Quality Translation in Health Care: Kaiser Permanente - Meeting the Challenge

- María Cornelio © 2004 Apuntes

According to the 2000 Census, over 21 million people in the United States have limited English proficiency (LEP). This language barrier can be a serious detriment to the provision of quality health care. It affects LEP patients' access to services, their ability to give informed consent for medical treatment, and their compliance with drug regimens and follow-up. A growing body of research shows that patients who speak little or no English are at greater risk of medical error or misdiagnosis if they are not provided with an interpreter, are less likely to use preventive care services, and more likely to use emergency rooms than English speakers. They also need more diagnostic tests, are less satisfied with the medical care they receive, and are often dissatisfied with the quality of the translated material they are given.[1]

Addressing these concerns, the U.S. Department of Health and Human Services has issued a number of guidelines for health care organizations with the goal of providing "meaningful access" to LEP patients. These guidelines are spelled out in the Department's National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS).[2] Of particular interest for this article is Standard 7, which states that "an effective language assistance program ensures that written materials that are routinely provided in English to applicants, patients/consumers, and the public are available in commonly encountered languages other than English. It is important to translate materials that are essential to patients/consumers accessing and making educated decisions about health care."[3] The guidelines discuss in great detail the importance of using qualified translators and the need for establishing procedures that will assure the quality of the translated materials given to the public:

"The use of qualified translators is crucial to ensuring the accuracy of translated written materials.

Organizations should have written criteria for selecting translators and translation vendors. At a minimum, organizations should ensure that translators have 1) previous experience, education, and training in translation; 2) command of both English and the language into which the material will be translated; and 3) familiarity with medical terminology. Criteria for selecting translation vendors should include a review of 1) translation methods and procedures used, from submission of English copy to printing of finished materials; 2) recruitment and training of translators; and 3) procedures for reviewing translated materials. Organizations also should have in place knowledgeable people to work with translators or vendors during the translation and review process and to determine the quality of purchased translations."[4]

The section ends with the injunction to "avoid 'wildcat' translation (e.g., the doctor's sister who took Spanish in college), however tempting the financial advantages."[5]

One major health care organization that is working systematically to put these guidelines into practice is Kaiser Permanente, the California-based health plan that provides coverage to 8.2 million subscribers in nine states and the District of Columbia. While many such entities are concerned about providing quality translations to their LEP patients, Kaiser is probably the first to be actively moving in that direction by developing and implementing a set of explicit policies and procedures in this area.

National Coalition for Quality Translation in Health Care

Kaiser has convened a National Coalition for Quality Translation in Health Care as part of a larger research study funded by The California Endowment to evaluate the impact of linguistic services on the health out-comes of LEP patients. The Coalition's mandate is to provide guidelines that will facilitate the production of high-quality, consistent, easy-to-read and cost-effective translations throughout the health care industry. With this work, it is Kaiser's intention to develop a standardized translation process for terms that are challenging to translate or unique to the U.S. health care system. This newly-established standardized process will then be applied to refine an existing English-Spanish glossary for use in future translation work. Spanish was chosen for the project because it is the most widely-spoken language among LEP patients in the United States. The ultimate goal is to identify and test the components that are crucial to this process in order to establish a general procedure that can be adapted for translating documents into other languages.

This system is also unique in that it is the first large-scale program for the translation of documents in the health care industry that puts linguists and translators at the center of the process. Kaiser's organizational chart shows its conceptualization of the various groups represented in the Coalition. A large central circle is made up of linguists and translators. Surrounding it are ten smaller circles, nine of them representing key stakeholders and content experts in health care from the fields of medicine, health policy, health care administration, member marketing, media, government, law, research, and advocacy. The tenth circle represents the consumer: the LEP patients who will ultimately validate the translated material through focus-group testing. All of these groups are vitally important to the process, and with their participation, Kaiser hopes to ensure the production of health care documents that provide information in a manner that is medically accurate, easily understood,

culturally appropriate, and that fulfills government regulations for the provision of information to patients regardless of their linguistic needs.

This project can be considered a sort of "coming of age" for the field of health care translation in the United States, with important implications for the way in which translation in general is viewed in this country. At present, most decision-makers in health care organizations have very little understanding of what it takes to do a quality translation, thinking that the only requirement is to be bilingual and, in the best of cases, to have familiarity with health care terminology. As a result, far too many of these executives are willing to entrust the translation of documents to people who lack the linguistic expertise to carry out the task. In structuring its Coalition the way it has, Kaiser has acknowledged the importance of interaction and consultation among the major health care sectors while also recognizing that, as language professionals, it is linguists and translators who must be at the heart of such an enterprise.

The first convening of the Coalition took place in Oakland, California in October of 2004. Coalition members arrived from all parts of the United States, and those who could not attend in person participated by teleconference. The meeting began with a general overview describing this project within the framework of Kaiser's National Linguistic and Cultural Programs of National Diversity. The rest of the day was devoted to an intensive series of exercises in which the various issues important in health care translation were first identified and then examined from the different perspectives represented by the participants. Gradually, a consensus emerged on several key points.

First, the group decided to work incrementally and to narrow the scope of the glossary that will be created during the first phase of the project. It was agreed that the most pressing need is to work on health insurance terminology and those terms designating professionals within the U.S. health care system for which no established and generally-accepted translations currently exist. Second, there will be close collaboration among the Coalition's translators, linguists, and lexicologists to ensure that the translated terms capture source-language meaning and context while avoiding false cognates and overly literal translations that violate target-language usage and grammatical/syntactical rules. In the third step, the resulting draft translations will be shared with the rest of the Coalition and other external stakeholders in order to obtain the broadest possible participation in the process. This will allow the Coalition to determine whether the proposed terms have practical application to a wide variety of health care settings in different parts of the country.

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The final step will be consumer validation through focus-group testing. This will be the most important test of the Coalitions' work -- are the translations useful and easy to understand? Are they acceptable to a majority of LEP persons regardless of educational level or national origin? In order to aid comprehension, the translated terms will be presented within the context of standard paragraphs found in documents commonly given to patients in the health care system. The Coalition recognizes, however, that it may not always be possible to find one term that is at the same time simple, medically accurate, and recognizable to every speaker of Spanish. Therefore, it will also provide definitions and descriptions as necessary with a view toward patient education and building a general consensus for term meanings.

Once the consumer-testing phase is over, the Coalition's findings (including the resulting glossary) will be shared with the entire health care industry. It is Kaiser's hope through this process to establish a system that can be refined and standardized, producing conclusions to inform industry policy and practice. The final goal is to generate cost-effective translations of consistently high quality that will benefit LEP patients in the United States.

Endnotes

[1] Dennis Andrulis, et.al., What a difference an interpreter can make, The Access Project, Brandeis University (April 2002) www.accessproject.org/downloads/c_LEPEngembarg.pdf; I.S. Watt, et.al., The health care experience and health behavior of the Chinese: a survey based in Hull, J. of Public Health Medicine 15 (1993)129-136; Louis Hampers, et.al., Language barriers and resource utilization in a pediatric emergency department, Pediatris 103:6 (June 1999)1253-1256; Aaron Manson, Language concordance as a determinant of patient compliance and emergency room use in patients with asthma, Medical Care 26:12 (Dec. 1988)1119-1128; Glenn Flores, et.al., Access barriers to health care for Latino children, Archives of Pediatric Adolescent Medicine, 152 (1998)1119-1125; Glenn Flores, et.al., The health of Latino children, Journal of the American Medical Association 288:1 (July 3, 2002)82-90; Jeannette Naish, et.al., Intercultural consultations: investigation of factors that deter non-English speaking women from attending their general practitioners for cervical screening, BMJ, 309 (29 October 1994)1126-1128.

[2] Office of Minority Health, U.S. Department of Health and Human Services, National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS), (March 2001). www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf.

[3] Ibid., p.77.

[4] Ibid., p.80.

[5] Ibid., p.80·