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What Moral Obligations do Healthcare Providers Have to Offer Language Services?

Katherine Gladhart-Hayes
University of Puget Sound

In this essay, I will argue that healthcare providers have a duty to provide language services to minimize language barriers for their patients. For my ethical framework, I will draw on the work of Charlene Galarneau in "'Ever Vigilant' in '*Ethically Impossible*': Structural Injustice and Responsibility in PHS Research in Guatemala." Galarneau uses a feminist lens to address the shortcomings of the President's Commission in considering the implications of the sexually transmitted disease research done in Guatemala between 1946 and 1948. Galarneau opposes the Commission's use of an "individual framework" for its analysis.[1] She instead emphasizes the importance of understanding structural issues at work in the case.[2] Drawing on other theorists, she promotes looking beyond individual harm and considering a "public, collective ethics."[3] For this vision of ethics, Galarneau describes structural injustice as rooted in social structures of dominance and distinct from individual action or policy.[4] She emphasizes "context is critical to meaningful bioethical analysis."[5] Her ethical framework is a feminist one, which focuses on structural relationships and the importance of understanding the role of oppression in ethical questions.

While healthcare practitioners are legally required to provide language services where necessary, there are still problems with language barriers in healthcare in the United States. There is a growing population of people in the U.S. who speak limited English and increasing diversity of non-English primary languages.[6] Sixty million people in the U.S. do not speak English as their primary language; twenty-four million of these have limited English proficiency

[1] Charlene Galarneau, "'Ever Vigilant' in '*Ethically Impossible*': Structural Injustice and Responsibility in PHS Research in Guatemala," *Hastings Center Report* 43, no. 3 (May-June 2013): 37.
[2] Galarneau, "'Ever Vigilant' in '*Ethically Impossible*,'" 37.
[3] Galarneau, "'Ever Vigilant' in '*Ethically Impossible*,'" 42.
[4] Galarneau, "'Ever Vigilant' in '*Ethically Impossible*,'" 42.
[5] Galarneau, "'Ever Vigilant' in '*Ethically Impossible*,'" 37.
[6] Alice Hm Chen, Mara K. Youdelman, and Jamie Brooks, "The Legal Framework for Language Access in Healthcare Settings: Title VI and Beyond," *Journal of General Internal Medicine* 22, supplement 2 (2007): 362.

(LEP).[7] The Supreme Court has ruled discrimination based on language is legally equivalent to discrimination based on national origin—which is protect against by Title VI of the 1964 Civil Rights Act.[8] Section 504 of the 1973 Rehab Act also requires that interpreters be provided.[9] This was reinforced by President Bill Clinton's Executive Order 13166, *Improving Access to Services for Persons with Limited English Proficiency*; this order was upheld by the Bush administration.[10] More recently, section 1557 of the Affordable Care Act requires that language services be meaningful in addition to being provided.[11] Healthcare providers who receive federal funds (which includes Medicare or Medicaid payments) are required to provide interpreters.[12] Additionally, at least forty-three states have laws requiring interpreters be provided.[13]

However, despite this strong legal requirement that language services by provided to LEP patients, many patients do not receive services. Federal requirements to provide language services have not been enforced consistently and not all providers are even aware that they exist.[14] Only 68.8% of hospitals nationwide offer language services, though the need is not consistent across hospitals.[15] Most private non-profit hospitals offer language services while most private for-profit hospitals do not. Despite federal requirements to provide services, most government hospitals do not offer language services.[16] In a study published in 2014, 91% of resident physicians felt their communication with LEP patients was worse than with fluent

[7] Melody K Schiaffino, Atsusushi Nara, Liang Mao, "Language Services in Hospitals Vary by Ownership and Location," *Healthcare Affairs (Project Hope)* 35, no. 8 (Aug 2016): 1399.
[8] Chen et al, "The Legal Framework for Language Access in Healthcare Settings," 362.
[9] Christopher M. Burkle, Kathleen A. Anderson, YaPa Xiong, Andrea E. Guerra, and Daniel A Tschidra-Reuter, "Assessment of the Efficiency of Language Interpreter Services in a Busy Surgical and Procedural Practice," *BMC Health Services Research* 17, (2017): 1.
[10] Chen et al, "The Legal Framework for Language Access in Healthcare Settings," 363.
[11] Burkle et al, "Assessment of the Efficiency of Language Interpreter Services," 1.
[12] Chen et al, "The Legal Framework for Language Access in Healthcare Settings," 363.
[13] Amy S. Tang, Jenna F. Kruger, Judy Quan, and Alicia Fernandez, "From Admission to Discharge: Patterns of Interpreter Use Among Resident Physicians Caring for Hospitalized Patients with Limited English Proficiency," *Journal of Health Care for the Poor and Underserved* 25, no. 4 (Nov 2014): 1785.
[14] Chen et al, "The Legal Framework for Language Access in Healthcare Settings," 363.
[15] Schiaffino et al, "Language Services in Hospitals Vary," 1401.
[16] Schiaffino et al, "Language Services in Hospitals Vary," 1401.

English speakers.[17] Nevertheless, residents reported frequently foregoing an interpreter despite feeling it reduced quality of care.[18] This was largely for rounds and updates. For conversations that were deemed more important—those with families, obtaining informed consent, and initiating treatment—interpreters were usually involved for LEP patients.[19] However, residents still reported "getting by" without an interpreter for informed consent conversations 9% of the time. Despite the legal obligation, language services are not being adequately provided within the U.S.

While many LEP patients may have family members who could translate for them, this is not sufficient. A Mayo Clinic study on the impact of interpreters in surgical settings found that 97% of patients used the hospital interpreter and only 3% used a family member or acquaintance.[20] This is significant and highlights the need for interpreters even though LEP patients may have family members who speak English; their English language abilities may not be sufficient to confidently translate complex medical information. It is generally recognized that medical interpreters require more than being bilingual.[21] The burden of translating should not be placed on the families given the likely emotional difficulty of a hospital scenario. When considering "the webs of relationships" around a patient,[22] it is clear that the family is also impacted and should not be required to provide their own language services. Furthermore, cases such as the 1999 case of thirteen-year-old Gricelda Zamora demonstrate that the patient may be the family's normal interpreter. Zamora's parents were not provided with an interpreter, and she

[17] Tang et al, "From Admission to Discharge," 1787.
[18] Tang et al, "From Admission to Discharge," 1785.
[19] Tang et al, "From Admission to Discharge," 1790.
[20] Burkle et al, "Assessment of the Efficiency of Language Interpreter Services," 2.
[21] Chen et al, "The Legal Framework for Language Access in Healthcare Settings," 364.
[22] Hilde Lindeman, *An Invitation to Feminist Ethics*, (New York: McGraw Hill, 2006), 114.

was too sick to translate for them; she died because they did not understand the directions given to them by their daughter's doctors.[23]

Considering this information about language services in U.S. hospitals and drawing on Galarneau's ethical framework, I believe that healthcare providers have a duty to provide language services. While the legal requirement to provide language services is clear, it is not carried out in practice, nor do providers face penalties for failing to comply with the requirements. As a result, LEP patients and families may be forced to provide their own language services or hope for the best, placing the responsibility for language services on the individual rather than the hospital. This is hardly Galarneau's "public, collective ethics."[24] Instead, patients face structural oppression as their need for language services is not adequately addressed. There are many structures of dominance at play here. A lack of English language proficiency may be tied to national origin, race, and/or ethnicity and is likely to be viewed through those lenses by clinicians. LEP patients may be refugees or immigrants who face additional structural oppression. Based on an understanding of this context, it is imperative that patients receive the language services to which they are legally entitled.

Healthcare providers are also morally obligated to provide language services from the perspective of Rawls' Contract Theory. Rawls' theory seeks to limit inequality by creating fair conditions in society through the principles of justice.[25] In this framework, "everyone is entitled to fair equality of opportunity and adequate (basic) health care enables fair equality of opportunity."[26] Thus, access to healthcare is necessary to provide equal opportunity in other aspects of society. In order to provide equal access to healthcare, patients must be able to seek

[23] Chen et al, "The Legal Framework for Language Access in Healthcare Settings," 362.
[24] Galarneau, "'Ever Vigilant' in '*Ethically Impossible*,'" 42.
[25] Lewis Vaughn, *Bioethics: Principles, Issues, and Cases* 3rd ed. (Oxford: Oxford University Press, 2017), 42-3.
[26] Vaughn, *Bioethics*, 43.

healthcare in a language where they feel comfortable with their ability to understand what it being said to them and make informed decisions from a place of understanding that is not limited based on a language barrier.

Considering Kantian ethics, failing to provide language services fails to uphold the categorical imperative of respect for persons. For Kant, it is necessary to perform moral actions for duty's sake alone and to respect human beings as intrinsically valuable.[27] Failure to provide language services limits the ability of patients to make rational choices because they will not have sufficient information. Furthermore, patients are unlikely to feel valued by their healthcare providers if their communication needs are not considered. A patient's language is also part of their identity and experience being tied to family, culture, tradition, heritage, and national origin. When patients are not provided with necessary language services, they are not respected as their decision-making capabilities are reduced and the intrinsic value of their personhood is not valued.

Some may argue that healthcare providers do not have a duty to provide language services given the impossibility of providing interpreters for all languages. They may also argue that in rural communities, finding interpreters for a range of languages may place an undue burden on hospitals. However, drawing on Galarneau's framework, we should consider the power dynamics at play in such a situation. The power lies not with the LEP patient attempting to seek healthcare but with the larger institutions. Thus, when we focus on the context, we must conclude that the patient's need for healthcare outweighs the hospital's potential difficulty in providing an interpreter. It is necessary to focus on the institutional responsibility rather than on the individual. Furthermore, there are ways to address these barriers. In the Mayo Clinic study, they found benefits to having telephone interpreters available so that care would not be delayed

[27] Vaughn, *Bioethics*, 38-9.

if an in-person interpreter was not available.[28] They also used video remote interpreting for patients who spoke less common languages in the area.[29] Clearly, the patient retains their right to language services, and modern technology offers providers access to interpreters that prevents an undue burden.

In the U.S., there is a growing LEP population and increasing language diversity within that population. Despite laws that mandate these communities receive language services in healthcare settings, these services are often not provided. LEP patients face further structural barriers connected to their language. As Galarneau says, "There is no naiveté here. Ending structural injustice is far more challenging,"[30] but with modern technology it is possible to provide adequate language services for many languages. This does not erase other structural oppression that these patients may experience in a healthcare setting, but it protects their access to healthcare. As Rawls argues, this gives them greater equality within society, and from a Kantian perspective, upholds respect for persons. While LEP patients may have family members with greater English language proficiency, healthcare providers still have an obligation to provide language services since families are under emotional stress in a hospital situation and may not have sufficient medical vocabulary. Patients may be able to largely communicate with their healthcare providers and still have significant gaps in their understanding. The lack of legal enforcement does not negate the moral responsibility of healthcare providers; language services must be provided to patients.

[28] Burkle et al, "Assessment of the Efficiency of Language Interpreter Services," 5.
[29] Burkle et al, "Assessment of the Efficiency of Language Interpreter Services," 3.
[30] Galarneau, "'Ever Vigilant' in '*Ethically Impossible*,'" 44.

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