on treatment of pain in the PACU setting.

Flores et al. (2000) encourages healthcare providers to consider evaluation of all care, by reflecting upon one question, “... could provider attitude be responsible, and if so, what could be done differently to avoid an adverse outcome in the future?” (p. 845). This question is the basic premise for evoking a paradigm shift of healthcare provider attitudes towards those with LEP. There needs to be a radical change of our perspective and how we view providing high quality care to those that are LEP. I would like to propose, in order to arrive at this paradigm shift, we must consider that a LEP person’s state of limited English is similar to that of a chronic, ongoing condition, such as a chronic pathophysiological disease states, like mood disorders, diabetes, or heart disease. Just as a chronic disease may stabilize, there too, may be a state of equilibrium for the person with LEP—evident by no change in their ability to speak English more proficiently. Nevertheless either state stabilization or worsening English proficiency does not change the trajectory of healthcare need for a person with LEP. Therefore, it is recommended that interpreter services should be billable in the same way as other health care procedures for disease conditions. This is the essence of the paradigm shift. In light of this new way of viewing interpreter services for LEP, as a billable code, I would like to recall that we, currently, recognize anyone who has diabetes or any other pathophysiological disease is entitled to the highest standard of healthcare, regardless of their language abilities. I would also like to suggest, that this high standard of care, also, become the norm for a person with LEP seeking any form of healthcare. Costs associated with LEP should be viewed similar to a diagnosis. Jacobs
et al. (2004), comments on this cost, for billable interpreter services, as reasonable in comparison to other current billable diseases. With this in mind, a healthcare provider is required to be aware of ethical and legal mandates when providing care for these persons, and therefore justify the billing of interpreter services uniformly nation wide—unlike the current state to state variance.

In addition to the recommended paradigm shift in a critical care setting, an acute/critical care interpreter services algorithm will be suggested, in order to assist healthcare providers in the delivery of ethical, culturally competent care for persons with LEP. From this direct evidence-based algorithm, with emphasis on the basic precepts of Maslow’s Hierarchy of Needs, a provider will be able to implement critical decision making skills, that will assist in the choice of an appropriate interpreter service mode for the given healthcare communication encounter.

Impact of Interpreter Services

Karliner et al. (2007) conducted a systematic literature search, in order, to determine what effect professional medical interpreters had on the clinical care of LEP individuals. They included articles and bibliographies, from PubMed, PsycINFO databases, and the World Wide Web, limited to English language from 1966 and September 2005. Search criteria included: (1) peer-reviewed English-language publication; (2) contained data about use of professional medical interpreters and a relevant clinic topic; and (3) compared results for the group using interpreters to another group (e.g., by type of interpreter, English speakers, language concordant LEP, LEP without interpreter use). Once inclusion criteria were met, 28 articles were analyzed. Of these, 21 articles examined professional interpreters use independently from ad hoc or chance interpreters (Karliner et al., 2007). The majority of the studies examined took place in an out-patient setting (\(N = 16\)). Eight studies took place in the Emergency Department (another form of
the out-patient setting, but considered acute/critical care environment). And finally, four studies occurred in the in-patient setting, distributed as follows: \( N = 2 \) OB ward, \( N = 1 \) psychiatric hospital and \( N = 1 \) Oncology. In light of a clinical focus, the outcomes of the systematic literature review, were categorized according to one of four measurements of improvement of care: 1) communication (errors and comprehension); 2) utilization (location of interpreter service utilization); 3) clinical outcomes (due to interpreter use); and 4) satisfaction with care (Karliner et al, 2007). Two, conclusions drawn from this literature review are that, first, the use of professional interpreter services resulted in better care of persons with LEP than ad hoc (chance interpreters) and second, the quality of clinical care of persons with LEP was improved and near equal to that of care of a patient without a language barrier (Karliner et al., 2007).

A model guideline that suggests how to best implement interpreter services was found in an article by Flores et al. (2000). She suggested five areas to consider when providing culturally competent care: normative cultural values, language issues, folk illnesses, parent/patient beliefs, and provider practices. Two issues directly impact interpreter services. The first is language issues. Healthcare providers are cautioned to consider the use of an interpreter if the healthcare provider is not fluent in the patient’s primary language; they are, also, encouraged to follow effective interpreter guidelines, in addition to continued education efforts in the area of foreign language themselves, to better communicate with their patients (Flores et al., 2000). Flores et al., (2000) reminds the reader that the continuing language education efforts, also, extend to the LEP patient. The second area is parent/patient beliefs. The provider is encouraged to explore parent and/or patient beliefs that can impact, or lead to a barrier of patient clinical care (Flores et al., 2000). In addition to identification of clinical barriers, a healthcare provider is expected to give explicit instructions for treatment or solicitation of consent (Flores et al, 2000). The latter
two activities are difficult without adequate language interpretation and, often times, *bridging* of differing cultures—through a cultural broker—are necessary.

This concept of bridging of two different cultures was first advanced in to nursing by Jezewski. Jezewski (1990) reports that culture brokering is defined as the act of bridging, linking or mediating between groups or persons of differing cultural backgrounds for the purpose of reducing conflict or producing change. Jezewski and Sotnik (2001) explain that the culture broker role, as a go-between, one who advocates or intervenes on behalf of another individual or group. The cultural broker is further described as a problem solver. Psychologist, Sukey Waller, in the book *The Spirit Catches You and You Fall Down*, also explains that being a cultural broker goes beyond the simple task of translating words from one language to the next; rather the cultural broker is also a teacher (Fadiman, 1997). The cultural broker is an ethnically concordant interpreter familiar with a specific population’s culture, customs, and non-verbal cues in context of the situation that may act as a barrier to care. An important role of this teacher is to interpret not only language but also cultural beliefs and values that may impact care or the development of a trusting healthcare provider and patient relationship.

**Indications for the Development of an Algorithm**

The preceding information indicates there are several reasons that provide the impetus to develop the proposed critical care interpreter service algorithm. The first is to recognize why interpreter services are needed: Quite simply: it is the law! Second, beyond the established law, lies potential for legal litigation when family members are used as an interpreter. Medical terminology can be inaccurately understood and/or described. Lehna (2005) indicates that this mode of interpreter service is a violation of patient’s rights—under Title VI. Using family (ad hoc) interpreters creates the potential for stress and ethical dilemmas. The literature reveals that
this ad hoc interpreting style can have a negative effect on patient care outcomes, due to conflict created within the family (Lehna, 2005). Poor communication that exists between patient and healthcare providers, without proper interpreter service utilization, can also result in potential litigation. An example of limited provider language proficiency and the need of a professional interpreter occurred when a 2 year old Latino girl had fallen off her tricycle, on her previously fractured, right, shoulder and sustained a distal clavicle fracture. When her mother, who had LEP, was asked what happened, she stated, “‘Se Pegó. Se Pegó,’” (Flores et al., 2000, p 845), which literally means she struck. The pediatric resident on duty interpreting this phrase thought it meant, “She was hit” (Flores et al., 2000, p. 845), when it actually meant she struck her shoulder against the pavement during a fall from a tricycle. This incorrectly interpreted data led to a grave situation, and the immediate transition of her children to the custody of Department of Social Services (DSS), because she voluntarily signed an English consent form, without an interpreter present. In order to reduce false fluency and potential litigation professional interpreter services need to be accessed (Flores et al., 2000).

To further expand on the potential legal litigation from this example, the concepts of proper informed consent must be discussed. Since this form—was in English and there lacked proper interpreter presence—how could this be adequate informed consent? Flores et al., (2000) has established four concise recommendations to assure LEP person truly makes an informed consent. They are as follows:

(1) Always have a trained interpreter present [active presence, not over a phone]. . . (2) Ask the parents or patient to repeat to you, through the interpreter, all essential items about the procedure and consent [This concept can be applied to the critical situations when a concern of non-consenting events exists to test understanding]. . . (3) The signed
consent document should be written in the parent’s or patient’s primary language [whenever possible]. . . (4) Ask the parents, patient and/or interpreter whether there are any cultural or personal beliefs relevant to the procedure that you and the staff should know (p. 847).

The third reason for algorithm development centers on the ethical requirement for patient advocacy. To uphold the therapeutic nurse-patient relationship, one must advocate for smoother communication—via a professional interpreter. This concept of advocacy is not limited to nurses, but extends to all healthcare providers. The fourth reason why interpreter services are necessary is due to documented increase patient length of stay (LOS) (John-Baptiste et al. (2004). Not only did this study assess LOS for LEP person in comparison to English proficient patients, it assessed the impact of LOS and co-morbidity. The study showed that persons with LEP stayed 6%, or about the equivalent of a half day, longer than English proficient patients, (John-Baptiste et al., 2004). A fifth reason for development of an algorithm is the documented compromise of patient care and dissatisfaction that takes place when an interpreter is not accessed. An example from Flores et al. (2000) not only highlights compromised care when a 3 year old Latino girl was found to have a perforated appendix, after the third visit to the same emergency room and provider in one day, but it also serves as an example of an increased LOS due to complications. The parents of this child were extremely upset and dissatisfied with their care, not only due to lacking interpreter access but also because of the rude pediatrician attitude. Although an extreme example, it emphasizes the importance of every facility to have an algorithm in place to follow, because this child suffered from peritonitis and incurred a complicated 30 day hospitalization because her parents were LEP and were unable to convey the exact symptoms of their child. I would like to suggest, as a piece of my proposed algorithm, if a
patient or parent returns to a healthcare facility upset (emotionally/mentally unstable parent), a face to face interpreter should be accessed to bridge the gap of failed communication and dissatisfaction. Rationale to support this algorithm guideline will be later discussed.

The sixth reason for algorithm development centers on the ambiguity that exists from the national level guideline recommendation for federally funded facilities. Currently, there are no concrete examples describing how to implement these guidelines, rather the Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons clearly states that the guidelines are only a recommendation not a requirement for facilities to execute (HHS, 2006). The guideline recommends the facility take “... reasonable steps to ensure meaningful access by LEP persons...” to interpreter services and allows facilities “... considerable flexibility in determining precisely how to fulfill their obligation...” (HSS, 2006). What is the definition of meaningful access? Ethically speaking, what is an appropriate amount of flexibility? Are the definitions of meaningful access to interpreter services the same for facilities and providers and persons with LEP?

Cost containment and reduction of safety errors highlight the seventh, and final, reason for an algorithm development (Lehna, 2000). With acknowledgement of rising healthcare cost, not only is there the need to reduce costs driven by complications, as previously outlined by the Jacobs et al. study, but cost reduction can also occur in the area of healthcare, such as diagnostic laboratories (John-Baptiste et al., 2004). Lehna (2000) goes on to confirm that when a language barrier exists, the average mean for diagnostic testing had increased. The specific documented increase in cost correlates to “$145 for people with LEP vs. $104” (p. 292) for those that were English proficient.
I have provided, as evidence, many specific patient case scenario examples, along with statistical study findings justifying the development and implementation of the critical care interpreter services algorithm. The following section will discuss the reasons why Maslow’s Hierarchy of Need was chosen as the theoretical framework for this proposed critical care algorithm.

Maslow’s Hierarchy of Need as an Impetus for Interpreter Services

Drawing from anecdotal comments I discovered when talking to colleagues about people with LEP, many colleagues had biased opinions and stated, “... if you are in America, you should speak English;” it is here the challenge of a paradigm shift exists. We have to change the normative opinion by recognizing that not every person upon arrival in this country will be fluent in English. Some may become fluent but others, particularly older adults, may spend a life time attempting to attain simple conversational skills. The central precept of this theoretical framework rests in the understanding that communication is a basic need of life; therefore, it must take precedence before the highest theory level, self actualization, can occur.

In Maslow’s Hierarchy of Needs, there are four steps that ascend to self actualization. These steps are as follows: 1) basic physiological needs 2) safety needs 3) love and belonging needs 4) esteem needs and, finally, 5) self actualization (Chitty, 2001). One can assert from this ascending list that communication is directly a part of meeting basic physiological and safety needs. If a person with LEP is unable to convey their need for air, water, food, or shelter then there is impedance to the delivery of ethical, competent care (Chitty, 2001). McEwen and Wills (2002) expand on this concept, by outlining the impact this theory has on nursing care, stating that this theory is a blueprint to be executed. Prioritizing patient care is done in reference to the hierarchy of needs. Therefore it is implied that to assure adequate communication for a person
with LEP, at a minimum, professional interpreter services—either telephonic or in person—are necessary to correctly ascertain their state of need. In light of this application of Maslow’s Hierarchy of Needs, it is appropriate to advocate at a national level, that all LEP person communication encounters should be deemed reimbursable, equivalent to that of a medical, surgical, or procedural code diagnosis.

Barriers to Use of Interpreter Services

From this compelling list of reasons why interpreter services should be used, one has to ask why they are often not accessed. There are three main reasons for the limited utilization. The first reason to resist interpreter services is the burden of cost to the healthcare system. Jacobs et al. (2004) found that even though there were increased costs, the cost did not exceed the yearly Medicaid expenditure for care of patients with chronic diagnoses, such as mood disorders, diabetes mellitus, and heart disease. These per person costs respectively were $1957, $1563, and $2328 in 1996 (Jacobs et al., 2004). The exact cost for the interpreter service program, he implements in his study, translates to a one year expenditure of $245,363 for 3089 documented interpretation encounters; which averaged to $79 per encounter (Jacobs et al., 2004). Among the interpreter service group the costs were $279 per person which, in comparison to the previously stated cost expenditure for other chronic diseases, is still quite reasonable (Jacobs et al., 2004). It should also be recognized here, there is statistically significant evidence that justifies the cost for interpreter services because of noted increased utilization of preventive services (P = .033), increased number of office visits made (P = .014), and written and filled prescriptions used by the interpreter service group (P = 0.001) in the study by Jacobs et al. (2004).
In addition, to increased preventive care services implementation, Bernstein, Bernstein, Dave, Hardt, James, Linden, Mitchell, Oishi and Safi (2002) and Jacobs et al. (2004) findings were similar, in that persons with LEP with access to interpreter services had the least Emergency Department return rates. In light of positive outcomes, healthcare administration must consider the benefit to cost ratio of interpreter services. The overall healthcare expenditure could be less in the long haul with the implementation of interpreter services in the acute care setting (Jacobs et al., 2004).

A second reason why professional interpreter services may not be utilized is due to the increased consumption of healthcare provider time. There is conflicting data about this. Karliner et al. (2007), observed an increase in provider time with patients when a telephone interpreter or chance interpreter was used; the increase was $8.3 \pm 4.6$ more minutes respectively, while another study referenced equal provider time when using face to face interpreter or language concordant providers. In light of this data, the recommendation of face to face interpreters can be justified, to assure the highest amount of time utilization. In another study it was found that when conversing with providers, LEP and English speaking patients take approximately the same time of 26 minutes (Karliner et al., 2007).

A final reason why interpreter services are cautiously accessed is due to limited reimbursement. Although all states have the option for reimbursement by Medicare and Medicaid, only 12 states, in addition to the District of Columbia, allow providers to be reimbursed for these services (Youdelman, 2007). For the year of 2004, Washington State provided over 180,000 encounters via one of nine regional brokers (Youdelman, 2007). According to the *Medicaid and SCHIP Reimbursement Models for Language Services* report, the cost of DSHS language services from November 2005 to October 2006 was approximately $1
million per month; the interpreter encounters totaled 217,865. The total Medicaid spending during this time was $38,225.47 (Youdelman, 2007). In light of this data, we can see that interpreter services are being under-funded and there is a need at a national level for new healthcare policy to ensure appropriate reimbursement.

Modes of Interpreter Services

There are seven modes of interpreter services described in the literature available to healthcare providers (Lehna, 2005). All seven modes of interpreter services will be critiqued in this section; however, the algorithm will focus solely on the appropriate choice to access a face to face (in-person) interpreter versus a telephone interpreter (Flores et al., 2000).

The best mode of interpreter services is the bilingual or language concordant provider (Lehna, 2005; Karliner et al., 2007). Currently, Karliner et al. (2007), reports there are over 100 commonly spoken languages within the United States. Lehna (2005) expands on this concept by emphasizing how it is unrealistic to find enough bilingual providers to ensure that every person with LEP is matched with a language concordant provider, especially in the urban setting, where there are many spoken languages. According to Lehna (2005) the least desirable, to most desirable hierarchy of service provision to individuals with LEP is 1) no interpreter 2) chance interpreter [such as friends, family member, or bilingual support staff] 3) uncertified bilingual support services 4) professional on-site interpreters 5) telephone interpretation 6) remote interpreting and 7) bilingual provider.

Each mode of interpreter service has its advantages and disadvantages. Face to face (in-person) interpreters are considered a reliable mode due to screened skills, ethical and interpretation training, in addition to cultural knowledge (Lehna, 2005). Lehna et al. ranks
telephone services higher than the professional face to face interpreter services, due to the convenience and availability of multiple languages for emergent situations (2005).

The disadvantage of certain types of face-to-face interpreters lies in the issue of accuracy. Ad hoc or chance interpreters incorrectly translated or misinterpreted data as often as 23% to 44% of the time (Flores et al., 2000). Family member editing and controlling of conversation can take place in ad hoc and uncertified bilingual support service interpretation modes (Lehna, 2005). Family members may edit conversation between provider and patient in order to protect or hide the seriousness nature of their health complaint (Lehna, 2005).

A disadvantage of telephone interpreter service is increased time consumption when accessing the relay service. Additionally, the need of having adequate telephone equipment and updating it periodically in order to complete the communication exchange is problematic (Lehna, 2005). All of the advantages and disadvantages have been taken into consideration in the development of the critical care interpreter service algorithm.

Proposed Algorithm

Based on Maslow's Hierarchy of Needs, the critical care interpreter service algorithm is as follows: first, a healthcare provider will need to establish whether the patient and/or family members present are stable or unstable, either mentally and/or physically. Please see Appendix A for a visual representation of the algorithm. Second, if the patient or family members present are stable, the provider is recommended to start with a telephone interpreter service mode; however, if either the patient or family member is unstable, mentally or physically, proceed to a face to face (in-person) interpreter service mode immediately. An example of a mentally unstable individual with LEP can be recognized when there is extreme deviation of emotion (ie: hysterical crying to angry yelling). Neither example requires exact understanding of conveyed
language to understand that there is a need for a professional interpreter to mediate the cultural and language chasm. Therefore, this algorithm guideline is suggested, in light of Maslow’s Hierarchy of Needs, by recalling that communication is a basic physiological and safety need of life.

An element of critical thinking is integrated into the utilization of this algorithm. Chitty (2001) explains that critical thinking is a learned process that becomes more perfected with experience, and that focuses on a nurse or healthcare provider’s ability to ask themselves, “‘What assumptions have I made about this patient?’ . . . ‘Do I need any additional information?’” and ‘How might I look at this situation differently? ’” (p. 361). A potential way to look at a situation differently, especially in light of a failed telephone encounter, is to implement, an alternate method, such as the face to face interpreter mode. Flores et al. (2000) provides an example to illustrate this point, when miscommunication occurs between a healthcare provider and a mother with LEP. Please note, however, it was unclear which mode of interpreter services was accessed. The mother gave birth to the full term, male, infant via emergency c-section, with a long resuscitation and who sustained severe neurological damage. However, two weeks later when a language concordant provider took over care of the infant, it was quickly discovered that the mother had little knowledge of her infant’s prognosis, and she believed that the baby would soon recover and go home. Flores et al. (2000) points out, that what may be perceived as an unrealistic expectation—or a deviation from what should be an expected reaction—can be indicative of failed communication between staff and of interpreter errors. An experienced critical thinker may recognize this unrealistic expectation, of the parent, as an example of broken communication. Therefore, the parental comments could serve as a trigger to activate an alternate mode of interpreter services, in order to ascertain complete understanding of the
situation. In this example, if a face to face encounter had not occurred, it would be prudent to have an interpreter present to assess non-verbal cues of communication and cultural variants that could potentially be recognized by the cultural broker (Fadiman, 1997). It is important to keep in mind, however, that not all face to face interpreters can be cultural brokers. Another technique that Flores et al. (2000) recommends using when attempting to understand a patient’s and/or family knowledge regarding a situation, is to have the person repeat back the information given to them. This technique can be very helpful in assessment of successful teaching. Again, this example points to the need of direct face to face interpreter in times of grave, serious, unstable patient condition, and times when staff perceive an unusual response or attitude from the parents. This is the essence of critical thinking.

The algorithm described provides principles that should be used when making decisions about telephone versus face-to-face interpreter services. Appendix B provides a non-exhaustive list of examples of situations, in which the two types of interpreter services may be employed.

Conclusion

In light of the increase of persons with LEP seeking health services, it is salient to address the issue of interpreter services. From legal and ethical vantage points, providing interpreter services to maximize high quality care is a necessity. A variety of modes of interpreter services have been identified and two significant forms, i.e. face-to-face services and telephone services, have been discussed in this paper. An algorithm has been presented to help providers determine which of those modes should be utilized based on situational scenarios.

Administrative issues such as cost containment, health outcomes, and patient satisfaction are significant to the discussion of interpreter services. A case has been made for the use of interpreter services, in order, to decrease cost, avoid negative outcomes and create patient
satisfiers through the implementation of the critical care interpreter services algorithm. The issue of cost containment was addressed in the call to a paradigm shift regarding the view of interpreter services. The paradigm involves viewing the process, and associated costs for communication encounter of persons with LEP, through the same lens as a chronic health condition. At a national level, there is a need for uniform reimbursement of interpreter services. In light of significant data, that implementation of interpreter services has positively impacted the health and well being of persons with LEP found in the outpatient area—i.e. preventative services—I would like to suggest the implementation of the critical care interpreter algorithm take place in the in-patient setting. There is potential for positive outcomes to be achieved, if healthcare facilities implemented and consistently used the algorithm to decrease costly complications and increased LOS in the in-patient setting. Additionally, access to consistent interpreter services could prove to be a patient satisfier. This possible combination could be found to be a true cost savings mechanism to the, already, financially burdened healthcare system.

Administrators and healthcare policy makers, alike, must recognize the need for a consistent credentialing body for medical interpreters. “Because [currently] medical interpreting is not yet a universally licensed or credentialed field, training can vary widely” (Karliner et al., 2007, p. 731) not only from state to state, but facility to facility. The process must begin with establishing a set of criteria that interpreters must meet for credentialing.

Nationally, policy makers must also increase reimbursement of interpreter services. As we shift our paradigm and view the need for interpretation as critical as the need for cardiac interventions, the reimbursement amounts must increase. Agencies must be compensated for this necessary service.
In addition to the need for more studies to explore person with LEP in the acute care setting, future recommendations also include collecting data on the length of stay and/or morbidity of patients when the algorithm is consistently used. Data can also be collected to determine cost outcomes as well. Through research, we must also continue to explore what other provider behaviors along with the provision of interpreter services will enhance the care and health outcomes of persons with LEP.
Reference


Appendix A: Critical Care Interpreter Services Algorithm

<table>
<thead>
<tr>
<th>Physically and Mentally Stable Patient and/or Family Member</th>
<th>Physically or Mentally Unstable Patient and/or Family Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>◀ Consider First Telephone</td>
<td>▼ Use Direct Face to Face</td>
</tr>
<tr>
<td></td>
<td>(Professional In-Person)</td>
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<tr>
<td></td>
<td>Interpreter Service Mode</td>
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Appendix B

<table>
<thead>
<tr>
<th>Examples of Situations Appropriate for Phone Interpreter Services</th>
<th>Examples of Situations Appropriate for Face to Face Interpreter Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Simple clarification of directions (ie: oral medication usage)</td>
<td>• Unstable patient and/or family focused care (ie: code patients, or emotionally distraught family members)</td>
</tr>
<tr>
<td>• Stable patient and/or family focused history and physical inquiry or treatment</td>
<td>• Teaching that requires direct hands on demonstration or return demonstration (ie: teaching injections)</td>
</tr>
<tr>
<td>• Most out patient procedure that does not require an informed consent signature</td>
<td>• Patient waking up from anesthetics (Assessment and intervention implementation)</td>
</tr>
<tr>
<td>• Most out patient healthcare provider visits</td>
<td>• Consent form signing</td>
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