A review of patient safety communication in multicultural and multilingual healthcare settings with special attention to the U.S. and Canada

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ABSTRACT

Purpose: The present work aims to raise awareness of the issue of patient safety communication in multicultural and multilingual healthcare settings and to present strategies on how to overcome emerging cultural and language barriers and enable healthcare providers to reduce the risk of miscommunication, prevent inequalities and disparities, and provide their patients with safe and quality care. It also strives to present the policies and measures the United States and Canada have implemented and the strategies U.S. experts have developed to advance effective communication between provider and patient. Methods: The literature review was conducted on academic works and publications by health associations, institutes of health, and government departments in topics such as adverse events in health care and strategies to reduce cross-cultural miscommunications and on guides for hospitals. Results/Discussion: Cultural diversity in a patient population, language barriers, and a lack of effective communication can impose an increased threat on an individual’s health. In order to radically decrease the incidence of adverse events, policies and systems on how to manage multinational and multilingual medical environments should be created at a national level. Cultural competence is also key to delivering care that meets patients’ social and cultural needs; furthermore, developing a language access plan and providing language assistance (interpretation, translation) for those in need can greatly contribute to providing quality care. Conclusions: Clear communication is key to quality care and patient safety in multicultural and multilingual healthcare environments, but to significantly reduce the incidence of adverse events, policies and systems should be created at a national level.

KEYWORDS

patient safety, communication barriers, health services accessibility, translations, culturally competent care

INTRODUCTION

“Health care interventions are intended to benefit patients, but they can also cause harm. The complex combination of processes, technologies and human interactions that constitutes the modern health care delivery system can bring significant benefits. However, it also involves an inevitable risk of adverse events that can – and too often do – happen” [1].

It was 2002 when the World Health Organization (WHO) brought the issue of patient safety and quality of care to the forefront of global concern and basically started a global patient safety movement. It all happened after the release of two publications: the Harvard Medical Practice Study in 1991 and To Err is Human: Building a Safer Health System in 1999, which raised awareness of the alarming frequency of adverse events registered in the U.S. health system and unveiled the shocking number of deaths resulting from preventable medical errors. In the same year, the organization passed resolution WHA55.18 [2], which urged policymakers of member states to prepare patient safety policies and practices to fight against adverse events in health care. In order to help countries shape their own patient safety...
agendas, the WHO has taken a leading role and developed several global norms, standards, guidelines, programs, and checklists. The World Alliance for Patient Safety (WAPS) was also formed in 2004 with the aim of fostering “international collaboration and action between Member States, WHO’s Secretariat, technical experts, and consumers, professionals and industry groups” [3].

However, almost two decades later the WHO’s provisional agenda for the Seventy-Second World Health Assembly could not report great achievement: “[p]atient safety is now being recognized as a large and growing global public health challenge. Global efforts to reduce the burden of patient harm have not achieved substantial change over the past 15 years despite pioneering work in some health care settings” [4]. Research shows that patient harm due to adverse events is among the ten most common causes of death and disability globally [5], and apart from personal harm, “the cost of safety failure includes a loss of trust in health systems, in governments and in social institutions” [4] and imposes great financial burden on countries [6].

The underperformance was explained by the low number of occasions when international scholars could collaborate with Ministers of Health and other high-ranking policymakers to address patient safety issues [7]. For the future, the WHO recommends further research to better understand the extent of the problem and its root causes. The organization also urges Member States to formulate research-based policies and strategies for patient safety and to raise awareness of the importance of collaboration and knowledge-sharing [4]. At this time there is hope for success, as the COVID-19 pandemic currently placing a heavy burden on health care delivery systems around the world has shown that healthcare stakeholders can actually unite when there is a global public health crisis; they share commitment and responsibility like never before and “[m]any spontaneously adopted key safety attributes such as transparency, active communication, collaboration and rapid adoption of patient safety practices” [8].

The WHO defines patient safety as “the absence of preventable harm to a patient during the process of health care and reduction of risk of unnecessary harm associated with health care to an acceptable minimum” [9], while an adverse event is “an injury related to medical management, in contrast to complications of disease. Medical management includes all aspects of care, including diagnosis and treatment, failure to diagnose or treat, and the systems and equipment used to deliver care. Adverse events may be preventable or non-preventable” [10].

Due to globalisation and migration, the cross-border flow of people has posed new challenges to healthcare organizations, one of them being language barriers between medical professionals and patients. If left ignored, it can lead to inadequate patient-provider communication, such as misunderstandings and miscommunication, which in turn can lead to serious harm and preventable adverse events.

Multiple research studies have reported on the difficulties of communication in multicultural, multilingual healthcare settings. To summarise, experts emphasise the necessity of clear communication, which can only be established if healthcare institutions have a policy and a system for managing multicultural/multilingual cases, their healthcare staff is trained, and professional language services are available.

The aim of this article is to raise awareness of the issue of patient safety communication in healthcare environments and to review the strategies the U.S. has proposed to reduce the number of adverse events such as forming policies, improving cultural competence, and developing a language access plan. It also aims to see what measures Canada has implemented after being recognised as one of the countries that took a serious look at the problem of patient safety back in 2002. In sum, this article gives an overview of the two main Member States of the WHO’s Region of the Americas and provides some guidelines on what should be taken into consideration when planning patient-safe communication in multicultural/multilingual healthcare settings.

This work is the product of a literature review, which is based on a thorough search on the issue of patient safety and the potential impact that language and cultural barriers have on it. Among the key words searched were language barriers in healthcare, language access plan, interpreting/translation policy in hospitals, right to language assistance, guidance on translation and interpretation, as well as LEP patient guide.

The section on adverse events aims to present the wide spectrum of cases induced by cultural diversity and language barriers in healthcare environments regardless of publication year or place. In the search for the measures Canada has introduced to advance effective communication in multicultural, multilingual healthcare settings, both English and French publications were included.

METHODS

This work is the product of a literature review, which is based on a thorough search on the issue of patient safety and the potential impact that language and cultural barriers have on it. The section on adverse events aims to present the wide spectrum of cases induced by cultural diversity and language barriers in healthcare environments regardless of publication year or place.

The study focuses on the United States, as the vast majority of the search results on strategies to reduce cross-cultural miscommunications and on guides for hospitals were released in the U.S., allowing it to serve as a blueprint for other countries. In the search for the measures Canada has introduced to advance effective communication in multicultural, multilingual healthcare settings, both English and French publications were included.

RESULTS AND DISCUSSION

Adverse events induced by cultural diversity and language barriers

Cultural diversity of a patient population, language barriers, and the lack of effective communication can impose an
increased threat on an individual’s health if healthcare providers are not educated on how to adequately address a multicultural, multilingual encounter. Although this topic has been researched in an abundant body of studies, the cases discussed in this article are only given as indicative examples and are not exhaustive. Studies [11–13], for example, emphasise the importance of cultural competence, because if healthcare professionals lack it, they tend to use their own culture as a template for how they interact with their patients and treat their disease [13], which is very likely to leave the patient misunderstood and can sabotage the prescribed intervention.

Publications [14, 15] also report on patients of minority origin being disproportionately more exposed to serious harm and preventable adverse events than the mainstream patient population. In the U.S., these groups also show worse health indicators (healthcare coverage, access to care, life expectancy) compared to their European American counterparts and exceed them in almost all acute and chronic disease rates, such as infant mortality, maternal mortality, cervical cancer, diabetes, or end-stage renal disease (ESRD). Though not researched and proved extensively, these disparities may originate from the fact that ethnic minorities are reluctant to seek care for themselves or their children if they are not sure their doctor will speak their language, they have barriers to routine preventive care, healthcare professionals lack adequate cultural competence when providing health care, or because minorities are underrepresented in the health professions.

Several studies report on cases where the wrong body part was involved in a procedure, when an instrument or other material was left in the patient’s body requiring reoperation, or when medication error led to adverse drug events [16–18]. Interestingly, under the common factors contributing to these medical errors, among the causes mentioned were translation issues in procedures and guidelines, communication problems between staff members or between staff and the patient or their family members, and the lack of an interpreter involved in the communication. Studies also stress that denying translation services to non-English speaking patients or using family members or caregivers for this task instead of professional translators can greatly hinder patient satisfaction, patient safety, and quality of care by compromising a patient’s understanding of diagnoses and treatment plans, and by exposing them to readmission, more medical tests, higher test costs, and a higher risk of hospitalisation, among others.

Another article revealed that OB nurses are unable to form proper nurse-patient relationships with their clients in labour and cannot offer them emotional support or provide the level of care they deserve [19]. It can also happen that despite non-English speaking patients asking for interpreters, medical providers override these requests and rely on their own foreign language skills instead, ignoring the fact that poor quality interpretation can result in medical errors and adverse outcomes [18].

Effective communication can be hindered by multinational staff as well [17, 20]. In Saudi Arabia, almost 70% of nurses are expatriates from various countries. As most of these expatriate nurses do not speak Arabic, English became their common language, even though they are not necessarily native English speakers. This results in communication problems among health professionals and between nurses and patients who speak Arabic natively but not necessarily English. Considering the role of clear communication in nursing care, Mebrouk found that using Arabic for communication between Saudi nurses and patients increased patient and family satisfaction and improved care outcomes [21].

Besides the multilingual nature of certain healthcare environments, effective communication is also greatly influenced by patients’ health literacy, i.e., “the degree to which individuals have the capacity to obtain, obtain, process, and understand basic health information and services needed to make appropriate health decisions” [22]. Bladd writes that the reason Middle East patients are not compliant with their medications and fail to show the expected health outcomes is partly because many of them are health illiterate: they lack “the ability to read, understand and respond to health information” [17].

Costly medical malpractice lawsuits can emerge from language barriers. One such case occurred [23] when an 18-year-old boy of Cuban origin was rushed to an emergency room with his mother and girlfriend. He had an abnormal mental status, and the phrase his family used for his condition was “intoxicado.” As no one in the emergency room spoke Spanish, the healthcare staff took it to mean that the boy was intoxicated and suffering from drug overdose. After a nearly three-day stay for his supposed substance abuse, the boy was sent for a routine neurological test, which showed that he had a brain aneurysm. It turned out “intoxicado” means “nauseated” in the Cuban dialect; the nausea had been caused by a break in a congenitally defective artery. Finally, after receiving the appropriate treatment for his condition, the boy regained consciousness, but was left with quadriplegia. This seemingly minor misunderstanding led to a malpractice lawsuit with a $71 million award to his family.

**Legal basis and legislative requirements in the United States**

In order to decrease the incidence of adverse events, policies and systems should be created at a national level, declaring how multinational and multilingual medical environments should be managed and how language should be used, and these guidelines should be implemented by every healthcare institute. This section of the article aims to discover the legal basis for patient safety communication in the U.S., where communication difficulties can originate from the high number of non-English-speaking and limited-English-proficient (LEP) patients: “individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English” [24].

In the U.S., Executive Order 13166 was issued in 2000, requiring hospitals, health programs and clinicians receiving federal financial assistance to take reasonable steps to
provide meaningful access [25] to their programs and activities to LEP patients. This order stems from Title VI of the Civil Rights Act of 1964, which states that “[n]o person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance” [26], which applies to all federal agencies, including the Department of Health and Human Services (HHS) [27].

Section 1557 of the Affordable Care Act (ACA), which went into effect in 2010 but was finalised in 2016, also tackles discrimination in healthcare programs and promotes the establishment of language access services and the monitoring of disparities in healthcare delivery. In addition, along with the National Medical Association and the National Hispanic Medical Association, the American Medical Association (AMA) established the Commission to End Health Care Disparities in 2004, which “committed to ending health care disparities by providing concrete initiatives and programs that achieve goals in the areas of data collection (both patient and physician), provider education, policy and advocacy, and workforce” [28].

However, Chen et al. [27] point out that “despite the federal right to language access for LEP patients in healthcare settings, the reality is that many healthcare providers are not aware of their responsibility, have not prioritised the issue, or have not been held accountable through consistent enforcement of these laws”. They also claim that although the introduction of these legal obligations has made major progress in protecting LEP patient rights, there is still a “somewhat haphazard patchwork” of implementations which “vary from state to state, from language to language, from condition to condition, and from institution to institution” stemming from “changing demographics, advocacy groups, adverse outcomes due to language barriers, the political climate of each state, and underlying political agenda(s)”.

In the last roughly twenty years, several guidelines and standards have been published, serving as a blueprint for states and healthcare institutes to follow. They all aim to help healthcare institutes develop their own policies and improve their communication and cultural competence to ensure that all patients receive the same quality of care and to eliminate healthcare disparities.

Apart from these standards and guidelines, several organizations, insurance companies, and healthcare institutes have issued standards and guidelines, though these only work at the institutional or state level. In general, they all aim to increase equality of access to health care regardless of the patient’s origin or first language, establish culturally and linguistically appropriate services, eliminate health disparities, increase awareness and education among health professionals about healthcare disparities, build effective communication and language assistance services, prepare Language Access Plans (LAP), promote the healthcare interpreter profession, standardise healthcare interpreting practices, design interpreter services appropriate for both patients and providers, organise training for bilingual staff, and translate vital documents [11, 29–34].

**Legal basis and associations in Canada**

Canada is a multicultural country with two official languages: English and French. Besides the recognised official languages, several minority languages are spoken in the country. Bilingualism in Canada dates from 1867 – the year of confederation – with the Constitution Act and from 1969 with the Official Languages Act. The two acts recognised the English and French languages throughout the federal administration with the aim to “ensure respect for English and French and ensure equality of status and equal rights and privileges as to their use in federal institutions, support the development of English and French linguistic minority communities, and advance equal status and use of English and French” [35].

Despite French being one of the two official languages of Canada, English is the primary language used in healthcare, and there is limited access to French language services in many provinces. Similarly to other language minorities, Francophone patients experience language barriers and avoidance of care [36].

In the case of patients with LEP, accessing one’s preferred language in health care varies “between individual provinces and territories, as do preferences for strategies to provide language access” [37]. In a thorough publication released in 2015, Bowen [38] discusses the obstacles hindering Canada from taking effective action in addressing language barriers, thus posing a risk to quality of care and patient safety. These obstacles are the dearth of Canadian research on the subject, the meagre awareness among health care providers of the negative impact of language barriers, misconceptions about the patient groups at risk, the lack of appropriate response to language barriers at the system level (ad hoc interpreters such as family members, non-professional interpreters), and the shortage of “clear and consistent definitions of the characteristics and competencies of a qualified community interpreter […] as a result, the quality of interpreting across Canada has been inconsistent, leading to potentially incomplete, inaccurate and dangerous communication” [38].

Still, there are several organizations across Canada dedicated to improving access to high-quality health care for patients with LEP. The Health Interpretation Network (HIN), Association de l’Industrie de la Langue/Language Industry Association (AILLA), Critical Link Canada, and the Association of Canadian Corporations in Translation and Interpretation (ACCTI) are all non-profit organizations with the aim to develop strategies to promote awareness of language barriers, raise standards for the language industry in Canada, and advocate for the provision of professional community interpreting services by social, legal, and healthcare institutions [38]. The National Standard Guide (NSG) provides a list of skills and competences of community interpreters, including linguistic, cultural, and technical skills, as well as the necessary certifications. Furthermore, the NSG clearly defines the responsibilities of clients and Interpreting Service Providers (ISP). The medical situations in which it is obligatory to hire interpreters is not regulated, but interpreters work in a wide variety of settings,
such as medical appointments, legal proceedings, and press conferences, to name a few. Similarly, no existing legal body determines which medical documents are to be translated.

Cultural competency

Cultural competency is essential for clear and effective communication and to avoid disparities in health care. This skill can be learnt or improved, while several tools have been developed to assess hospitals’ competency [9, 39, 40]. According to Betancourt et al. [41] cross-cultural trainings aim “to equip health care providers with knowledge, tools, and skills to better understand and manage sociocultural issues in the clinical encounter”. Cultural competency in health care is defined as “the ability of systems to provide care to patients with diverse values, beliefs and behaviours, including the tailoring of health care delivery to meet patients’ social, cultural and linguistic needs” [11]. It also means the “awareness and integration of three population-specific issues: health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy” [42].

At the individual level, leaders as well as other health professionals need to be educated about the prevalence of disparities induced by language barriers. Frontline health workers are expected to learn how to obtain information effectively from LEP patients, how to share clinical information with them and ensure its comprehension, how to build a proper doctor-patient or nurse-patient relationship, and how to respond to patient emotions and encourage them to care for themselves [31, 40]. All employees should be fully aware of the policies, procedures, and available language assistance services (in-person, telephone, or video interpreter services; translated materials, etc.) and how to choose and apply the best one for the target situation [33].

Culturally competent healthcare institutes provide language assistance for non-English speaker (NES) patients or patients with LEP by working with trained interpreters or hiring bilingual staff. According to Lindholm et al. [18] the three most critical events where interpreters are highly recommended are admission, patient education, and discharge, as these greatly contribute to reducing the risk of disparities and hospital readmission. Medication instructions should always be given in the patient’s preferred language.

Translating vital documents – especially discharge papers and patient education materials – monitoring the quality of communication and carrying out necessary improvements or establishing new standards are all essential for clear communication and patient safety [32, 39]. Regenstein et al. [33] writes that patients with LEP often value it when physicians interact with them in their mother tongue. Such direct interactions show respect for the patient and help build a stronger patient-physician relationship. Communicating with patients in their first language also improves health education and health outcomes, increases patient satisfaction, and reduces costs and disparities [42, 43].

Producing easy-to-understand materials is key; these require regular revisions concurrently with the original materials [44]. Avoiding jargon or heavily technical medical terms is also recommended. Instead, these terms and phrases should be explained in plain English [31].

Further practices that can make a healthcare institute more culturally competent are the display of taglines, notifications, and translated materials at registration desks, front desks, waiting rooms, exam rooms, or at the checkout, as they draw attention to available language assistance in services or written documents [31, 32]. Maintaining a record-keeping system is also recommended for storing demographic data, including the patient’s first language, preferred language for discussing healthcare issues, and their spoken and written language needs, allowing the institute to more easily schedule an interpreter for the patient [30, 33].

Name badges indicating the employee’s language skills and technological tools, such as smartphones, automated translation and interpretation services, or computer-assisted real time translators (CART) are also useful [34, 39, 44]. Another practice is to provide pictorial signage and non-text information such as informational videotapes and audio-tapes for those with low literacy regardless of their primary language [43, 44].

Language access plan (LAP)

Though it is not compulsory for healthcare institutes to have a language access plan (i.e. it is not legally binding in the US), the presence of one can greatly contribute to providing quality care for NES and LEP patients, as it embraces policies and procedures for providing guidance to the healthcare employees and language access services for patients [39, 45, 46].

The Colorado Trust [32] explains that the need for an LAP is most commonly articulated by front-line staff (providers and support staff), but it can only come about if the leadership supports the idea and promotes the necessary policies and procedures to avoid pitfalls and aims to communicate with LEP patients in a manner that meets their oral and written communication needs. When preparing a language plan, the prevalence of LEP patients served by the healthcare institute needs to be considered, as well as their language needs, the nature of language services provided, and the resources and costs of providing language assistance services [44].

Also, when designing an LAP the following issues need to be discussed: what oral (interpretation) and written (translation) services are available, how to access them, how to work with an interpreter and what to do if the patient refuses them; who can provide interpretation services; what certification professional interpreters need to have; what training bilingual staff need to obtain; and what documents need to be translated and into what language(s). In the case of translations, legacy materials also need to be revised to see whether their cultural appropriateness and literacy level fit the needs of the institute’s LEP population. Establishing a centralised budget is recommended to cover the costs of language services, while continuous monitoring and feedback collection need to be conducted in order to make further improvements [30, 32].
Oral (interpretation) services

On top of the aforementioned legal basis, several U.S. state legislative initiatives have been made to improve or increase language access in health care. In general, they all discuss how to establish interpreter services suitable for both patients and institutes, who can provide interpreter services, how interpreting should be done in health care, and who covers the costs.

Preparing policies and practice standards regarding the role of healthcare interpreters, as well as the necessary skills, knowledge, and ethics, contribute to the standardisation of the profession and simultaneously to the quality of care by providing LEP patients better access to healthcare services. Although certification is not obligatory to interpret, it helps to establish competency [47].

Competent interpreters or bilingual staff understand culturally versatile communication styles in terms of tone or eye contact, for example [31]. They are also aware of language differences – even within the same language – as certain cultures use different expressions or idioms for the same term, and interpreters are expected to know whether a word has more than one meaning [23, 28, 48]. Interpreters are advised to use teach-back techniques in order to make sure the patient understood them [34, 49].

Studies and guides all agree that the best choice for mediating between cultures and languages is a qualified healthcare interpreter, though a license or certificate to carry out the activity is only required in a few states [47]. If there is no in-person interpreter available, healthcare institutes can contract freelance interpreters or agencies or seek telephone or video remote (off-site) interpretation [13, 39, 49]. Asking bilingual staff to translate is inevitable; they may even share similar cultural backgrounds with LEP patients, and hence present a lower chance for cross-cultural miscommunication, although to avoid adverse outcomes resulting from poor interpretations and the lack of professional skills, these employees need training [44].

Apart from an emergency where there is an imminent threat to the safety of the patient, relying on untrained, ad hoc individuals – family members, minor children, friends, assistive personnel – as interpreters is something that must be avoided, as it can easily lead to misinterpretation, the loss of confidentiality, conflict of interest, misdiagnosis, potential invalid informed consent, low quality of care, or even adverse events [30, 38]. These people do not have the necessary medical vocabulary and language skills to mediate efficiently; in addition, they “may not feel comfortable conveying some sensitive types of information to the patient, such as about sexual health, substance abuse, or a terminal diagnosis” [34]. Adverse events can also come from healthcare professionals overestimating their own foreign language skills or self-identifying as bilingual and underestimating the quality of work a professional interpreter can provide [18].

Based on Executive Order 13166, health programs receiving federal funding have to ensure that LEP patients have meaningful access and an equal opportunity to participate in their programs and activities, which also entails that any kind of language assistance must be free of charge for the patient [38]. However, despite the legal requirement, healthcare institutes are struggling to comply with this rule and to hire professional interpreters [32, 33, 39, 50]. One of the main reasons is the cost of language services and the fact that these expenses are not covered, i.e., they cannot be reimbursed by most medical insurance. Another difficulty is caused by the logistics of introducing an interpreter – finding someone available on- or off-site – which can delay or disturb the normal flow of medical care. Sometimes it is also a challenge to find the right staff with the desired competency or to make healthcare professionals understand the value of a trained interpreter in the patient-provider relationship and educate professionals on how to use their services.

Written (translation) services

“Clear communication is a cornerstone of patient safety and quality health care. Quality translated health materials can serve as valuable communication tools for both patients and providers, and can help to ensure the delivery of safe, effective and high-quality care” [51]. Although federally funded healthcare institutes are legally required by Title IV of the Civil Rights Act of 1964 and Executive Order 13166 to take reasonable steps to ensure that LEP patients have meaningful access to their programs and activities, the term meaningful access has not been defined officially. Still, policy makers believe the key is to make sure LEP patients can effectively communicate in healthcare environments and that healthcare materials are available for diverse audiences. However, Hablamos Juntos [29] warns that if translation is motivated only by compliance with the law, the result might be word-by-word translations that fail to fulfil the purpose of communication in another language and culture.

Standards and guides created by state-level organizations, health insurance companies, and non-governmental organizations in the U.S. all agree that for the sake of quality translations, equal access to healthcare for LEP patients, and for preventing adverse outcomes originating from cultural and language barriers, centralised responsibility needs to be taken for translations, including policies and generally accepted national standard practices, style guides, and glossaries. It is also paramount to invest in communication improvements: not only developing language services, but also hiring qualified and experienced translators and establishing standards for training healthcare language mediators [51, 52].

In addition, documents vital for programs and for patient safety and education must be translated. Such documents include signage, directions, and notices about the availability of interpreter services, administrative and legally binding documents (consent forms, client rights and responsibilities, privacy notices, complaint forms, emergency room release and discharge forms, documents establishing and maintaining eligibility for services, and notices of non-coverage); clinical information (prevention and treatment
instructions; what to do before, during, and after a procedure or treatment; how to take medicine; and how to perform routine self-care or self-monitoring: medication labels; education, health prevention, and promotional materials (brochures, fact sheets, pamphlets, promotional flyers and posters, health advisories, and other materials that support treatment programs (e.g., for chronic disease or mental health)); and prevention activities (e.g., cancer or high blood pressure screenings) [31, 42, 44, 52].

Vital documents need to be translated into the language of each frequently-encountered LEP group at the given health institute, however, there is no provision stating what languages they have to be translated into. But according to the HHS, if an LEP language group “constitutes five percent or 1,000, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered” [53] vital documents have to be translated. If the size of the language group is less than the minimum, the institute has to provide oral interpretation of those written materials free of charge.

Literature also recommends reviewing legacy translated materials to determine whether their style, cultural appropriateness, and level of health literacy are suitable for the target audience [32]. Written translated materials should be phrased following the principles of plain language, which corresponds to a fifth grade or lower reading level [30]. The Joint Commission [30] also recommends using interpreters at patient education and discharge – even if translated materials are available – in order to facilitate communication.

Hablamos Juntos (Together We Speak), a national demonstration project aiming to improve language access for Spanish-speaking Latinos by developing affordable models for healthcare organizations [54], encourages the development of so-called Translation Briefs, which are “a set of instructions that specify how the translated product will be used, by whom, in what setting, for what audience and the communicative objective(s) to be accomplished” [55]. These instructions not only help and guide the translator, but also function as a criterion for assessing the quality of the translation. Besides Translation Briefs, standards and style guides perform the same functions, while back-translation can assist in ensuring the accuracy of the information being conveyed [32].

CONCLUSIONS

The present review has shown that clear communication is key to quality care and patient safety. To obtain results in reducing the incidence of adverse events resulting from cultural and language barriers, policies and procedures need to be developed to manage multicultural and multilingual medical environments, funding for language services needs to be obtained, educational campaigns must be run to raise awareness of the negative impact language barriers have on patient satisfaction and health outcomes, cultural competence needs to be developed on the individual and institutional levels, and language access plans have to be created.

Despite the WHO’s active efforts since 2002 and the significant amount of research, standards, guides, and toolkits, the implementation of patient safety communication greatly varies between states, provinces, territories, institutes, and languages both in the U.S. and Canada, a phenomenon that also suggests that LEP patients and French speaking patients cannot fully exercise their federal right to language access in healthcare settings.

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