

Still Lost in Translation



¿Habla español? Bạn có nói tiếng việt? If you don't, then make sure you bring the interpreter into that patient's room. Not only is it likely your hospital's policy and a Joint Commission requirement,¹ but it's also good medical care. The pediatric literature over the past few decades has highlighted the importance of quality interpretation for Limited English Proficient (LEP) patients to provide quality care. For a decade, Glen Flores has pointed out the health risks associated with not speaking English.² Poor outcomes such as disparities in care, adverse events, readmissions and medical errors all can complicate a hospitalization of a patient with LEP. In this month's *Hospital Pediatrics*, researchers from Seattle Children's add to the growing literature of challenges faced by LEP patients in the hospital.

Ebel et al in the first article highlight a new methodology for capturing LEP patients. Using "capture-recapture" methodology, the researchers were able to identify hospitalized patients who were not screened positive for requiring language services.³ While your average pediatric hospitalist won't be implementing this methodology on a daily basis, this strategy could be employed as a performance improvement (PI) initiative to assure that your hospital is meeting its obligatory requirements to provide culturally competent care to LEP patients.

In a companion article from the same group, the consequences of LEP patients and inadequate translation become apparent. Only one third of the LEP post-operative patients at Seattle Children's received interpretive services at least twice a day and LEP patients were had significantly higher levels of pain prior to receiving an opioid.⁴ The authors conclude "it is likely that consistent use of interpreters enhanced the overall communication of patients, families and healthcare providers and improved the evaluation and treatment of each child's pain." This study adds to the already robust literature of adverse outcomes of post-operative pain control in LEP adults and the previously noted literature in pediatrics.

Taken together, these articles highlight that even in a well-resourced, top-10 Children's Hospital with doctors with the best intentions, we are still missing opportunities to provide interpretive services to LEP patients. Since recent immigrants may deny the need for interpreters due to embarrassment, shame or misunderstanding, or feel that their children are able to speak English well enough, this work highlights the responsibility of the pediatric hospitalist to assure quality care and err on the side of using all available resources for interpretation and to do in a culturally competent manner.

The real question is – why do we need to keep doing these studies? How many more studies need to highlight our inability to provide the same standard of care

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to LEP patients as English speaking patients? Hopefully not many more. In 2007 Karliner et al published a systematic review demonstrating that professional interpreters improve clinical care in LEP patients,⁵ yet we still struggle to implement this simple intervention. Perhaps the next wave of studies ought to be PI projects that reduce barriers to use of interpretive services, or incorporate them into rounds, or integrate them into the health care delivery team. The time has come to move from identification of the problem to implementation of the solution.

In the mean time, some advice to pediatric hospitalists – use a professional interpretive service (or become one on

your own....). Yes, logistically this is a challenge. Yes, your family centered rounds will take a little longer. Yes, it can feel impersonal talking into a phone. But a small amount of hospitalist inconvenience pales in comparison with the alternative of not adequately treating pain, misdiagnosing a condition secondary to not understanding the history, or causing harm through a medical error. I'll stick with the inconvenience thank you.

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