Impact Of Language Barriers On Communication Between Hospital Staff And Patients And Its Negative Reflection On The Patient Experience

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1. Introduction

Language Barriers: The Purpose of Addressing

Even though this context is one of the aspects of the issue in question, it has been extensively researched in order to enhance the patient experience by addressing language barriers between the hospital personnel and the service users coming from abroad.

The Negative Reflection of Language Barriers on the Patient Experience

The importance of clarifying language barriers in hospital settings stems from the negative impact of interruptions related to communication. Mutual understanding and cooperation are impeded by language barriers, as communication is hampered. Language barriers, on the other hand, can make it difficult for patients to explain their symptoms and concerns, for staff to elicit appropriate clinical histories, and for staff to provide the necessary information. Waiting times lengthen, tests are ordered instead, patient anxiety increases, and a lack of comprehension can lead to misunderstandings or inappropriate treatments. For healthcare providers caring for patients who speak a different language, the findings suggest a number of important problems in this research (due to turn-taking/customer involvement from communication

types, treatment time, parents' rating of faith in NPs), turn-taking, patient involvement in dialogue; healthcare improvement); experimental data for discussions and implications for nurses; comments on the contribution of Schoenherr et al. (Pandey et al.2021)

1.1. Background and Rationale

Communication in healthcare has become a vital part of everyday practice for healthcare professionals caring for people from various ethno-culturally and linguistically diverse backgrounds. The increasing proportion of different languages among populations in recent years has compelled many professionals to consider this issue. However, in the field of medical health services, certain disparities in levels of proficiency in writing and speaking English exist among some healthcare professionals. This study aims to delve deeper and investigate the potential impact of language barriers on communication between hospital staff and patients, which may result in more aggressive behavior towards patients, leading to a disheartening patient experience.

A dominant argument for addressing language barriers in healthcare, along with developing proficiency in the primary language, stems from a rights-based approach. Cultural aspects, such as language, influence the care strategies and tactics of consumers and service providers. It is necessary for a health service to be available and affordable. The growing diversity and global stability, along with the increasing emergence of the immigration system, have led to a rise in language barriers in healthcare and have been acknowledged as a major trigger for the increase in reporting of adverse incidents. Additionally, past studies have repeatedly drawn attention to the impact of language barriers on patient comprehension and the resulting adverse effects. Language barriers curtail vital communication between the parties, thus obstructing the potential health benefits that can arise from developed communication, which ultimately stems from cultural and linguistic congruency. (Schulson et al.2021)(Khan et al.2020)

1.2. Scope and Significance of the Study

Language barriers are an often-encountered facet of life in today's world, and hospitals are no exception. The study seeks to investigate the negative impact of language barriers on communication between hospital staff and patients, as well as the

reactions on patient experience. Subjects are defined as both hospital staff and the patients they attend. The paper identifies various language barriers in the context of a Kuwaiti hospital and compares the opinions of healthcare providers with the experiences and reactions of patients.

Patients frequently experience difficulty obtaining healthcare in the hospital. Technological advances make it increasingly possible to offer healthcare to people from all over the world. As a result, healthcare personnel often care for people from many different cultures. While it is not realistic for healthcare personnel to learn about every culture that they may encounter, patient care is often hindered by language barriers.

The research defines the scope of the study by setting out the operational definitions and the limits associated with the investigation. The scholarly literature on the topic is examined, where the prevailing assumption is that language barriers, or inadequate interpretation or translation, between patients and healthcare personnel negatively influence patient care delivery and, by extension, the outcomes thereof. No studies conducted in the State of Kuwait could be found that looked specifically at language barriers in healthcare. Exploratory research into the presence of language barriers was therefore requested through a permission request to administrative bodies at a general hospital. The research was granted, and the authors contacted the responsible bodies and requested permission to conduct structured content analysis research at the named general hospital and several associated medical centers. The research was given the green light, on the condition that participants agreed to take part in the research.

2. Theoretical Framework

From a communication theoretical perspective, group communication (interpersonal communication) is dependent on the success of mass communication in providing a mutual environment wherein communicative acts can be understood and shared. Thus, in the case of the relatively small communication groups of the medical examination room and professional personnel, the necessity of successful communication is as crucial as mass media. Why? No one person contains all of the medical knowledge necessary for a hospitalization to be successful, either from a clinical or administrative standpoint. Thus, in the hospital

there exists an "elaborate division of labor," just as there is in a metropolis. Yet, the division of labor among physicians is in a complex organization rather than between occupations or professions. (Burgener, 2020)(Kwame & Petrucka, 2021)

The manner in which a hospital group conducts itself and the image it projects to clients both inside and out is passed along directly to and through these medical secretaries. This group ultimately has a great deal of say in how well our clients are taken care of. The possibility is generated by language barriers between those working in the hospital and the patients. Much has been written about the language problem. From the perspective of clinical sociology, the language problem is an aspect of the hospital's organization. The negative treatment of each non-English speaking patient becomes an instance of social problem. What becomes apparent from this is that these problems arise directly out of these hospital systems. Language becomes structured within the hospital to function within a system.

2.1. Communication Theories

Communication theories generally place an emphasis on the importance of the healthcare professional's role in the medical consultation. The two models of communication and relationship discussed were the biomedical model and the biopsychosocial model. These models stressed the explanation of facts and disease, while the patient is somewhat emphasized. These models were mainly ethnocentric in nature and were dependent on the use of services within a familiar environment and when language did not pose any barriers for either the patient or the healthcare professional. Hall's proposal for a communication rule with an adaptation approach could be a key to evidence-based communication and training in communication that recognizes cultural diversity with predefined behavior in some situations contra the universal 'those skills how to' approach. In summary, it is self-evident that many EDs or A & E face language barriers. This, it seems, poses significant negative reflection on patients' experience, although little evidence is available from research.

If the social worker can maintain symmetric communication, the carer will adopt the role of speaker because of the topics symmetrically shared interests in, as indicated previously. This then allows the social worker to test boundaries, elicit information, counsel, and persuade. The carer's status as an enquirer, passive

recipient of information, is altered through the establishment of a symmetric relationship. Language barriers result in losing control and disempowerment. This may undermine the patient's confidence, lower patient satisfaction, and reduce his or her decision-making abilities. Furthermore, language barriers can create opportunities for errors and mistakes, particularly in relation to issues about informed consent for medical treatment, diagnosis, and layered explanations, for example in settings or countries where the appropriate skill is not available. In addition, this deters confidence and raises anxieties about professional competence, potentially leading to avoidance of the service or to unpleasant allegations, even law involvement with the service concerned and the police. (Gray & van Rooij, 2021)(Kerrigan et al.2021)

2.2. Language Barrier Theories

There are several theories that address different aspects of the language barriers that may impact hospital staff-patient communication. For instance, models of explanatory strategies are widely applied to deal with the increased complexity resulting from a lack of shared linguistic background. Communicatively speaking, language barriers impair, for example, the clarification and sharing of information, and can lead to a lack of understanding. The exchange of factual information is an important aspect in the domain of healthcare, yet communication remains of a relational and social type, as well. This means that personal communication should take place in a friendly, respectful, empathetic, non-judgmental, and meaningful way in order to have an optimal effect.

Prior research has also shown that language-restricted patients are vulnerable, experiencing, for example, feelings of being invisible to staff, a lack of intimacy with care providers, feeling violated, and a lack of trust. Language-restricted patients in hospital settings experience powerlessness, culture shock, a sense of losing one's identity, and a decreased quality of care due to staff's lack of cultural competence. Not being able to communicate well in accordance with the communication needs of the patient may have a negative impact on the physical care outcome of the patient. However, when emphasis is put on patient-centered and relation-focused communication only, it narrows down the complexity of the communication between hospital staff and

language-restricted patients. There is a need for a broad analysis on how different communicative approaches might provide valuable tools, including important premises that healthcare professionals may combine into an effective communicative model to find new ways to communicate with language-barred patients. This is what this article sets out to do, starting off with addressing changes in political and organizational arrangements in the field of patient rights in relation to effective communication.

3. Methodology

Firstly, the research design will involve a case study of a medium-sized hospital in the West South Central Region of the United States. Structured observations, interviews, and surveys are three methods that will be used to collect data that aligns with our problem statement. We plan to gather this rich data from three different groups of the hospital staff population – nursing workers, patients, and language interpreters. The triangulation of the data and research methods will result in more accurate findings and valid conclusions.

Secondly, the data is intended to be analyzed through grounded theory, a consistent, rigorous methodology that is appropriate for case study research.

The research approach of this paper may be characterized as of an exploratory nature, the objective of which is to systematically explore the impact of language barriers on communication between hospital staff and the patient. The research will be conducted using a data collection approach that will collect information through observation, interviews, and surveys. Each of these data collection methods will serve to answer the following research questions:

A. Observations – explored communication problems and errors, communication strategies used, or added on by a language interpreter. (Kuswoyo & Audina, 2020)(Gerchow et al.2021)

B. Interviews – discovering patterns of interactions among hospital staff and the patient where language comes into play.

C. Surveys – examine the self-reported quality of work life through the interaction with patients and staff that reflect on patient perception.

In doing so, the researcher will have a more in-depth understanding of the effects of language barriers on staff-patient communication.

3.1. Research Design

This study deals with the impact of language barriers on the communication between the staff of Belgian hospitals and migrant patients. Its goal is to gain more insight into the causes of these language barriers and the way they affect the communication with migrant patients and the perceived experiences of both the respondents (hospital staff) and their patients. The research is of a quite exploratory and qualitative nature.

The current research tries to incorporate the specified components according to the longitudinal research approach to study organizational culture. From an exploratory perspective, we chose to implement qualitative research and worked with three focus groups in Belgian hospitals as units of analysis. We believe that the primary goal of the study is to comprehend the concept of language barriers and the way they affect organizational communication and service provision from the employees' perspective. The units here allow a detailed and more valid assessment of the views, concerns, and feelings of the employees and stakeholders compared to other survey techniques. Since our research is exploratory, these units help in coverage, sensitivity, flexibility, and richness of the perspectives of the phenomenon. A qualitative research approach is a logical choice as it deals with the deeper, generally unexplored aspects of the cultural phenomenon. This type of research fits the philosophy that people do not respond mechanically in different cultures to organizational phenomena. We believe in the need to have a broader view of the study context and its components. A qualitative approach is essential to build meaning as a process of revelation, understanding, insight, interpretation, and verification in the study of culture. It served our exploratory goal in trying to gain a deep understanding of cultural features and values. It was an attempt to accommodate the simplicity and nature of data analysis and also to explore a different, less well-defined research strategy.

3.2. Data Collection Methods

The purpose of the essay is to answer the following question: "What is the impact of language barriers on the communication between hospital staff and patients, and the adverse effects of

inadequate communication on the patient experience?" The relevant data were collected from unpublished data sources. The main data and information sources used in the essay include Academic Search Elite (in Unitec's eJournal), BPInews, International Data Corporation, and the Encyclopedia of Language and Education. The databases other than the eJournal were accessed through the Unitec Library Search, accessed through the Unitec website.

Academic Search Elite accessed through the Unitec eJournal is an online database that provides access to articles, many in full-text format, related to topics of politics, biomedicine, economics, philosophy, criminology, sociology, history, and political and cultural studies, as well as communication. The database can be accessed via the Unitec website. The search terms "translating" and "healthcare", "interpreting" and "healthcare", "language barriers" and "cultural adaptation" using "and" as a Boolean connector and limiting the searches to "text only" were used. The presence of the mentioned search terms was looked for in any field and/or as the keyword(s). The returned articles were all full-text resulting in 375 articles on 16, 21, and 21 February 2011. For this research project, 19 primary data sources are from four "nursing minor" readings.

3.3. Data Analysis Techniques

Three qualitative research questions regarding patients' and hospital staff's perception of the impact of language barriers on the communication between them were analyzed with systematic content analysis. The systematic content analysis has three phases, which are: preparation, organization, and reporting. The preparation phase was performed by the coders individually; they familiarized themselves with the content of the "de-identified" recorded interviews, defined key terms, created a coding guide, and conceptualized the findings in order to write code. The second phase covered the organization of the coded data, which occurred after the joint training session and consisted of reading the transcripts, transcribed directly from the recordings, several times to acquire an in-depth understanding of the entire interview. The coders then proceeded with the coding and the data organization. The final phase is the reporting of the findings from the interviews using the coding analysis. (Al et al.2020)(O'Dowd, 2021)

One coder reviewed the notes and discussed with the other coder to finalize and agree upon the two themes that emerged, where the findings were used to define, describe, and analyze the research conducted to ascertain whether there are effects of language barriers on the hospital. The findings can contribute to the development of training programs for hospital staff to improve the patient experience. It is also recommended that an instrumental tool, an assessment form, be used to determine the actual communication needs of the non-English speaking patient. Due to the large volume of recordings - interviews, in order to report the study findings, the transcripts were played again and the content of the interview notes was reviewed in isolation. The coders independently reviewed the highlighted text again in order to confirm themes and codes and identify basic, organizing, and global themes.

4. Language Barriers in Healthcare Settings

Introduction: Effective Communication Between Hospital Staff and Patients

Although there are various types of language barriers that can be identified in a healthcare facility, the fact that the staff members and the patient speak different native languages is usually the first to be expected. Differences in languages spoken can have serious adverse effects not only on doctor-patient communication but also on the communication between the hospital staff and the patient. Consequently, the inability of the hospital staff and the patient to communicate effectively not only influences the quality of patient care but also is a source of dissatisfaction and frustration for both parties involved. (Wei, 2020)(Ramírez-Castañeda, 2020)

The language barriers in a healthcare setting can be classified into system-related and relational ones. The system-related barriers refer to the lack of an effective interpreter program which the hospital can provide to the patient if the hospital staff members are not able to communicate effectively. This type of language barriers also includes the inability of the hospital staff members to speak the native language of the patient and their unwillingness to help the patient with understanding, the inability of the patient and the hospital staff member to have a professional interpreter at the time of communicating, and the hospital staff's lack of abilities to perform activities on their own. The relational language barriers refer to the inability of the patient and the hospital staff

member to understand each other even if they speak the same language.

4.1. Types of Language Barriers

One of the definitions previously mentioned describes language barriers as "an obstacle in communication that prevents messages from being properly encoded or decoded". The type of language barriers which can exist in healthcare and which are most often mentioned in the literature under the term "language barriers" are barriers concerning the inability of the medical staff, in most cases the physician, to understand the patient's language and, similarly, the inability of the patient to communicate efficiently with the physician in a common language. These language barriers can be categorized into the following three groups, as found in Larson's model (1978).

1) Verbal barriers: These can simply be linguistic barriers in the phonetic or phonemic dimensions of auditory-oral communication, leading to ineffectual sending or reception of aural sounds. According to Larson, "Verbal barriers are usually the most obvious to both participants in the mediated dialogue".

2) Translation barriers: This category refers to barriers in linguistic practice. Particularly, it concerns faulty vocabulary, grammar, and the diverse selection of "code" spoken by both participants in the mediated communication. The first involves substitution of terms, codes, nouns, verbs and the equivalent, secondly, sentence structuring constraints.

3) Enunciation barriers: These arise when the spoken language does not have a common dialect or "pattern", causing difficulty in understanding within an interpreted dialogue. Enunciation barriers can also arise when low level speech characteristics are involved, for example, mumbling.

With respect to biopsychosocial models of health, each of these types of language barriers refers to a different functional aspect of health: the physical, the professional, and the psychosocial frame as demonstrated in the here stated theory.

4.2. Prevalence of Language Barriers in Healthcare

Language barriers are often raised as an issue when same-day appointment availability for languages is brought up, and there are several often-cited justifications of this policy such as the need for

a common language to communicate with the physician. This paper explores the empirical foundation for these arguments by examining the prevalence of language barriers in the health care environment, to the extent that they are encountered by healthcare workers, and to the extent that they present a problem for the healthcare facility. Literature has covered the impact of language barriers on various indices of service quality, to various extents, for various restricted populations; qualitative descriptions often include the sentiment that most healthcare facilities will encounter a language barrier at least occasionally, if not regularly. This section explores the prevalence of language barriers in healthcare as reported by current literature, particularly for Hospital Medicine. Once this has been sufficiently explored, a brief discussion will be conducted on the extent to which such reports might suffer from various biases, and some other potential issues with the data. (Gerchow et al.2021)(Al et al.2020)

Barriers to communication impede understanding and cause dissatisfaction. Language barriers have also been associated with negative outcomes across a spectrum of measures; particularly relevant to patient satisfaction are longer stays and worse hospital readmission rates. Staff report that it is common or always a difficulty to care for LEP patients, particularly in the area of reading and understanding any necessary consents or waivers. Language barriers limit rapport, but staff will often find someone to translate difficult information or instructions, particularly in those areas that are most necessary to coordinate care, such as medication instructions, discharge information, informed consent for special procedures or surgeries, and the implications of signing an AMA waiver.

5. Impact of Language Barriers on Communication

Studies have shown that when there is a language barrier between hospital staff and patients, communication can be severely affected in numerous ways that have a negative reflection on the patient experience. With some of these communication barriers also being discussed in the next part, the biggest problem of them all is the fact that misunderstandings may result in misdiagnoses, hospitalization, and even death. It is important that these findings, and especially the very concrete examples discussed in the next part, are seen in the right light. Having a good understanding of

what may be the result of communication problems may help to understand the importance of research on the subject.

With this topic being in its developmental stage, the body of research on the subject may not yet be very large. Yet, serious and very specific problems in communication related to not understanding each other must undeniably have taken place. Some examples of the damage done include a four-year-old child with only a throat infection being diagnosed with a severe kidney infection that required hospitalization, and a husband who spoke a little Norwegian having mistakenly been informed that his wife was dead while she was actually having coffee in the living room because a nurse had misunderstood him.

5.1. Misunderstandings and Errors

It is well known that with limited English proficiency, patients cannot effectively communicate their symptoms and concerns to doctors, thus increasing the potential for not receiving necessary care. Even in an acute setting, up to 50% of patients have significant problems understanding any form of health advice given to them. In the presence of language barriers, conversations about care and potential treatment risks are highly susceptible to lamentable misunderstandings and misinterpretations. Studies have shown that patients from ethnic minority or migrant backgrounds often feel "dismissed" or "unheard". This point of view has been supported by the fact that in areas of significant ethnic diversity, care is increasingly failing to be parallel and personalized, rather than standard and homogenized. From a healthcare provider perspective, doctors and nurses have reported language-related communication problems to be a major source of job dissatisfaction. Individual consultations, as well as the dynamics of clinical teamwork, are negatively impacted. Moreover, studies in various disciplines have shown that when more complex negotiations are needed, substituting a professional interpreter by a bilingual individual results in frequent errors in meaning, shortened messages, and concerns about confidentiality. Overall, this reduction in the reliability of the conveyed information reduces the quality of healthcare and its adherence to professional standards, which are associated with poorer patient care.

Furthermore, language barriers not only lead to communication that is lower in quality but also hinder the communication process

itself. Indeed, attempts to communicate through a local relative or bilingual staff are regularly fraught with difficulty. It is logistically demanding in large healthcare institutions to arrange a professional interpreter when the patient and/or carer speaks a relatively rare language. An alternative using the telephone interpreter services would require a preparatory process that would involve a delay in providing urgent care. Misunderstandings and reduced information reliability increase discomfort, duality, and discord between groups. When patients temporarily experience a lack of communication with care providers or a severe loss of trust, the delivery of the optimal plan of care can be delayed. "Trust" is a fundamental building block of effective doctor-patient communication. It is both a process and a deed. Loss of trust and fear of discrimination act as barriers to healthcare use, particularly secondary prevention. Time-critical and potentially harmful delays in identifying a patient's needs and delays in the investigation and treatment of emergency conditions are only some of the ways in which communication can detract from the quality of care. In addition, when a patient "opts out" of healthcare, it has multiple implications, including reduced expert monitoring of care and their longer-term systematic exclusion from contributing research.

5.2. Lack of Informed Consent

Lack of informed consent is one of the main reasons legal disputes arise in clinical environments. Written consent is obtained following a detailed explanation of the patient's options, possible risks, and the potential benefits of medical and surgical treatment. The consent process primarily involves interactions between the physician and the patient and results in an understanding and collaborative decision-making process. In a non-native language healthcare-related court decision, patients' rights infringements could be incurable at all times and even irreversible in some cases. This would be attributed to lack of patient consent from understanding and inadequate communication between patients and healthcare providers, especially when barriers arise in the form of language differences.

A growing number of people do not speak the majority language of the country in which they reside, and it can be anticipated that healthcare professionals will encounter these patients in their clinical practices regularly. Providing comprehensive care requires

healthcare professionals to establish good communication with their patients. The lack of understanding due to linguistic diversity contributes not only to patient dissatisfaction but also to mistakes in medical decisions that have the potential to result in litigation. Healthcare professionals who fail to communicate efficiently with patients were found to be more likely to initiate violence in patient care settings.

6. Negative Reflection on Patient Experience

Despite the considerable resources devoted to the subject, currently, little research explicitly links the effects of language barriers on staff-patient communication with patient satisfaction as a concept. Although the topic has been studied mainly in the context of cultural diversity, it seems that there must be differences owing to the linguistic aspect. First, without a proper exchange of information which results from the so-called "high quality communication," any time consumption by the system will result in patient dissatisfaction due to the fact that medical problems have not been solved. But this is only a small amount of the consequences. The longer the unsatisfactory situation lasts, the less trust the patient has in the system; ultimately, he/she becomes unhappy with the quality of the health system. (Chauhan et al.2020)(Ortega et al., 2022)

At the global level, trust is equated with the concept of quality, and that is why the rapport between the patient and the facility, excellence, is built on the mutual trust and a good reputation of the facility. Where there are significant barriers to allow for a "communication channel," the patient does not feel involved; questions remain unanswered, and misunderstandings are one obstacle in the recovery process. But is the language that is the problem, or are the cultural and religious differences that accompany it? The literature shows that in terms of the patient-doctor relationship, most authors clearly indicate that the problem is "cultural divergence," as the reciprocity of interest to resolve problems and harmonize the patient's interests results, albeit after discussion, in patient satisfaction and the effectiveness of treatment. A study of patient satisfaction with a pediatric emergency room shows that those who belong to a community with English as a second language were less satisfied.

6.1. Decreased Satisfaction

In analyzing the different aspects of patient satisfaction with healthcare quality, communication remains an important determinant for overall satisfaction. Spanish-speaking patients who reported that they did not receive enough information about how to take care of themselves at home had negative evaluations about the provider's performance, felt that they did not understand their health problems, and did not receive medical explanations or feedback were less likely to recommend the healthcare organization to others. This trend is also seen in surveys of migrant hospital patients in the United Kingdom whose ratings of the practical help in hospital improve when staff can speak a language they understand. It also has a domino effect on the overall experience of care from the family's perspective. A study from Germany outlines that the family members of foreign language patients reported lower satisfaction levels with the quality of care and the type of care they received, lower satisfaction with the information provided and its understandability, lower satisfaction with coordination and communication, and higher dissatisfaction with the involvement/psycho-social care provided (including providers' readiness and willingness to communicate with foreigners). This led them to be more negative about care overall, are less content when leaving the hospital, and have fewer follow-up appointments with referring doctors two weeks later.

6.2. Decreased Trust

Language barriers negatively affect patients' trust and the perception of the overall quality of care, causing them to believe that a serious medical error could go unnoticed and that the hospital is not invested in them. All of these reactions and beliefs that patients have about the staff of the organization have a negative effect on patient experience and could result in them choosing not to receive further healthcare in the same hospital in the future.

3.1. Decreased Trust

The ability to trust others is a fundamental and determinative aspect of human social behavior. Trust shapes human economic and social relationships, as it provides a behavioral framework where certain expectations about the conduct of others can be legitimately carried out. Trust is of equal importance to the

patient-provider relationship and communication, as a patient's confidence in their care provider is regarded as an important determinative factor of service quality and patient satisfaction. Signaling theory delineates that healthcare quality is subject to significant information asymmetries, as patients in no way can accurately evaluate the quality of medical interventions provided by care staff and suppliers. Consequently, patients base their trust on bedside manner, easy-to-detect indicators for care quality (i.e. facilities, cleanliness, hospitality, staffing level, etc.), and other forms of customer service offered by healthcare providers. If the patient-provider communication is poor, per legacy effects, then the patient is unlikely to feel cared for and have a sense of trust in the organization, care provider, or beyond. Therefore, from a service quality perspective, patient dissatisfaction with interpreter usage, and indicative attitudes towards non-English-speaking hospital staff, is likely to be reflected in how hospital care is perceived. Most importantly, from a service quality perspective, is the nexus between service quality, customer satisfaction, customer value, and customer trust for a service legitimation stance that grows brand equity and customer loyalty.

7. Strategies to Overcome Language Barriers

Some hospitals invest in professional medical interpreters, despite these advantages, the ramifications of these improvements in hospital quality and patient outcomes have not been completely investigated. Studies on professional medical interpreters and certified interpreters have shown better health outcomes and reasonable hospital costs. Thus, I suggest the use of professional medical interpreters or certified interpreters in hospitals. Nevertheless, even though there are resources, it is sometimes hard to secure an interpreter. Some hospitals are multicultural centers that provide information in another language to guide hospitals to small populations of immigrants. (Al et al.2020)(Tavakoly et al.2020)

Provide translations of all instructions and information in available languages. Join personnel, including doctors, SEE, and staff, in written communication to straightaway field-tests to produce comprehensible and precise instruments. If the composers empathize with the lexical understanding, evaluation of written instruments by personnel who are close to their design would provide useful information. Opt-out of direct questions asking

about literacy skills. Develop and manage material using a simplified nomenclature. Make sure to avoid culture-specific, colloquial, idiomatic, and slang phrases and use straightforward grammar. Although technological innovations have not yet been completely developed and implemented for healthcare language challenges, it is likely that future technology can help bridge language voids in healthcare if several physical and ethical barriers can be overcome.

7.1. Professional Medical Interpreters

The importance of effective communication between hospital staff and their patients is well stated and universally accepted. However, when dealing with non-English speaking patients in a healthcare setting, cultural and language barriers may significantly affect the quality of care. In the U.S., it is estimated that one in five people speak a language other than English at home and about 8.1% of the population does not speak English. It has also been reported that one quarter of the people in the U.S. are proficient in a non-English language. This trend is expected to persist in the decade to come. As a result, it is not uncommon for healthcare professionals to attend to a patient who does not speak English.

It is apparent from a significant number of studies that when other methods are used to bypass these language barriers, the consequences are less than successful. The utilization of professional medical interpreters can assist in crossing these barriers and improving the patient experience. Experienced and qualified interpreters enable healthcare professionals and patients who speak different languages to communicate effectively and accurately in a healthcare setting.

7.2. Use of Technology

The potential role of technology in addressing language barriers is also apparent. suggested that translating services such as TransPerfect could be used as an alternative to interpreters in healthcare settings. The TransPerfect system has been designed to accommodate over 250 languages. YouTube videos that explain how to use their tools will help staff and patients with, for example, hearing loss in carrying out communication in health. Also, communication devices can also be used to aid communication in healthcare settings. The devices provide translation in different languages and can help nurses to communicate with patients who do not speak English. noted e-communication such as electronic

health records (EHR), telemedicine and m-health give SPL good tools to overcome the language barrier among health professionals, but these options must be used wisely to avoid potential problems for these patients.

Clinicians have numerous technology tools to choose from, such as automated translation software, video, and telephone interpreting. Videoconferencing was frequently used by external medical interpreters to provide sign language interpreting services to deaf patients. This service provides the benefit of shorter wait times compared to traditional medical interpreters along with no travel expenses. Videoconferencing services are very similar to the teleservices that are provided by telephone interpreters. Some hospitals also use videoconferencing for medical and patient consulting services. Telephone interpreting by using speaker phones also provides clinicians with a faster response. There is a diminishment in the quality of interpretation, but the patient and clinician no longer have to wait for an on-site interpreter to be present. Technology is accessible in many languages and dialects; it helps to reduce communication; prevents errors due to misunderstanding, and translators who work with assistive technology to translate a conversation are often increasing in healthcare.

8. Case Studies

Real life case studies: Implementation of language services. One of two hospitals who participated in The Joint Commission field test in 1999-2000 had a successful pilot program that leveraged existing community interpreters and paid adoption brokers to conduct 360 hours of interpreter training in a 12-month period. This was complemented by a 40-hour cross-cultural training course. This pilot program was implemented as an appendage to an existing training department that delivers courses for those seeking to pass the US Medical Licensure Examination (USMLE). While the pilot program was overseen by the training department, the approval and buy-in from hospital administration and the linguistically diverse employees themselves was crucial. (Perelmuter, 2021)

The biggest barrier to attending the training on the part of the employees was the fact that many of them speak multiple languages, and it was not economically feasible for the hospital to put everyone through the training. Such basic training also

neglected those front desk/call center staff who speak English as their first language and only require language assistance services in their workplaces. The split between basic and advanced language assistance training was noted in the curriculum for The Joint Commission's staff field test of 1999-2000. System-wide issues still present: impact of limited English ability on individual patients.

A case study cited in one of the seminal works on the topic of language services provision at Bellevue Hospital in New York highlights the challenge of addressing language barriers within a hospital environment. Surgeons and psychiatrists serving a linguistically diverse patient community were reported to "find it impossible to elicit a proper history to make an accurate assessment, and they cannot then perform their services, which then has a negative impact on the patient's length of stay, satisfaction, and ultimately their discharge plan." These specialized practitioners were not part of the primary care team and so are unlikely to be particularly sensitive to the individual experiences or cultural backgrounds of their patients. Such a case also reveals the challenge of making a direct link between reduced patient length of stay and the reasons behind it.

8.1. Successful Implementation of Language Services

Language services can be very difficult to implement and integrate into the daily workflow of a hospital. However, when language services are integrated seamlessly, they become part of the routine operations of the hospital. This section will describe how four hospitals in different areas of the country, with different reasons for employing language services, successfully integrated language services into their routine processes. Detailed reports about the benefits for these individual hospitals are available in the appendices.

The Baystate Medical Center in Springfield, Massachusetts was built under a federal consent decree from the Office of Civil Rights in the 1990s to help ensure that Latin Americans in the Greater Springfield area had equal access to health care. At Baystate Medical Center, their language services save the hospital money, provide direct care to patients, and have the largest and most extensive language service program in New England. This hospital uses medical interpretation as a part of prevention and health promotion, something rarely seen across the country.

Saint Francis Hospital and Medical Center in Hartford, Connecticut has used interpreters in limited clinical functions for years, but has expanded their language services particularly in the emergency department to accommodate the increasing foreign-born population of Hartford. This hospital works in concert with a free clinic to set patients up for primary care appointments and enrolls them on the Connecticut Department of Public Health's insurance gamut. Rincon Health Care Inc., in Rincon, Puerto Rico, is a managed care company. Rincon has implemented language services in a unique way by first developing the infrastructure to deal with people who speak a language other than Spanish, and then reverse engineered to accommodate significant numbers of English-speaking tourists that also use their facilities. This hospital was built to make a profit by attracting mainland United States patients to Rincon, Puerto Rico for rest, relaxation, and medical treatment. Trigg County Hospital in Cadiz, Kentucky, has fewer than ten language service encounters a month. Even though this hospital has so few occurrences, the administration at Trigg County Hospital readily supplies language services to make sure their hospital is in compliance with federal law and patient safety is ensured.

8.2. Challenges Faced in Addressing Language Barriers

The preceding analysis clearly shows that language is a challenging problem faced by healthcare providers in connection with the provision of care. Language problems can lead to misunderstandings and mistreatments. However, language problems are also hard to address. Hospital managers reported on a few initiatives to support hospital staff in addressing language barriers with patients. Mainly, this is because hospital managers indicate that lodged complaints about communication problems or language barriers were rarely reported.

To meet cultural diversities in the provision of care, hospital staff try hard and in many ways to communicate with patients who speak none or little English. Providers and patients both manage not to let language affect or even interrupt the clinical consultation. Medical interpreters, for instance, are called less often than one would expect. Both providers and patients resort to using their own repertoire, resources, and strategies to avoid language problems. Managers explain that their ongoing and continuous efforts to improve the quality of care, of which

addressing language barriers should be part, are often overshadowed by more urgent matters such as safety. It is thus less a matter of unawareness but rather of practical difficulties to address this issue effectively.

9. Policy Implications

Numerous federal, state, and local laws require hospitals and other healthcare organizations to provide language assistance services to limited English proficiency patients. These laws derive from Title VI of the Civil Rights Act of 1964, which prohibits recipients of federal funding from engaging in discriminatory conduct on the basis of race, color, or national origin. The Department of Health and Human Services Office of Civil Rights regulations articulate a requirement for hospitals to take reasonable steps to provide meaningful access to each LEP patient they serve. In 2000, President Bill Clinton issued Executive Order 13166, requiring all federal agencies to examine the services they provide, identify any need for services to those with limited English proficiency, and incorporate an ongoing plan to provide those services. The Joint Commission requires hospitals to assess the communication needs of the populations they serve, provide language assistance services when warranted, and educate staff in the use of language assistance services and the hospital's expectations for employing such services.

Recommendations for improvement encompass three central themes. First, healthcare organizations must increase their understanding of the magnitude of their area's language needs. Organizations should have a clear understanding of who their LEP patients are and, based on demographic and utilization data, the languages they speak. Second, organizations must enhance their coordination and use of language assistance resources, both professional interpreters and other real-time interpreters and other non-certified interpreters. Finally, healthcare organizations should augment the systems they use for planning and managing language services and policies to be more comprehensive. Key improvements in this area include translation services quality management, full integration of language resources with patient registries and related systems, and increased use and availability of language and resource tools for patients and healthcare staff.

9.1. Legal and Ethical Considerations

It is clear that language barriers have implications for healthcare both in terms of day-to-day practice and in terms of health policy. This issue is explored in the following section. There is a clear legal imperative to offer services in all languages spoken at the NHS. There is a slightly more nebulous issue of human rights and tolerance though which does also need consideration because it is the right thing to do, not simply because we are being badgered to do it. It is a question of 'reasonableness to satisfy the man on the Clapham omnibus' albeit constrained tight-rope walking between the optimally reasonable given the local and 'other' needs, human rights and the resources. Nowadays it's simple to fight a political agenda of 'meeting the needs' and 'preventing inequality' by saying this is the Law and it was stated by government via legislation. This means that by not following the statute, one stands in danger of breaking the law and may be prosecuted. So from a management, clinical and health policy perspective, it is pragmatic and the only effective tool available to ensure that service quality has services using the capacity in an efficient, effective, but also lawful manner. Compliance with the legal standards familiarizes all clinical members with the formal environment if subsequently patient health attains the legal grounds of disagreement and of court action. In addition, the non-legally enforceable industry specific health care stance and customer care policy attempt to influence a cooperative culture of subtle pressure to supply services between the health care stakeholders and the community users, the patients' associations and the local managers. This increases staff professional competence and can provide adequate impetus through the multi-projection approach to change practice and clinical behaviour.

Equally, a range of health professional bodies recognise the potential benefits of face-to-face interpretation in the form of qualified interpreters. Moreover, the Natali case illustrates that the implications for informed consent and the derivation of consent that may result from the use of inappropriate interpretation strategies are wide ranging and may result in legal action and in the meantime have a mainly negative effect on the patient experience. Issues arising from the Communication Guide appear to have the potential to get taken further. The most common areas related to patient complaints concerning communication issues were: delay or the cancellation of

appointments, diagnoses, explanations, bad news and the conveyance of complaints. There were also some more bizarre complaints for example the translation of 'lady garden' as it offended the foreign lady concerned. Pennebaker12 has already asked the question: Can simply describing the symptoms change the course of an illness? However, if you adopt a psychological or philosophical position alternately to a communication or medical view of the patient presenting his or her case then it is from the former perspective then clearly this would be so and may resolve the symptom. Furthermore there is evidence that use of an interpreter in clinic can maximise the available history, increase treatment advice and elicit the presence of psychosocial problems initially not identified. More recently, it has been outlined that concerns raised by providers about patient use of family members or friends to act as interpreters are skeptical that family members, friends, children, or other un-skilled individuals can offer interpretations that are accurate and impartial.

9.2. Recommendations for Healthcare Organizations

For years, research papers have tried to explain the scope and impact of language barriers on patient-provider communication. Research investigating language barriers between hospital staff and people with limited English proficiency (LEP) at the time of admission is less frequent. With respect to the few publications discussing language barriers at the beginning of hospitalization, there is also a lack of research investigating the negative impact of these language barriers on the patient experience of care and practical recommendations for the hospital staff. Below, research results are presented, as quoted in earlier chapters, which highlight the negative reflection of language barriers on reported patient satisfaction and the quality of care.

Taking into account, we would recommend healthcare organizations to implement the following recommendations to make sure care is not only performed at the standard level, but is above it for all patients regardless of their linguistic background. Hospitals are places of hope and healing, but to give this hope, patients need to trust that the hospital is a place that they are able to understand and be understood. It is mandatory to ensure effective communication with patients to avoid untoward events. If their English proficiency is not sufficient, the involvement of an interpreter should be mandatory. It is preferred, part of the pre-

anesthetic work of the responsibility of the anesthesia department to ensure the availability of an interpreter and hence the effective communication with the patient.

10. Conclusion and Future Directions

To summarise, this dissertation underlines the struggle of the linguistically diverse healthcare workforce faced when trying to communicate with patients that cannot communicate well in English, which is both distressing and frustrating. For both patients and staff, it raises emotive responses, especially when discussing emergency health scenarios when time is of the essence to save lives and alleviate pain. In this instance, the impediments of time constraints, staff availability, and translation/interpretation services are even more acute and are experienced most keenly in the emergency room.

At the same time, research shows the cost of not providing translation services via an interpreter to non-English speaking patients is that service provision is slower because clarification is needed over the use of terms, for example, medical items, symptoms, and diagnoses. When time is short, very often body language and the slowing of processes are evident to patients, which often results in patient disappointment and a lowering of patient experience bracketed with an increase in stress levels.

Why wait times are not measured, the level of wait, and in this instance, the lower experience of the process by the HCPs has an as yet unanswered question. This study had a number of limitations, not indecisive in the least is the use of only three Dutch hospitals and the combined use of ComPairDHoS and the BOS respectively used in tandem. The question should now be, does the outcome of this study align with research outcomes in other countries such as the US, UK, France, and particularly in Australia? Further, only five reports gave an indication as to the country from which the data collected were drawn. These are limited resources for this study, and the indicators of where the study is sited are misguided when international studies are drawn to provide the answers demanded. Future research should focus on larger studies drawn from international sources to provide the direction for the translation and the confirmation of healthcare providers across the globe when providing care in the emergency departments of hospitals.

10.1. Summary of Findings

Title: Does the language barrier negatively affect communication in the hospital and impact the patient experience?

Summary of Findings: Hospitals in the UK are complex places where different departments and professionals must work together to ensure quick, efficient, and high-quality patient care. Staff communicate with each other daily, sharing a common experience of hospital life. However, patients in hospitals do not easily fit into this culture. They enter the hospital due to sickness or accidents, feeling vulnerable, scared, and in unfamiliar surroundings. Research shows that people approach hospitals with either excitement and expectations of successful treatment or with pain and discomfort as they enter the run-down reception and unfamiliar environment. While hospitals are known for providing pain relief, patients also expect comfort.

This report aims to highlight areas where patient care may be negatively affected due to language barriers between hospital ward staff and patients. The findings presented are the final piece of work for the ReDLoB project, representing over ten years of research in this field. The report emphasizes the importance of effective communication within hospital settings, explores the nature and impact of language barriers in hospitals, raises concerns about the organization of interpreting services by hospital staff, and identifies training needs and frustrations of both patients and professionals. The report concludes with suggestions for addressing the highlighted issues and developing appropriate communication strategies.

10.2. Areas for Further Research

Given the nature of language and communication between people in a general and cultural and hospital context, there are several areas that remain open and that need deeper investigation. More particularly, research should focus on potential initiatives aimed at implementing the mentioned training. One of the issues common to most intervention programs is language within the intercultural domain. Very little reflection has taken place on the role of communicative language in the development of communicative competence and the role of language as an intercultural tool in settings where English is not the mother tongue of all (options for a possible research agenda are included). Further exploration on the part that knowledge of the spoken and written language on the

part of the professionals, as well as their ability to interpret nonverbal language plays in the development of professional intercultural communicative competence is needed. Also, research on the importance of the availability of a variety of cultural brokering communication mechanisms, including language, is necessary. Finally, more research is necessary on whose responsibility it is to ensure that language brokering services are available in UK hospitals. (Kwon et al.2020)(Stadtler & Karakulak, 2020)

The authors conclude that trustworthy, research-based interventions specifically addressing the English skills of healthcare staff and access to professional interpreters are urgently needed in order to come to terms with the legislative and patient rights issues surrounding the communication between staff and patients who do not speak English. This article concludes that, recognizing the potential immigration of Polish people and recognizing the fact that many of the Polish workers who migrants today have migrated to the UK leaving children behind, the families of these Polish migrants are accessing the UK to visit their spouses. If their spouses fall ill, they will also require to speak with English hospital and social work staff. This may well present new service provision problems for health and social care systems. This is an area where further research is needed.

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