MACON & JOAN BROCK VIRGINIA HEALTH SCIENCES
Eastern Virginia Medical School
AT OLD DOMINION UNIVERSITY

Medical Interpreters in Goals of Care Discussions: A Palliative Care Perspective

Nwonukwuru Amadi, MD
Palliative Medicine Fellow 2025-2026
East Virginia Medical School/Old Dominion University
January 21, 2026

Learning Objectives

Illustrate the **role of medical interpreters** in facilitating accurate and culturally humble goals-of-care conversations

Recognize how **ethical principles (autonomy, justice)** apply during interpreted palliative care discussions

Identify **best practices for effective interpreted GOC encounters**, including pre-briefing and managing emotional conversations

Macon & Joan Brock Virginia Health Sciences
Eastern Virginia Medical School
at Old Dominion University

Why This Matters in Palliative Care

- Serious illness conversations are value-laden
- Small misunderstandings → big consequences

Case Presentation

A 34-year-old Spanish speaking male with a past medical history significant for acute lymphoblastic leukemia (ALL), anemia, thrombocytopenia presented to the hospital with one week of worsening shortness of breath and fatigue. According to the patient, his last chemotherapy session was one month prior to admission.

On admission, the patient appeared markedly fatigued. Laboratory evaluation was notable for severe thrombocytopenia. Physical examination revealed petechiae and oral mucositis, consistent with chemotherapy-related complications and bone marrow failure. Patient admitted to hospital with chief diagnosis of generalized weakness and fatigue and respiratory distress requiring 3L oxygen via nasal cannula.

Palliative Medicine was consulted for goals-of-care discussions and symptom management and complex decision making.

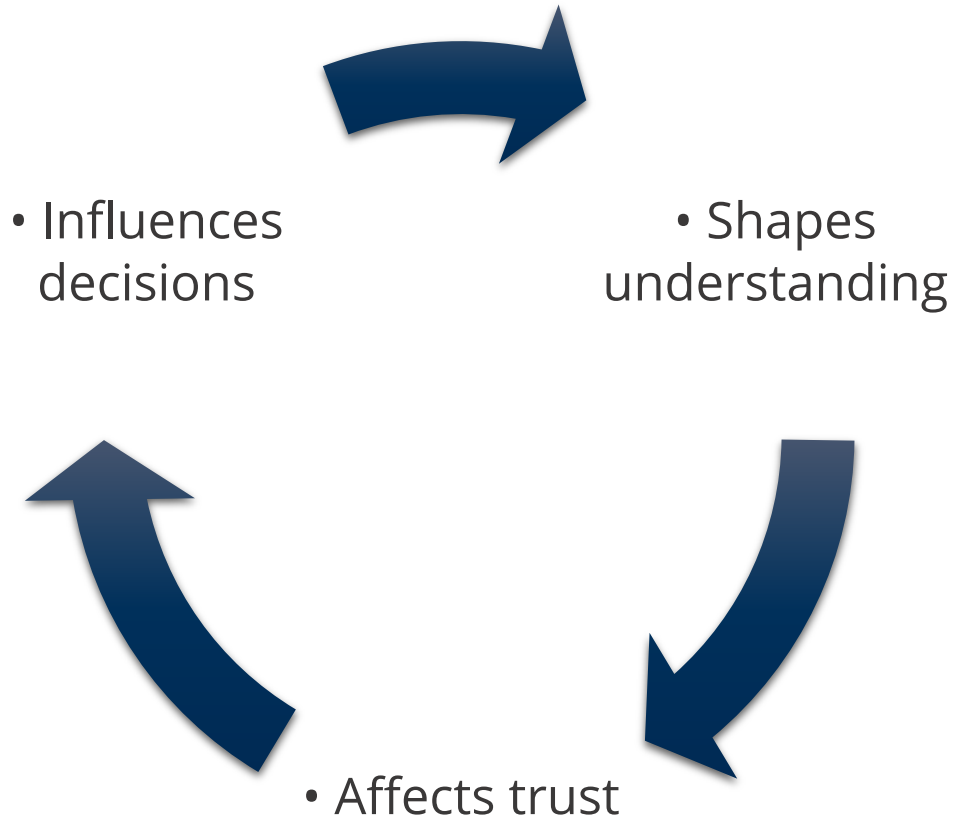
GOC Conversations Are Especially Challenging with:

- PROGNOSTIC UNCERTAINTY

- EMOTIONAL IMPACT

- CULTURAL INFLUENCE

Language = Power



Limited English Proficiency (LEP)

Over 27 million people in the U.S. have limited English Proficiency (LEP)

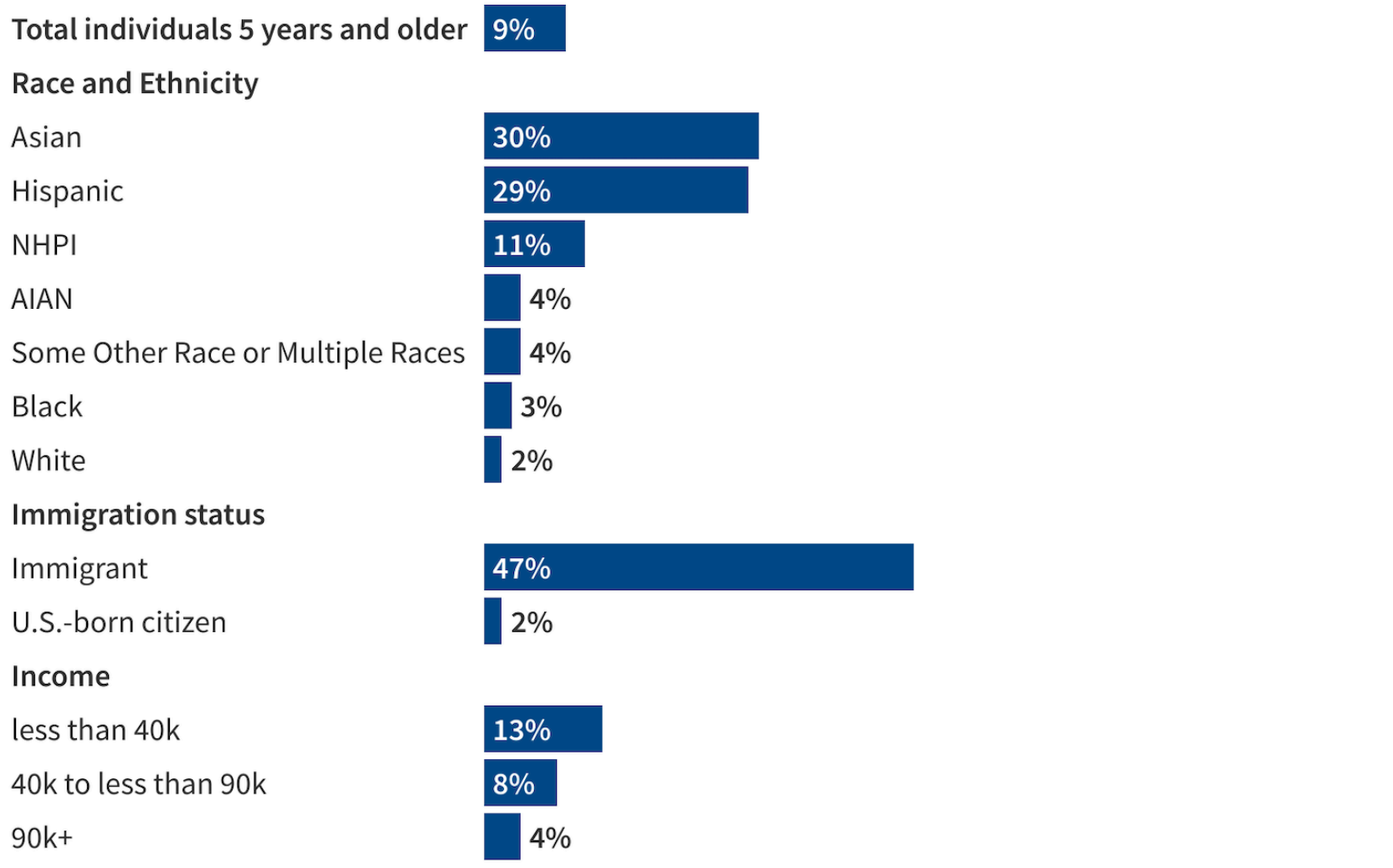
Prior to March 1, 2025, the US didn't have an official language

- English serves as the primary language
- The US is one of the most linguistically diverse countries in the would with over 300 languages and dialects are spoken

Can affect individuals access to services, such as healthcare

- May Increased barriers in obtaining and receiving care

Hispanic and Asian People, Immigrants, and Those With Lower Incomes are More Likely to Have Limited English Proficiency



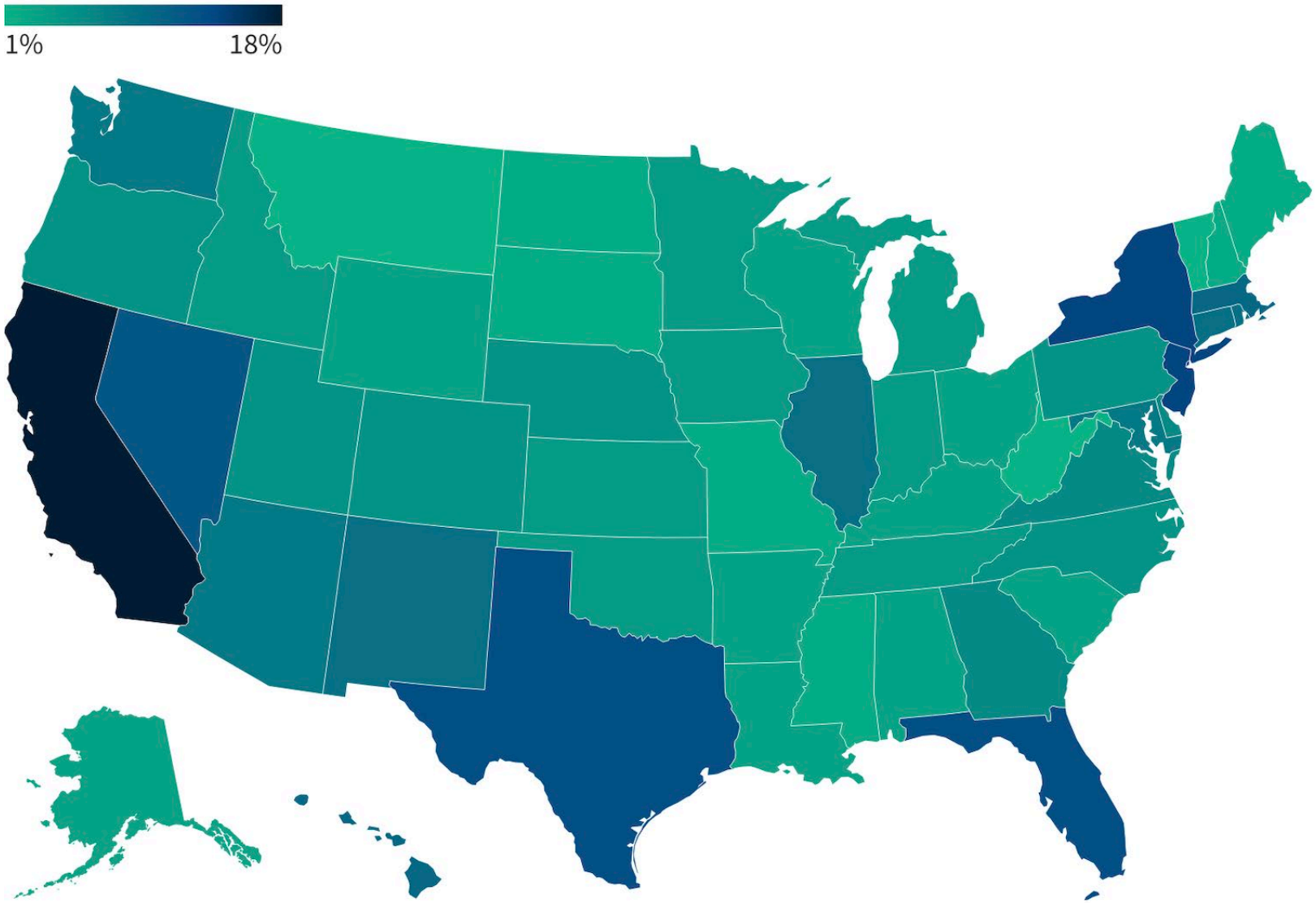
Note: Limited English proficiency includes individuals who speak a language other than English at home and who speak English less than very well. AIAN refers to American Indian or Alaska Native. NHPI refers to Native Hawaiian or Pacific Islander.

Source: KFF analysis of 2023 American Community Survey, 1-Year Estimates.

KFF

The Shares of People with Limited English Proficiency Vary Across States

Percent of individuals 5 years and older with limited English proficiency:



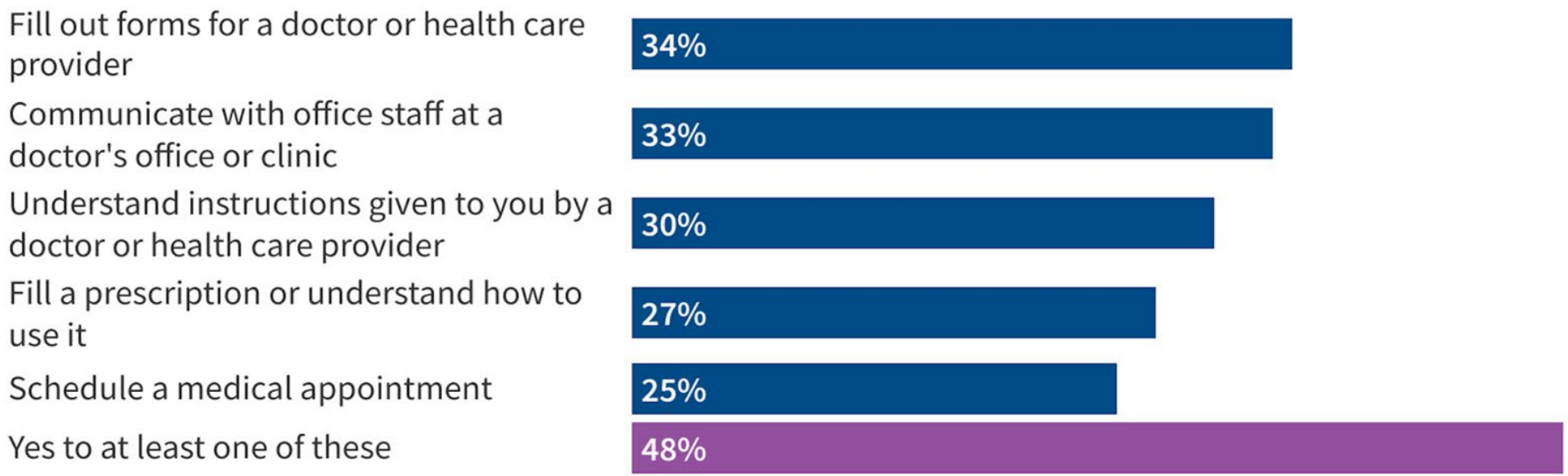
Note: Limited English proficiency includes individuals who speak a language other than English at home and who speak English less than very well.

Source: KFF analysis of 2023 American Community Survey, 1-Year Estimates.

KFF

About a Half of Adults With Limited English Proficiency Say They Have Faced Language Barriers When Seeking Health Care

Percent of adults with limited English proficiency who say there was a time in the past three years when difficulty speaking or reading English made it hard for them to:



Note: Asked of adults with limited English proficiency who have used health care in the past 3 years. See topline for full question wording.

Source: KFF Survey on Racism, Discrimination, and Health (June 6- August 14, 2023)

KFF

What Goes Wrong Without Interpreters

- Discordant care in general medical treatments
- Potentially unwanted aggressive care and resuscitation efforts
- Family conflict

Family ≠ Interpreters

- Bias to filtering information
- Emotional burden
- Loss of patient voice

Benefits of Using an Interpreter for GOC with LEP Patients

- **Ensures accurate communication** of prognosis and treatment options
- **Supports informed decision-making** and patient autonomy
- **Enhances emotional support** for patient and family
- **Incorporates cultural humility** in GOC discussions
- **Reduces medical errors & ethical risk**

Macon & Joan Brock Virginia Health Sciences
Eastern Virginia Medical School
at Old Dominion University

Ethical Framework

- **Autonomy**: Respecting a patient's right to make informed decisions about their own care, free from coercion, based on their values and preferences.

- **Justice**: Fair and equitable treatment of patients, including fair distribution of healthcare resources and non-discrimination in care.

- **Beneficence**: The ethical obligation to act in the best interest of the patient by promoting good, preventing harm, and providing benefit.

- **Nonmalenefice**: "Do no harm" or avoid causing unnecessary suffering or harm or injury to others

Justice ---> Legal Obligations

- Civil Rights Act (Title VI)
- CMS (Medicare & Medicaid)
- AAMC Best Guidelines

Civil Rights Act of 1964 (Title IV)

- Title VI of the Civil Rights Act requires organizations receiving federal funding to provide meaningful access for individuals with Limited English Proficiency (LEP)
- Healthcare organizations must provide:
  - Qualified medical interpreters
  - Translated documents for critical information
- These services must be provided at no cost to the patient

CMS (Medicare & Medicaid)

- Requires hospitals to provide **language assistance services**
- Interpreter services must be:
  - Timely
  - Accurate
  - Confidential
- Requires hospitals receiving Medicare and Medicaid payments to provide **language assistance services**
  - **May utilize virtual and in-person interpreters**
- Use of family members is **strongly discouraged** except in true emergencies

In-person vs Virtual Interpreters

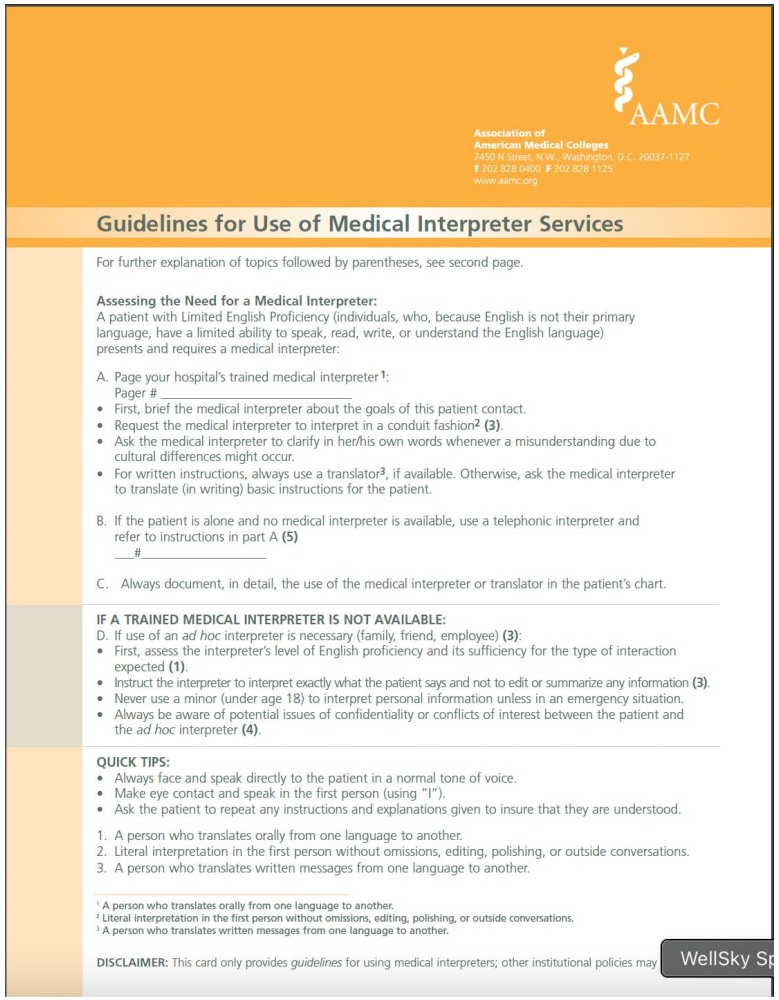
DOMAIN	IN-PERSON INTERPRETER	VIRTUAL INTERPRETER (VIDEO/PHONE)
Ideal scenarios	Goals of care, prognosis, consent, end-of-life	Routine care, urgent needs, rare languages
Communication depth	Highest—verbal + nonverbal cues	Moderate (video) / limited (phone)
Emotional nuance	Excellent	Limited
Rapport & trust	Strong	Moderate
Family dynamics	Easier to manage groups	More challenging
Availability	Limited; may require scheduling	Immediate; 24/7
Cost/logistics	Higher	Lower
Technical issues	None	Possible A/V disruptions
Overall recommendation	Preferred for complex, sensitive discussions	Appropriate when in-person unavailable or for routine care

AAMC Best Practices

- Guidelines for use of Medical Interpreters
- Asset in delivering care with patients with LEP

AAMC Best Practices

- Introduce interpreter to patient and patient's family
- Clearly Explain role of the interpreter with the medical team overseeing care for the patient
- Face and Speak directly to patient in a normal tone of voice.
- Pause frequently
- Make eye contact and speak in the first person (using "I")
- Ask the patient to repeat any instructions and explanations given to ensure that they are understood



AAMC

Association of American Medical Colleges
2450 N Street, N.W., Washington, D.C. 20037-1127
T 202 828 0400 F 202 828 1125
www.aamc.org

Guidelines for Use of Medical Interpreter Services

For further explanation of topics followed by parentheses, see second page.

Assessing the Need for a Medical Interpreter:
A patient with Limited English Proficiency (individuals, who, because English is not their primary language, have a limited ability to speak, read, write, or understand the English language) presents and requires a medical interpreter:

A. Page your hospital's trained medical interpreter[1]:
Pager # _____
- First, brief the medical interpreter about the goals of this patient contact.
- Request the medical interpreter to interpret in a conduit fashion[2] **(3)**.
- Ask the medical interpreter to clarify in her/his own words whenever a misunderstanding due to cultural differences might occur.
- For written instructions, always use a translator[3], if available. Otherwise, ask the medical interpreter to translate (in writing) basic instructions for the patient.

B. If the patient is alone and no medical interpreter is available, use a telephonic interpreter and refer to instructions in part A **(5)**
___#_____

C. Always document, in detail, the use of the medical interpreter or translator in the patient's chart.

IF A TRAINED MEDICAL INTERPRETER IS NOT AVAILABLE:
D. If use of an *ad hoc* interpreter is necessary (family, friend, employee) **(3)**:
- First, assess the interpreter's level of English proficiency and its sufficiency for the type of interaction expected **(1)**.
- Instruct the interpreter to interpret exactly what the patient says and not to edit or summarize any information **(3)**.
- Never use a minor (under age 18) to interpret personal information unless in an emergency situation.
- Always be aware of potential issues of confidentiality or conflicts of interest between the patient and the *ad hoc* interpreter **(4)**.

QUICK TIPS:
- Always face and speak directly to the patient in a normal tone of voice.
- Make eye contact and speak in the first person (using "I").
- Ask the patient to repeat any instructions and explanations given to insure that they are understood.

1. A person who translates orally from one language to another.
2. Literal interpretation in the first person without omissions, editing, polishing, or outside conversations.
3. A person who translates written messages from one language to another.

[1] A person who translates orally from one language to another.
[2] Literal interpretation in the first person without omissions, editing, polishing, or outside conversations.
[3] A person who translates written messages from one language to another.

DISCLAIMER: This card only provides *guidelines* for using medical interpreters; other institutional policies may

Let’s Recap

Revisiting our Case Presentation

A 34-year-old Spanish speaking male with a past medical history significant for acute lymphoblastic leukemia (ALL), anemia, thrombocytopenia presented to the hospital with one week of worsening shortness of breath and fatigue. According to the patient, his last chemotherapy session was one month prior to admission.

On admission, the patient appeared markedly fatigued. Laboratory evaluation was notable for severe thrombocytopenia. Physical examination revealed petechiae and oral mucositis, consistent with chemotherapy-related complications and bone marrow failure. Patient admitted to hospital with chief diagnosis of generalized weakness and fatigue and respiratory distress requiring 3L oxygen via nasal cannula.

Palliative Medicine was consulted for goals-of-care discussions and symptom management and complex decision making.

Case Presentation-Continued part 2

Patient was seen at bedside with his wife and the palliative care team. During the initial assessment, it was noted that the patient has **limited English proficiency (LEP)**. Initially, the patient's wife served as an interpreter; however, given the complexity and sensitivity of the discussion, a **video medical interpreter** was obtained. Communication significantly improved with use of the interpreter.

Further discussion revealed a **communication breakdown between the primary oncology team and the patient/family regarding prognosis**. After contacting the primary oncologist, it was confirmed that the patient has undergone **three prior lines of chemotherapy** and is now **refractory to multiple lines of treatment**. He received palliative chemotherapy approximately **one month prior** to current hospitalization.

The primary oncology team has determined that no further disease-directed therapy is available The patient and family were informed that the **prognosis is poor, with an estimated life expectancy of less than one month**. The importance of close follow-up with palliative medicine and a **discussion regarding hospice care** was strongly emphasized.

Macon & Joan Brock Virginia Health Sciences
Eastern Virginia Medical School
at Old Dominion University

Case Presentation-Continued Part 3

Case Management was consulted. A decision was made to utilize an **in-person medical interpreter** to facilitate more nuanced and culturally appropriate goals-of-care discussions. With appropriate language support and multidisciplinary involvement, the family was able to engage in further conversations regarding the patient's **prognosis and end-of-life care**.

Inpatient oncology team determined that the patient wasn't a candidate for any more chemotherapy. Recommended strongly against **aggressive or invasive interventions**. Pt was informed of **poor prognosis and limited time remaining of less than one week**.

Both the patient and his wife demonstrated understanding and acceptance that he was approaching the end of life.

After further discussion, the patient's **code status was changed from Full Code to Comfort Measures Only (CMO)**, and **hospice** was selected. The patient verbalized that he did not wish to die at home in front of his children, with goals focused on **comfort and medical stabilization in the hospital setting**.

Despite supportive care, the patient's clinical condition continued to deteriorated over the next 24 hours. The patient **died peacefully in the hospital two days later**.

Review

	Family Member Interpreter	Video Interpreter	In-person Interpreter
Type of Interpreter	Least effective method of communication with LEP	Better communication with patients with LEP	Best communication with patients with LEP Allows us to see and hear effect of statements delivered from medical team to patients/families
Barriers	Unsure if messages where being delivered Limited understanding of pt Biases and family burden/dynamics tends not to be addressed Medical nuances often lost	Difficult for interpreter use visual cues to interact feelings of pt Interpreter may miss patient interjections or emotional shifts	Full use of visual, verbal, and emotional cues Allows medical team to see and hear effects of statements in real time

Review Continued

Type of Interpreter	Family Member Interpreter	Video Interpreter	In-person Interpreter
Delivery of Care	Unable to address problems with medical care and patient Underlying patient concerns and perspectives may not be accurately conveyed	Better at understanding problem and direct care to family in the best way possible Underlying patient concerns and perspectives may not be accurately conveyed	Best at understanding problem and direct care to family in the best way possible Enables direct, nuanced communication with patients and families to guide care optimally
Ethical Framework	Difficult to protect Patients Autonomy and Justice Increased risk of injustice from incomplete or biased interpretation	Better at protecting patients Autonomy and Justice	Best at protecting patients Autonomy and Justice Supports ethical, patient-centered, and equitable decision-making

Rules for Interpreters

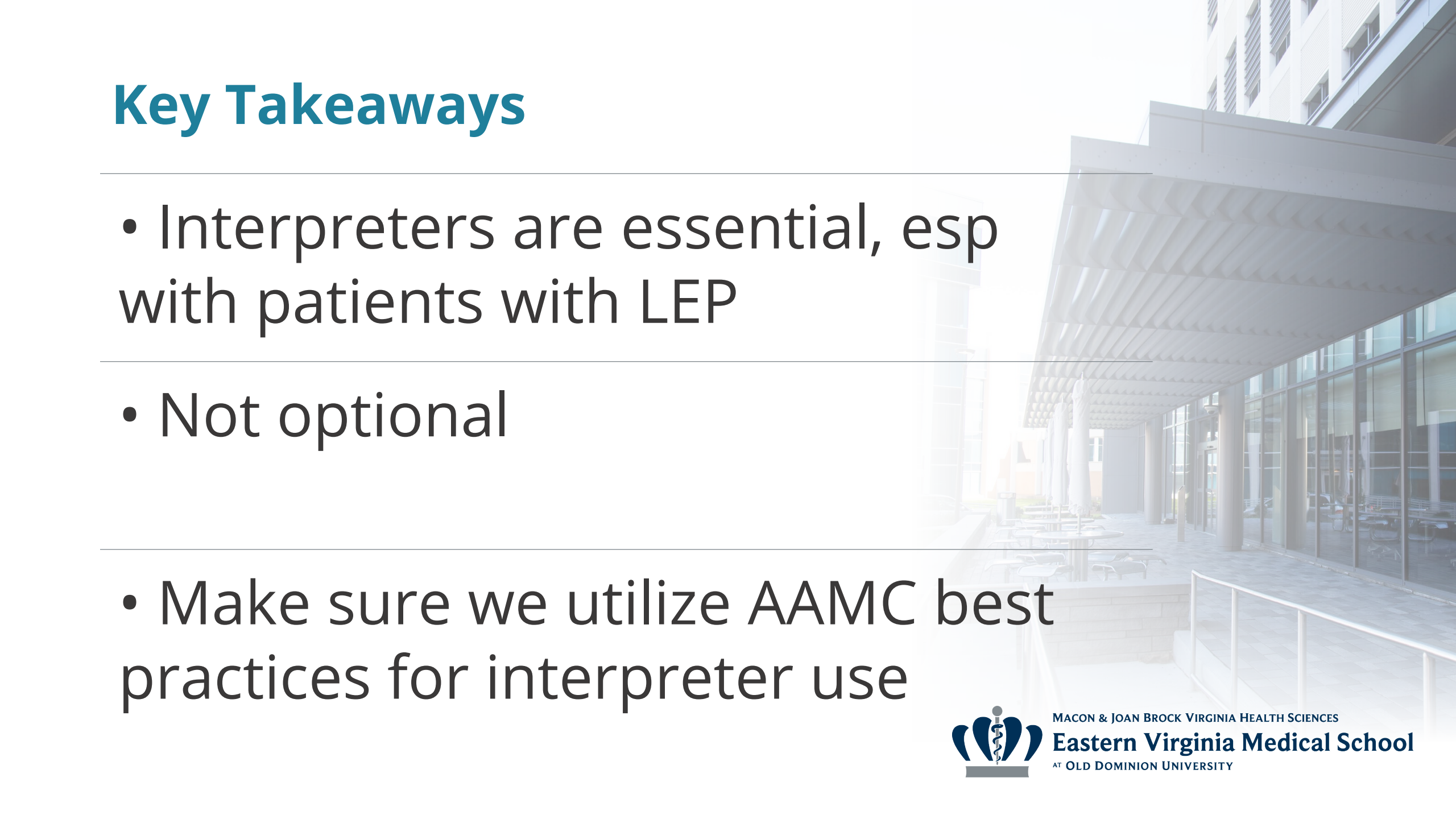
- Incorporate AAMC best practices model
- Use plain language AND Avoid medical jargon
- Confirm understanding
- Note interpreter use in documentation
    - Language and ID

Key Takeaways

- Interpreters are essential, esp with patients with LEP

- Not optional

- Make sure we utilize AAMC best practices for interpreter use



Closing Thought

- Language access = quality palliative care

References

Association of American Medical Colleges. (n.d.). *Guidelines for use of medical interpreters in clinical care*. https://www.aamc.org

Centers for Medicare & Medicaid Services. (n.d.). *Language access and auxiliary aids requirements*. https://www.cms.gov

Karliner, L. S., Jacobs, E. A., Chen, A. H., & Mutha, S. (2007). Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health Services Research, 42*(2), 727–754. https://doi.org/10.1111/j.1475-6773.2006.00629.x

Diamond, L. C., Schenker, Y., Curry, L., Bradley, E. H., & Fernandez, A. (2009). Getting by: Underuse of interpreters by resident physicians. *Journal of General Internal Medicine, 24*(2), 256–262. https://doi.org/10.1007/s11606-008-0872-7

National Consensus Project for Quality Palliative Care. (2018). *Clinical practice guidelines for quality palliative care* (4th ed.). National Coalition for Hospice and Palliative Care.

U.S. Department of Justice. (n.d.). *Title VI of the Civil Rights Act of 1964*. https://www.justice.gov/crt/fcs/TitleVI

Kff.org

Juckett G, Unger K. Appropriate use of medical interpreters. Am Fam Physician. 2014;90(7):476-480.

Flores, G. (2005). The Impact of Medical Interpreter Services on the Quality of Health Care: A Systematic Review. *Medical Care Research and Review*, 62(3): 255-299. Available at: https://www.researchgate.net/publication/7846174

Karliner LS, Jacobs EA, Chen AH, Mutha S. Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. Health Serv Res. 2007 Apr;42(2):727-54. doi: 10.1111/j.1475-6773.2006.00629.x. PMID: 17362215; PMCID: PMC1955368.

Diamond LC, Schenker Y, Curry L, Bradley EH, Fernandez A. Getting by: underuse of interpreters by resident physicians. J Gen Intern Med. 2009 Feb;24(2):256-62. doi: 10.1007/s11606-008-0875-7. Epub 2008 Dec 17. PMID: 19089503; PMCID: PMC2628994.

National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care, 4th edition. Richmond, VA: National Coalition for Hospice and Palliative Care; 2018. https://www.nationalcoalitionhpc.org/ncp

Rao A, Pillai D, Artiga S. Designating English as the Official Language of the United States Could Impact Millions with Limited English Proficiency. KFF. October 10, 2025. Accessed January 21, 2026. https://www.kff.org/racial-equity-and-health-policy/designating-english-as-the-official-language-of-the-united-states-could-impact-millions-with-limited-english-proficiency/