



SPECIAL ARTICLE

The healing power of language: caring for patients with limited english proficiency and COVID-19

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Over the last 40 years, the number of individuals at least 5 years old in the U.S. who speak a language other than English at home has increased from 11% (23 million) in the 1980s to 21.5% (71 million) in 2018.¹ Of those 71 million, almost 40% (25.7 million, ~8.5% of the U.S. population) have “Limited English Proficiency” (LEP),¹ defined as a self-rated English-speaking ability of “less than very well.”² Patients with LEP face numerous healthcare inequities and poorer health outcomes, as LEP adversely impacts multiple aspects of healthcare including access and utilization, patient–physician communication and trust, satisfaction, quality and safety, and duration of hospitalization.^{3,4} The majority of individuals in the U.S. with LEP speak Spanish (66%), and the Latinx population continues to grow. There are now more people who speak Spanish at home in the U.S. than in any country in Latin America, with the exception of Mexico, Colombia, and Argentina.⁵ Despite this, only 5.8% of U.S. physicians identify as Latinx,⁶ creating a major challenge for representation in healthcare.

The Civil Rights Act of 1964 and the Department of Health and Human Services (HHS) regulations mandate that institutions that receive federal financial assistance from HHS provide language services to individuals with LEP where required.⁷ In recent years, healthcare institutions have made significant efforts to ensure the provision of language services for patients with LEP, utilizing strategies including identification and documentation of patient preferred language in the medical record and harnessing technology to increase the availability of interpreters.^{8,9} However, many healthcare systems continue to struggle to provide appropriate language services,^{10–13} and the COVID-19 pandemic has magnified significant challenges in providing equitable healthcare to patients with LEP. In our own institution, during the initial COVID-19 surge, existing interpreter services were unable to meet the in-person language needs of the overwhelming number of patients with LEP, in particular Spanish-speaking patients, and the use of telephone language services proved challenging in full personal protective equipment.¹⁴ These challenges created an opportunity for us, as Spanish-speaking neonatologists, who normally care for newborns, to care for Spanish-speaking adult patients with LEP.

At the height of the pandemic in Boston during spring 2020, approximately 60% of the inpatients at Massachusetts General Hospital had LEP, and around 40% of the inpatients were Spanish-speaking with LEP. This was a significant increase given, at baseline, 9% of our inpatients have LEP and 6% of our inpatients are Spanish-speaking with LEP.¹⁴ As Qualified Bilingual Staff (QBS), alongside 51 other Spanish-speaking clinicians from 14 countries

and 13 specialties, we were part of the new Spanish Language Care Group (SLCG).¹⁴ The SLCG was an initiative developed to provide compassionate and culturally competent care for Spanish-speaking patients with LEP and COVID-19 in the setting of a shortage of in-person interpreters, rationing of personal protective equipment, and increased demand during the initial COVID-19 surge. We evaluated patients in Spanish as part of the COVID-19 surge teams and assisted with conversations about prognosis, decision-making, symptom management, goals of care, and discharge planning. Putting aside our usual medical arsenal, we stepped into a new role as healers, armed with the power of language.

We assisted with the care of a new mother in the ICU who had recently extubated. A few days earlier, she had required an emergency cesarean delivery due to COVID-19 respiratory failure, and her premature baby had been transferred to another hospital in the context of ventilator allocation at our institution. Her husband was quarantined at home, unable to hold her hand or be with their newborn. Separated from her family and unable to speak English, she looked at us with confusion and fear. Her first question to us was: “¿Dónde está mi bebé?” [Where is my baby?]. We were surrounded by noise – monitors beeping, nurses running, clinicians speaking rapid-fire English. But through the chaos, this mother heard only what was missing: her newborn’s cry. As neonatologists volunteering in the adult intensive care unit, we found ourselves tasked with evaluating her mental status and reviewing the nightmare she was currently living in her native language. Our experience extended beyond the perinatal period. We cared for adults with COVID-19 and respiratory failure, explaining the process of intubation in Spanish and reviewing end-of-life wishes with the families of patients on extracorporeal membrane oxygenation (ECMO). As a group, the SLCG provided coverage 24 hours a day, 7 days a week, with 3 SLCG members during the day and 2 at night, in 12 hour shifts. Collectively, we averaged 10-15 patient encounters per shift.

As Latinx physicians, prior to the COVID-19 pandemic, speaking Spanish and advocating for Latinx families in the Neonatal Intensive Care Unit (NICU) lent us a special connection to our Latinx community. When the pandemic struck our city, we watched in horror as high volumes of Latinx patients became gravely ill and died. As neonatologists, we are trained to act during crisis, but we could not fix the disproportionate suffering that befell our community. Instead, we expanded our role as healers using our language and culture through the newly established SLCG. Our experience recentered us around the reason we chose

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Table 1. Recommendations to improve equitable healthcare for all, independent of language proficiency, during the COVID-19 pandemic and beyond.

Specific areas	Strategies for implementation
Accessible and high-quality healthcare	<ul style="list-style-type: none"> - Expand hours of in-person interpreters and ensure video/phone interpreters are easily available 24/7 for providers and patients - Clinician training in appropriate interactions with and use of interpreter services, both in-person and virtually - Clinicians proficient in other languages should obtain certifications (e.g., Qualified Bilingual Staff) and should be recognized as an asset at the institutional level - Translation of all healthcare materials and medical records to available languages
Legislative and policy advocacy	<ul style="list-style-type: none"> - Advocate for all states to provide Medicaid and CHIP reimbursement for language services (currently only 15 states in the United States provide reimbursement for language services)²¹
Research and public policy	<ul style="list-style-type: none"> - Improve documentation of race/ethnicity, primary language, and language preference in electronic medical records - Inclusion of LEP population in research studies
Medical education and training	<ul style="list-style-type: none"> - Culturally competent training of medical students, residents, and fellows using simulation and standardized patients - Continued training and support of faculty and staff on best practices for approaching a patient with LEP - Formal training of multilingual and multicultural trainees to become multilingual and multicultural physicians - Training on how to advocate for and inform patients about their rights to interpreter services and translated materials - Increase representation of black and Latinx communities in medical schools, residencies, and fellowship programs, by commitment to the recruitment process and opportunities for faculty positions - Increase representation of underrepresented minorities in leadership positions

medicine—to provide holistic, compassionate, and equitable care and reminded us that the true gift of the physician-patient connection lies beyond clinical science.

The COVID-19 pandemic has exposed and amplified staggering racial and ethnic health disparities deeply rooted in structural racism and socioeconomic inequality.^{15,16} COVID-19 has disproportionately affected the Latinx community and other underrepresented minorities in the U.S., with increased incidence, hospitalizations, and mortality in these groups.¹⁷ The underlying causes are complex and include a high risk of viral exposure through increased representation in the essential workforce, limited healthcare access, increased baseline comorbidities, poverty, racism, and discrimination.^{16,18,19} In addition, some Latinx individuals belong to “invisible” communities of undocumented immigrants, putting them at even higher risk of viral exposure in frontline jobs or at the border in overcrowded detention centers with poor healthcare access.²⁰

As we continue to battle another wave of COVID-19 infections, the risk to underrepresented minorities continues.¹⁵ As physicians we must be prepared to provide equitable care for all patients. The SLCG was an innovative model of care developed to address the COVID-19 surge among Spanish-speaking patients with LEP and to provide equitable care at a time when the inpatient needs surpassed the resources. The SLCG was appreciated by patients, families, and providers and served as a model for other hospitals locally and nationally, including two community hospitals and four east-coast tertiary referral centers, among others. Based on our experience as QBS and through the SLCG, we want to highlight the importance of the implementation of several actions to improve the quality of care we provide all families with LEP (Table 1).

Although adequate for a crisis situation, models like the SLCG may not be sustainable long-term and improved healthcare for patients with LEP requires intervention at multiple levels. There are important barriers to providing and expanding appropriate language services as recommended in Table 1, namely the cost of services and limited reimbursement. One study of 1381 pediatricians demonstrated that those in states with reimbursement for language services had twice the odds of formal interpreter use versus those in non-reimbursing states,³ supporting the need for continued advocacy for reimbursement of language services.

While these barriers prove challenging for us all, through the SLCG we have advocated for strengthening our interpreter services at the institutional level, leading our institution to support this as a fundamental milestone of a hospital-wide plan for structural equity developed through the summer/fall of 2020. This plan includes consolidation of interpreter services to one vendor to maximize availability for a negotiated cost, expansion of interpreter services so Spanish-speaking patients with LEP can now directly communicate with hospital providers 24/7, and renewed emphasis on the QBS certification and encouragement of hospital staff to obtain this certification where appropriate.

Sometimes the most powerful thing we can do for our patients is also the simplest—to speak their language, understand them and their lived experiences outside the hospital, and offer compassion and solidarity in a time of crisis. COVID-19 has taken many lives and has uprooted our sense of normalcy, but it has also taught us meaningful, lasting lessons through our participation in the SLCG. First, the pandemic has brought us back to our core Latinx identity, the truth of being a culturally competent physician when everything else is stripped away. Second and most importantly, a crisis that disproportionately harmed our community gave us an opportunity to fight for healthcare equity for patients with LEP, bridging our Latinx identity with our practice of medicine through advocacy and feeling the power of representation in healthcare made tangible.

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E.M.H., A.B.-C. and J.D.M. worked as members of the SLCG, conceptualized this manuscript, drafted the initial manuscript, and reviewed and revised the manuscript. All authors approved the final manuscript as submitted and agree to be accountable for all aspects of the work.

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