Allyship Means Action Tip Sheets
Department of Obstetrics, Gynecology and Reproductive Sciences
Providing Linguistically Appropriate Care

Reference Administrative Policy Number 9.05: Language Access Services.

- **Recognize that linguistically appropriate care is a fundamental component of equitable and safe care, and commit (as individuals and teams) to providing linguistically appropriate care to all patients.**
    - Promote self/team-awareness (and necessary action) about the factors which enhance and reduce capacity to meet this goal.
    - Include patients' language needs as a standard element of team communication.
    - Normalize "speaking up" by all team members as a means of advocating for linguistically and culturally appropriate care.

    I'm concerned that the patient may not understand all of what we say (or that we do not understand the patient). Let's call a time-out to partner with an interpreter.

- **Effectively elicit patient's language preferences at the beginning of the encounter.**
    Which language do you prefer? Or In which language do you prefer to receive your care?

    <u>Not</u> *Do you speak English*? (Note that clarifying language preferences may require partnering with a Qualified Interpreter.)

- **For patients with limited English proficiency, regardless of whether they state English or another language as their preferred language, explicitly state that they are legally entitled to communication with the support of Qualified Interpreters.**

- **Collaborate effectively with Qualified Interpreters.**
    The clinician…

    - faces the patient, ideally at eye level.
    - speaks directly to the patient and uses active listening, including nonverbal cues such as eye contact.
    - negotiates a shared agenda with the patient that accounts for the time demands of an interpreted encounter.
    - builds rapport and trust with verbal and nonverbal expressions of empathy.
    - speaks briefly, allowing for the Qualified Interpreter to provide thorough interpretation.
    - provides timely clarification when requested by the Qualified Interpreter or patient.
    - uses teach-back to assess understanding, especially for key elements of the care plan.

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- **For patients who decline a Qualified Interpreter (either to engage with a Certified Bilingual Clinician, Designated Bilingual Staff, Non-approved Bilingual Staff, or family member OR utilize English as a second language), explicitly invite ongoing feedback regarding the adequacy of communication.**
    - Consider that power dynamics inherent to the patient provider relationship may necessitate repeated check-ins before a patient feels empowered to request interpreter services.
    - Avoid relying on family members as interpreters, especially when discussing themes that may be heavily influenced by family dynamics or personal values, such as family planning, end of life care, or choosing between treatment options where the evidence does not clearly guide practice.
    - Recognize that partnering with a Qualified Interpreter may be necessary to provide safe care even when it is not the patient's preference.

We are committed to communicating effectively with you. Throughout the encounter, we want you to understand and also feel understood. If at any time we are not meeting this goal, please let us know immediately.

I'd like to check in with you about how the encounter is going. What can I do to improve our communication?

I understand that you prefer to communicate with the help of your family member. At this time, I need for us to work with a Qualified Interpreter so that I can provide you with the best care.

- **Promptly identify "red flags" indicating the need for a Qualified Interpreter.**
  [excerpt from Regenstein M, Andres E, Wynia MK. Appropriate Use of Non-English Language Skills in Clinical Care. *JAMA*. 2013;309(2);145-146]

    - **Word finding**
      The clinician cannot think of a good word to describe a concept.
    - **Rephrasing**
      The patient displays lack of understanding during a teach-back communication, and the clinician cannot rephrase the concept or instruction in a different way.
    - **Emotional disconnect**
      The patient displays an emotional response that does not seem to match the content of the conversation.
    - **Patient editing**
      The patient needs to edit what she or he says or speak noticeably more slowly than normal. This may require exploration on the clinician's part to elicit.
    - **Novel topic or issue**
      The encounter turns to a subject that is unusual, novel, or something the clinician does not usually handle.
    - **Confusing answer**
      The patient's description or answer to a question does not make sense and requires repeated clarification.
    - **Confusing question**
      The patient asks a question that is confusing or seems to be out of context.

- Other potential red flags of a current or prior communication barrier:
    - The patient has no questions.
    - The patient chooses to speak English with English speakers and another language with staff fluent or proficient in that language.
    - Documentation about the patient's history is not consistent with current history or the patient does not recognize elements of the history being reviewed.
    - The patient describes a previous clinical encounter very differently from how it is documented in the patient's chart.
    - The patient has numerous questions about a conversation had with a previous team member.
    - The patient defers to a family member to ask and answer most of the questions, allowing that this may be culturally appropriate in some cases.
    - The encounter does not pass the "English-speaker equivalency test": *Would my counseling/education/treatment options have been the same (within culturally appropriate norms) were this patient an English speaker?*