Importance and Promotion of Linguistic Safety in the Healthcare Setting

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The United States has always been and will continue to be a nation of many cultures and languages. In the healthcare arena, this means safety will depend on clear, linguistically appropriate communication between the patient and family and the healthcare provider. Three obstacles exist to this type of essential communication: limited English proficiency, low health literacy, and cultural barriers.

The Joint Commission, founded in 1951, accredits more than 18,000 healthcare organizations and programs and is the largest and oldest standards-setting and accrediting body in health care in the United States (Joint Commission, 2010). They set the standards for and enforce high-quality care. The National Patient Safety Goals come directly from the Joint Commission (2013); however, none of those goals address language, health literacy, or culture (Joint Commission, 2013). The U.S. Department of Health and Human Services (2010) Office of Minority Health developed National Standards on Culturally and Linguistically Appropriate Services in Health Care to encourage appropriate care and communication by healthcare providers for individuals with limited English proficiency. The standards were created in 2001 and updated in 2010 in an attempt to address proper verbal and written communication in a multilingual and multicultural society. However, no financial incentives exist for compliance or regulation of the standards. The standards serve as a guide and conceptually provide guidance. However, without funding and cost-effective strategies to enhance the application of the standards, they only rank with minimum importance in the healthcare setting.

The Joint Commission’s (2010) roadmap for hospitals defined communication as a “two-way process in which messages are negotiated until the information is correctly understood by both parties” (p. 1). The Joint Commission (2010) addresses communication between the patient and family and the healthcare provider in the roadmap for hospitals. The purpose of the roadmap is to “inspire hospitals to integrate concepts from communication, cultural competence, and patient- and family-centered care fields into their organizations” (Joint Commission, 2010, p. 3). Admission, assessment, treatment, end-of-life care, discharge or transfer, and organizational readiness are addressed in this document. The roadmap also contains information on how to ensure that each healthcare facility excels in communication between the patient and family and the healthcare provider. However, the guidelines provided may not be working. In an account given by a nurse (L. Allchin, personal
communication, February 13, 2013) of a limited English-proficient patient newly diagnosed with metastatic colon cancer, the nurse stated,

I used the interpreter phone to speak with my Cantonese patient. His scheduled surgery was for a colon resection. The cancer was so widespread, no resection was done, and the incision was closed. I asked the patient how he was doing. The patient said all he knew was the surgery did not get done and that he had to follow up with a cancer doctor. When I asked him how he felt about his current situation, he said he was “okay.” The physician had not used the interpreter telephone, and the patient never really understood the severity of his situation and was unsure why the surgery had not been completed.

The National Patient Safety Goals for the sections of hospital, critical access hospital, and laboratory include improving staff communication as a goal. For each, the specific intervention is to, “Get important test results to the right staff person on time” (Joint Commission, 2013, p. 1). A nurse about to administer chemotherapy must have accurate information about each patient’s laboratory values. Another safety goal in the sections that mention communication is identifying patients correctly. Nurses strive for this safety goal by using double identifiers. Communication goes from sender to receiver and back to the sender, and linguistically appropriate communication must exist so that each party understands the other. A patient who does not understand English cannot know when he or she is asked for his or her name and birth date to determine identification, ensuring that the correct medication, test, or treatment is given to the correct patient. Comprehension may be compromised for patients who have limited English proficiency, do not speak English, or have low health literacy. National Patient Safety Goals are rooted in communication. The goals conceptually describe communication (e.g., prioritizing care, reassuring families, identifying risk factors) between patients and families and healthcare providers. However, a patient who does not know English will have a difficult time with comprehension. The National Patient Safety Goals should work to address language barriers.

Health Literacy

Low health literacy is another barrier to linguistic safety. Low health literacy affects an individual’s ability to navigate the healthcare system, complete complex forms, and engage in self-care. About 10% of the adult population in the United States is considered to have proficient health literacy. People with low health literacy tend to have worse health outcomes, have higher rates of hospitalization, and have less frequent use of preventive services, which all result in higher healthcare costs (U.S. Department of Health and Human Services, 2010).

Many skills are needed to navigate the healthcare system. Patients and families must be able to read, write, speak, and listen in English. Individuals must be able to do numerical computing (e.g., understanding medication dosing and frequency, health insurance copays, and nutritional labels), have critical thinking and decision-making skills (e.g., selecting insurance plans, treatment options, and deciding when to seek help), and be familiar with technical biomedical vocabulary. The ability to understand biomedical terminology is difficult for English-speaking patients and becomes more difficult when patients have limited English proficiency.

Cultural Barriers

Cultural barriers also affect linguistic safety. In oncology nursing, differences in culture may influence how pain is assessed and treated, which medications are used, who may attend to a female patient, or how death is managed. Many examples and vignettes can be found on government websites and can facilitate understanding of cultural needs in the United States. One such Web site is A Physician’s Practical Guide to Culturally Competent Care (www.cccc.thinkculturalhealth.hhs.gov) where clinical cases with complex cultural and linguistic issues are presented via the Internet for learning purposes.

The major immigrant populations in the United States originate from Mexico, the Philippines, India, China, and Vietnam (U.S. Census Bureau, 2010). Languages spoken include Spanish, Chinese, Tagalog, French, and Vietnamese (U.S. Census Bureau, 2010). Understanding that culture influences all aspects of a person’s life is essential to the promotion of safe, high-quality cancer care. Oncology nurses need to be able to understand a patient’s advanced directives, intensity of pain, or suicidal thoughts, to name a few instances when communication is vital. Cultural differences encompass verbal communication as well as nonverbal communication between a patient and his or her healthcare provider. A patient may not look into the eyes of a healthcare provider out of respect rather than a lack of understanding. Healthcare providers should be aware of these cultural differences to avoid miscommunication with patients.

Conclusion

Establishing a culture of safety will be difficult until linguistic safety becomes a priority. The foundation of safety standards is the knowledge that the patient and family understand communication about prevention, acute care, long-term care, and rehabilitation from healthcare providers. The foundation of safety standards also must include the knowledge that all healthcare providers understand patients and their families. The key to patient safety is mutual understanding and communication. Forward movement has occurred in providing healthcare professionals with resources to implement cultural and linguistic services. Additional webinars and literature can be found at www.minorityhealth.hhs.gov.

References