Patients With Limited English Proficiency: A Challenge for Oncology Nursing Providers

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BACKGROUND: Limited English proficiency (LEP) is a limited ability to read, write, speak, and understand English. About 145,000 individuals with LEP will be diagnosed with a new cancer annually, and English remains the dominant language spoken in the U.S. medical system.

OBJECTIVES: The goal of this article is to discuss the issues faced by patients with LEP and cancer who are unable to communicate effectively with oncology providers.

METHODS: This overview used published U.S. government statistics, information from consensus and policy organizations, and clinical studies published between 2017 and 2022.

FINDINGS: Federal laws prohibit discrimination based on immigration status. People with LEP experience delayed cancer diagnoses and often receive inadequate treatment. Patients with LEP often have limited understanding of the medical system and do not receive language-concordant information about their cancer and treatment options.

KEYWORDS
limited English proficiency; language barriers; cancer care disparities

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LIMITED ENGLISH PROFICIENCY (LEP) IS DEFINED AS ENGLISH as a second language and a limited ability to read, write, speak, and understand the language (Foiles Sifuentes et al., 2020). Between 2016 and 2018, about 64 million Americans aged 5 years or older spoke a language other than English at home, of whom 40% reported that they speak English less than very well (Farina et al., 2022; U.S. Census Bureau, 2022). A 2022 report by the Migration Policy Institute reported that 25 million people, 8.2% of the U.S. population, have LEP (Esterline & Batalova, 2022). The United States' immigrant population is expected to increase from 44.9 million in 2019 to 69 million by 2060 (Esterline & Batalova, 2022; Vespa et al., 2018), representing an increase from 13.5% to 17% of the total population (see Table 1). This is the second highest rate of immigration since 1890 when immigrants comprised 14.8% of the U.S. population (Esterline & Batalova, 2022). Asia has replaced Latin America as the main region from which U.S. immigrants originated (Vespa et al., 2018). The literature often uses the terms "foreign-born" and "immigrant" interchangeably when referring to people who were not U.S. citizens at birth, lawful permanent residents, refugee and asylum seekers, people on certain temporary visas, and unauthorized immigrants (Esterline & Batalova, 2022); this article will use "immigrant" as an all-inclusive term. Individuals born in the United States may also have LEP.

Cancer remains the second most common disease in the United States, with nearly 1.9 million new cancer cases expected in 2023 (American Cancer Society, 2023). Cancer care disparities among underrepresented and minority immigrant populations are increasing as population demographics continue to change (Alcaraz et al., 2019; Smith et al., 2009). Smith et al. (2009) predicted a 100% increase in cancer cases among underrepresented populations by 2030. Overall, cancer death rates have decreased in the United States, but immigrant populations still have a disproportionately higher incidence of cancer and mortality rates (Alcaraz et al., 2019). Fang and Ragin (2020) reviewed 42 studies pertaining to the topic and noted that immigrant, migrant, and refugee populations continue to experience a greater risk of cancer and have less access to cancer screening and health services. Although several studies have reported progress in reducing disparities in screening rates, it remains a challenge to close the gap in cancer screening among U.S. immigrants (Fang & Ragin, 2020).

It is estimated that about 145,000 people with LEP will be diagnosed with a new cancer annually (Farina et al., 2022). Although many people are emigrating from countries where English is not the predominant language (Vespa et al., 2018), English remains the dominant language spoken in the U.S. healthcare system.

The overarching goal of this article is to examine the healthcare issues posed by language barriers in the face of a growing immigrant population, recognizing that LEP is only one component of a complex set of social factors that affect health outcomes in immigrant populations with LEP. Oncology nurses and other healthcare providers (HCPs) are called upon to provide care to an increasingly diverse population. Oncology nurses provide direct patient care and serve as patient educators, cancer navigators, and leaders. Nurses play a critical role in advocating for patients with LEP. The American Nurses Association's (2015) Code of Ethics for Nurses addresses individual actions and collective nursing intentions. The code of ethics requires each nurse to demonstrate ethical competence in the conduct of their professional life and to act courageously in protecting others and advocating on their behalf (American Nurses Association, 2015). The aims of this article are to (a) discuss the challenges for patients with LEP and cancer who are unable to communicate effectively with HCPs or within the healthcare system, (b) review the legal protections provided by the judicial system, and (c) describe the types of interpretation and translation services available for patients with LEP and associated barriers to effectively using these services.

Methods

This overview is based on data from the U.S. Census Bureau, U.S. Department of Health and Human Services (HHS), and U.S. Department of Justice; critically reviewed information from consensus and policy organizations; and synthesized relevant clinical studies pertaining to cancer care and health care in individuals with LEP that were published between 2017 and 2022.

TABLE 1.
PRIMARY COUNTRIES OF ORIGIN FOR IMMIGRANTS BETWEEN 1960 AND 2021

COUNTRY OF ORIGIN	IMMIGRANTS[a]
Mexico	10.9
India	2.7
Philippines	2
El Salvador	1.4
Vietnam	1.38
Cuba	1.36
Dominican Republic	1.17
Guatemala	1.11
Korea	1.04

[a] Per million in the U.S. population
Note. Based on information from Esterline & Batalova, 2022; Migration Policy Institute, 2021.

Findings

Social Determinants of Health

Following the passage of the Patient Protection and Affordable Care Act (ACA), substantial efforts have been made to reform the U.S. healthcare system and to reduce disparities related to social determinants of health (HHS, 2023). Social determinants of health include language barriers, cultural differences, immigration status, neighborhoods, housing, education level, social conditions, access to health care, and economic constraints such as lack of health insurance coverage (Alcaraz et al., 2019). Cancer data collection does not typically include immigration variables, such as primary language spoken or country of origin (Alcaraz et al., 2019). However, the data that are available demonstrate considerable gaps in cancer screening and cancer care in immigrant individuals as compared to individuals born in the United States. Immigrants and individuals with LEP tend to live in communities where racial-, ethnic-, religion-, and nationality-based stigmas are prevalent (Alcaraz et al., 2019). There is a tendency for these individuals to avoid healthcare institutions for fear of discrimination, incarceration, and deportation, regardless of legal status (Alcaraz et al., 2019; Metchnikoff et al., 2018). These factors can delay the diagnosis of cancer and the start of treatments (Boscoe et al., 2016).

Effects of LEP on Issues Faced by Patients With Cancer

Studies have consistently identified adverse health effects in individuals with LEP (Al Shamsi et al., 2020; Foiles Sifuentes et al., 2020), particularly among Latin and Asian immigrants and other underrepresented ethnic populations in the United States. LEP is associated with poor comprehension in patient–provider interactions and trouble understanding medication labels (Al Shamsi et al., 2020). Individuals with LEP are at risk for healthcare disparities related to limited access to health care and not obtaining preventive services, such as cancer screening and early-detection screening (Foiles Sifuentes et al., 2020). A number of factors contribute to poor cancer outcomes, including the following: cultural and ethnic beliefs about cancer, inability to navigate the U.S. medical system, limited access to screening services, lack of health insurance, lack of language-concordant education about cancer and treatments, and institutional barriers impeding access to high-quality cancer care (Berdahl & Kirby, 2019; Perez et al., 2016) (see Figure 1). The diagnosis of cancer may be delayed in patients with LEP because they are less likely to have a regular HCP and often postpone visits because of apprehension or because they do not recognize symptoms of cancer. Individuals who live in poverty, whether they are immigrants or not, are diagnosed with later-stage cancers (Boscoe et al., 2016). Patients with LEP report difficulty expressing their symptoms to providers, which may lead

to prolonged evaluations, incorrect diagnoses, delays in care, and extended hospital stays (Bonilla et al., 2021; de Moissac & Bowen, 2019; White et al., 2018). Perez et al. (2016) found that patients with LEP were given discharge paperwork and treatment instructions only in English. They often were not offered supportive services, such as visiting nurses and hospice care (Perez et al., 2016). Many patients reported not understanding their diagnosis or the prescribed treatment and therefore used an emergency department visit to clarify the diagnosis and proper medication dosing (de Moissac & Bowen, 2019; Diamond et al., 2019). Patients expressed a lack of confidence in the quality of care received and felt that their needs were unmet (de Moissac & Bowen, 2019; Seible et al., 2021). Discontented feelings with the healthcare system are correlated with feelings of distrust that affect participation in cancer treatments and clinical cancer trials (Farina et al., 2022).

Legal Protections for Patients With LEP

The U.S. legal system prohibits discrimination based on race, color, or national origin under the Civil Rights Act of 1964 (U.S. Department of Justice, 2000). Title VI of the Civil Rights Act of 1964 mandates that interpretation services be provided to patients with LEP. HCPs receiving federal funds are required to provide equal access to care for patients with LEP (U.S. Department of Justice, 2000). The National Culturally and Linguistically Appropriate Services (CLAS) Standards were formulated to reduce disparities and to aid providers to implement culturally and linguistically appropriate services to all patients (HHS, 2023). Further protections and recommendations were introduced in the expanded ACA (HHS, 2023). The ACA recommends linguistically appropriate patient education documents and signage, and provides financial incentives to hospitals to accommodate patients with LEP by providing qualified interpreters (Burkle et al., 2017). Ad hoc interpreters and a reliance on family members to serve as interpreters are generally discouraged.

The Office of Inspector General (2010) found that only 64% of surveyed hospitals met CLAS Standards when providing language assistance services. There are also discrepancies between the legal requirements and actual practice because most providers consistently used only ad hoc interpreters for communication (Diamond et al., 2019) and frequently used only English when informing patients of their rights, rather than using patients' preferred language. Perez et al. (2016) identified underusing professional interpretation services as the primary factor affecting quality patient care. Perez et al. (2016) found that reasons for underusing translation services also included patient factors, particularly a lack of awareness that interpretation services are free, privacy concerns, and familial barriers.

Types of Available Interpretation and Translation Services

The use of trained medical interpreters and translation services improves health care, patient outcomes, and satisfaction with HCPs (Diamond et al., 2019; Lor & Martinez, 2020).

FIGURE 1.
ADVERSE EFFECTS FOR PATIENTS WITH CANCER FACING LANGUAGE BARRIERS

- Limited understanding of diagnosis
- Delays in cancer care
- More frequent emergency department visits
- Misdiagnosis
- Increased medical errors
- Poorer quality of care
- Decreased health-related quality of life
- Reduced patient satisfaction
- Lower cancer screening rates
- Decreased access to preventive services
- Failure to enroll in cancer clinical trials

Note. Based on information from Bonilla et al., 2021; Farina et al., 2022; Genoff et al., 2016; Perez et al., 2016; Seible et al., 2021.

LIVE INTERPRETERS: In-person interpreters are preferred by HCPs whenever possible. This is not always an option because of scheduling conflicts, availability of specific languages, and costs (Burkle et al., 2017; Fiedler et al., 2022). Effectively using live interpreters requires training them and setting goals because live interpreters may edit the discussion, omit vital information, or falsely reassure the patient. These issues may be avoided by briefing the interpreter before meeting the patient and discussing expectations.

VIDEO REMOTE INTERPRETERS: Video remote interpreters provide rapid access to many languages at any hour of the day while being cost effective (Kushalnagar et al., 2019). The primary drawbacks to video remote interpreters are technical difficulties, connectivity issues, limited regional dialects, and limited available devices in the clinical setting (Kushalnagar et al., 2019). There is also the sense that video interpreters are less personal compared to live interpreters (Feiring & Westdahl, 2020).

TELEPHONE OR AUDIO INTERPRETERS: Telephone or audio interpreters are a helpful option for simple questioning. Many HCPs prefer not to rely solely on telephone interpreters, citing concerns about communication skills, excessive background noise, and a lack of visual aids (Fiedler et al., 2022).

AD HOC INTERPRETERS: Ad hoc interpreters, such as family, are often used because of convenience and the interpreter's insight into the patient's medical history, symptoms, medications, and current therapies (see Figure 2). Many patients prefer to use a family member rather than a professional interpreter (Burkle et al., 2017). However, ad hoc interpreters lack specific training and clinical knowledge that may impede accurate translation (Fiedler et al., 2022). Emotional involvement and

FIGURE 2.
CASE STUDY

A native Chinese woman aged 84 years who spoke Cantonese presented for consultation at a surgical oncology practice in a large U.S. medical institution with a recent diagnosis of colorectal adenocarcinoma. The patient was accompanied by her adult son, who was raised in the United States and did not speak Cantonese. After the AOCNP® introduced herself, the patient took out her mobile telephone and made a call. The telephone was handed to the AOCNP with the explanation that the patient's daughter-in-law, Alice, who speaks English and Cantonese, would be translating over the telephone. The AOCNP greeted Alice on the telephone, and Alice began to relate the symptoms that her mother-in-law had been experiencing. After a few minutes of conversation with Alice, and with the patient occasionally adding a few words, the son stated that he thought that it would be better if an interpreter was used. The AOCNP readily agreed and left the examination room to arrange for the interpretive service. The medical institution used a national medical interpretation service, which had a 20-minute wait time to connect with a male audio interpreter who spoke Cantonese (no visual image was provided). The AOCNP and the surgeon then greeted the patient. With help from the audio interpreter, the surgeon explained the diagnosis and the proposed surgery to the patient and her family. Visual aids were provided by the AOCNP to explain the procedure. At times during the process, the interpreter asked for the spelling of a medical term if he was unfamiliar with it. The process with the interpreter went smoothly. Afterward, when the family was asked about the service, they responded with a thumbs-up sign.

This case illustrates the complexity of language barriers and LEP even within a close family. The son reported that he and his mother often spoke a less formal dialect of Cantonese, but that he is not fluent in Cantonese and his mother is not fluent in English, although she can understand simple exchanges. Alice was comfortable describing her mother-in-law's symptoms but was unfamiliar with medical terms and recognized her limits. The AOCNP entered the examination room unaware that the patient had LEP and, therefore, had not prearranged interpretive services. The audio interpreter sounded somewhat mechanical and was asked at the end if he was an actual person or artificial intelligence. He chuckled and replied that he was a real person.

Of note, ideally at the time of scheduling, the scheduler would have inquired about LEP concerns. If language barriers were known in advance, interpretive services could have been organized more expeditiously.

AOCNP—advanced oncology certified nurse practitioner; LEP—limited English proficiency

paternalism may result in the interpreter withholding certain information. It may also be awkward for a family member to be thrust into a semiprofessional role for their own relative.

Bilingual staff members are often used as ad hoc translators. This is a valuable service, and staff members should be supported in completing formal interpreter training and certification. Although convenient, bilingual staff members possess similar deficiencies as family ad hoc interpreters. Most notably, bilingual staff members may lack the training or the knowledge of clinical terminology to provide proper translations.

TRANSLATION APPLICATIONS: Translation applications are mobile device applications that are readily available for digital download. A study by Hwang et al. (2022) suggested that there is enthusiasm among patients to learn about and use this resource. Nurses had concerns about mistranslation because they could not always verify the accuracy of the text and felt that there could be errors in regional dialects (Hwang et al., 2022). In these instances, nurses felt that the process was tedious, requiring multiple translation attempts to convey the right message (Hwang et al., 2022). Many of these translation applications are not designed for the clinical setting. Studies recommend that translation applications should not be replacements for professional interpreters and advise caution when using them (Panayiotou et al., 2019, 2020).

Barriers to Effective Interpretation Services and Suggestions for Improvement

Providing medical interpretation services for patients with LEP and cancer is a significant responsibility. Interpreters must modify the discussion to allow for culturally sensitive dialogue. Interpreters may experience discomfort when asked to deliver bad news because they may lack the proper training, experience, and emotional support capacity required. Efforts can focus on addressing the drawbacks that hinder certified interpreter use.

PROVIDER BARRIERS: HCPs often find it more expedient to avoid using any interpretation services because of time constraints and heavy workloads. HCPs may believe that they have established rapport with the patient and that the patient's questions were "easy" (Martin et al., 2022; White et al., 2018). There is a sense that the amount of effort required to use an interpreter is not worthwhile (Jaeger et al., 2019). In a mixed-methods study of language interpretation, nurses described a preference for in-person interpreters for patients being discharged with medical devices that required the patient or family to perform complicated tasks (Lee et al., 2018). In contrast, they noted that telephone interpreters worked well for simple discharge instructions (Lee et al., 2018).

When interpretation services are readily available, HCPs are less likely to use their own nonproficient non–English language skills or ad hoc interpreters when communicating with patients.

By establishing goals with the interpreter before the patient interview, HCPs can set expectations, provide pertinent clinical background, and build rapport with the interpreter. During the interview, short sentences are recommended to verify patient understanding while talking directly to the patient. It may be more effective for interpreters to translate the entire exchange, even if there is a prolonged exchange between the patient and the HCP. Debriefing with the interpreter is recommended because they may have noted certain subtleties, barriers, and reservations during the interaction. Similarly, debriefing allows HCPs to appreciate the interpreter's well-being, perspective, and translation issues.

INSTITUTIONAL BARRIERS: HCPs often express that in-person interpreters are difficult to schedule (Jaeger et al., 2019). Providers may be uncertain about how to set up a face-to-face meeting (White et al., 2018). Burkle et al. (2017) reported that providing interpretation services to patients with LEP leads to procedural delays because the average arrival time of the interpreter is 19 minutes but can occasionally take as long as 100 minutes. Hospitals and healthcare organizations can help by providing adequate and regularly maintained translation equipment, addressing connectivity issues, ensuring technological proficiency, and providing budgetary funds (Feiring & Westdahl, 2020; Jacobs et al., 2018).

PATIENT BARRIERS: Even when medical interpreters were used, patients reported not fully understanding the information presented and feeling unequipped to ask questions (Perez et al., 2016). Patients reported that they felt ill-prepared to participate in treatment decisions and cited this as a contributor to treatment nonadherence. Patient-centered strategies focus on empowering patients by providing visual aids that describe the roles of interpreters and how to obtain translation services (Perez et al., 2016). Nurses can also educate patients about the U.S. medical system, advising them of their right to ask questions and to inform HCPs about their experience with adverse symptoms (Perez et al., 2016).

IMPLICATIONS FOR PRACTICE

- Anticipate the need for medical translation services in the clinical setting to the benefit of patients and providers, and seek linguistically and culturally appropriate learning opportunities.
- Advocate for patients with a limited English proficiency by recognizing their language limitations and that they may not understand the complexity of the U.S. medical system.
- Empower patients with limited English proficiency and their families to become involved in their health care by providing language-concordant information materials (e.g., booklets, visual aids).

FIGURE 3.
LEP RESOURCES FOR PATIENTS, FAMILIES, AND HEALTHCARE PROVIDERS

JOINT COMMISSION
Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals
- www.jointcommission.org/Advancing_Effective_Communication

NATIONAL HEALTH LAW PROGRAM
A publication for providing language services; developing a language access plan; and identifying language services, training programs, and assessment tools
- https://healthlaw.org/resource-library/?search=language

STATE OF OHIO OFFICE OF CRIMINAL JUSTICE SERVICES, THE NATIONAL ASSOCIATION OF JUDICIARY INTERPRETERS AND TRANSLATORS, THE SUMMIT COUNTY SHERIFF'S OFFICE, AND THE AMERICAN TRANSLATORS ASSOCIATION
I Speak . . . Language Identification Guide
- https://www.ojp.gov/ncjrs/virtual-library/abstracts/i-speaklanguage-identification-guide

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Access for individuals with LEP
- https://bit.ly/3knYn2s

LEP resources for effective communication
- https://bit.ly/3mSfmuL

LEP—limited English proficiency

Discussion

The diagnosis of cancer is life-changing and the magnitude of information that patients receive on cancer type, stage of disease, and decisions about treatment options can be daunting, even more so for patients with LEP (Perez et al., 2016). Caring for patients with LEP presents a challenge for oncology providers because of the complexity of communicating information accurately while providing care that is compassionate and culturally sensitive (Yeo et al., 2011). Education and training in linguistically and culturally competent care can help to diminish barriers (Perez et al., 2016). Effective education initiatives can include the following: (a) providing formal training about caring for diverse populations (Yeo et al., 2011), (b) educating about the different types of interpretation services and the importance of using a certified medical interpreter, (c) offering language courses, (d) developing one's language skills, (e) assessing competency in interpretation services, (f) raising awareness of interpretation services, (g) ensuring accessibility, and (h) encouraging staff from diverse backgrounds to become certified and trained in medical interpretation (Jaeger et al., 2019; Jones et al., 2020; Martin et al., 2022).

Implications for Practice

Communication between patients with cancer and oncology nurses can be influenced by individual biases, personal cultural beliefs, stereotypes, and learned behaviors (Yeo et al., 2011).

Nurses can take immediate action to lessen these barriers. By recognizing differing cultural familial roles, values, and preferences, nurses can prioritize and improve the clinical experience for patients (Perez et al., 2016). By being familiar with available medical interpretation services and other resources (see Figure 3), nurses can lessen gaps in communication. In clinical areas, it is crucial to verify that interpretation devices are functional and well maintained. Nurses can strive to learn another language, at a minimum mastering essential medical terminology, and potentially proceed to earn an interpreter certification.

Conclusion

Caring for patients with LEP and cancer presents a series of opportunities to improve patient outcomes. Oncology nurses, nurse practitioners, and other HCPs can have a significant impact in reducing the stigma felt by patients with LEP by improving the quality of patient–provider interactions in oncology settings. The effectiveness of language-concordant care is well documented in improving patient outcomes. Improvements can be made to provide linguistically appropriate and culturally competent cancer care to a changing U.S. population. These challenges require a holistic approach that includes providing adequate resources and staffing, easily accessible language translation and interpretation services, and education and training on cultural differences, as well as making changes in the hospital culture. Addressing these challenges can level the playing field and reduce LEP-related cancer care disparities.

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QUESTIONS FOR DISCUSSION

USE THIS ARTICLE FOR JOURNAL CLUB

Journal club programs can help to increase your ability to evaluate the literature and translate those research findings to clinical practice, education, administration, and research. Use the following questions to start the discussion at your next journal club meeting.

- From your clinical oncology practice, describe a situation when you could not communicate effectively with a patient and their caregivers with limited English proficiency (LEP).
- To better communicate with patients and caregivers with LEP, what services and resources can you call on to support you and the oncology provider team?
- Based on your clinical experience, what are your recommendations to effectively use professional in-person or telephone/audio interpreters? Translation applications?

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