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CRITICAL CONVERSATIONS

Bridging Language Gaps: Ensuring Safety in Multilingual Veterinary Care

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Language barriers in practice create patient safety risks that receive far less attention than they deserve. Over 25 million people in the United States have limited English proficiency (LEP), representing approximately 8% to 9% of the population aged 5 and older.[1] When clients cannot fully communicate with the veterinary team, critical information gets lost. Given that patients cannot advocate for themselves, accurate communication with owners is essential to safe care.

UNDERSTANDING LIMITED ENGLISH PROFICIENCY

LEP refers to individuals who do not speak English as their primary language and have a limited ability to read, write, speak, or understand English, defined by the U.S. Census Bureau as speaking English less than "very well."[2] Proficiency is not binary. It exists on a spectrum; varies by context; and is greatly affected by stress, illness, and emotion. A client who schedules appointments confidently in English may still struggle to process a difficult diagnosis or follow discharge instructions in their second language, and medical terminology presents additional barriers even for those with functional conversational English.[3]

THE SCOPE OF THE PROBLEM

Recent research found that 89% of veterinary hospitals have Spanish-speaking clients with LEP, yet only 8% of practices have staff members who could converse fluently in Spanish.[3] This gap between client needs and practice capacity creates daily opportunities for miscommunication that directly affect patient outcomes in a number of areas (**BOX 1**). When communication breaks down at any of these points, patients bear the consequences.

ASSESSING LANGUAGE NEEDS

Veterinary nurses/technicians are often the first team members to identify communication barriers and the ones best positioned to flag them before they affect care. Before implementing language access strategies, practices need to evaluate their current situation by identifying which languages are spoken in their surrounding community. Practices should also track which clients prefer receiving medical information in a language other than English, even when those clients speak conversational English. Many bilingual individuals prefer their first language for medical discussions, particularly under stress, when the ability to process information in a second language is reduced.[3] Staff language capabilities require honest evaluation, as conversational ability and medical communication proficiency are not the same. Someone who speaks conversational Spanish may not be prepared to explain chemotherapy side effects, obtain informed consent for surgery, or communicate that a patient requires emergency intervention with an estimated cost of $10 000.

INTERPRETER SERVICES

When direct communication in the client's preferred language is not possible, professional interpreter services are the standard of care (**BOX 2**).

BOX 1

Areas Where Language Barriers Introduce Risk

- Obtaining accurate medical histories
- Explaining findings and treatment options
- Providing discharge instructions
- Discussing prognosis and end-of-life decisions
- Communicating during emergencies

BOX 2

The Do's and Don'ts of Working With Interpreters

Do:

- Speak directly to the client, not to the interpreter
- Use short, simple sentences and pause frequently
- Avoid medical jargon even when speaking to the interpreter
- Ask the interpreter to interpret everything, not summarize
- Allow time for questions and clarification
- Verify understanding through the interpreter before concluding

Don't:

- Use children as interpreters (except in true emergencies)
- Assume family members will interpret accurately
- Speed through complex information without pausing
- Ask the interpreter for their opinion on the client's understanding
- Skip verification because it takes extra time
- Assume nodding indicates comprehension

Professional interpreters are trained in medical terminology, accuracy, confidentiality, and cultural mediation. These all affect the quality of information exchanged. When in-person interpretation is not feasible, telephone and video remote interpreting services provide access to trained interpreters in numerous languages without requiring bilingual staff.

Using family members or friends as interpreters introduces significant risk. Family interpreters bring emotional involvement that affects accuracy. They may omit uncomfortable information, soften difficult news, or add opinions that were not part of the original message. Power dynamics within families further influence what gets communicated. Children should never serve as interpreters except in a true emergency where no other option exists.

TECHNOLOGY AS A SUPPLEMENT

Translation applications can support basic communication, including scheduling, reminders, and routine questions, when no other option is available. They are *not* a substitute for professional interpretation in clinical discussions, and errors carry consequences. Technology serves as a single tool within a broader communication strategy, not a replacement for it.

MULTILINGUAL MATERIALS

Translated written materials can support verbal communication and provide clients with information they can reference at home. Professional translation services should be used to create these documents, as a single mistranslated word can change whether a medication is administered with food or without, in the morning or at bedtime, once a day or 11 times a day. Translated materials must also be updated whenever protocols change, as outdated documents may create a false impression that accurate communication occurred.

The highest-priority materials for translation are registration and client information forms, financial policies and estimates, surgery and anesthesia consent forms, euthanasia consent forms, and emergency care instructions.

Secondary priorities include preventive care guidelines, common disease information sheets, medication instructions for frequently prescribed drugs, and nutritional and behavioral recommendations.[3]

TOOLS AND DEMONSTRATIONS

Visual aids may also support client comprehension across language barriers. Effective visual aids include anatomical models and diagrams, medication schedules with universal symbols, dosing instructions with pictures, pictograms for common procedures, and videos demonstrating at-home care techniques. Well-designed visual materials should use simple, clear illustrations with limited text, consistent symbols and icons, and culturally sensitive imagery.[3]

Two methods are particularly reliable for verifying understanding regardless of language. The teach-back method asks the client to explain in their own words what they will do at home. When working through an interpreter, have the interpreter facilitate and relay that response. Demonstration with return demonstration takes the same principle into physical skills: Show the client how to administer a medication or perform a technique, then watch them perform it before they leave. A correct return demonstration is actual evidence of comprehension, not an assumption of it.

CULTURAL COMPETENCE

Language access alone is not sufficient, as cultural factors shape how clients understand illness, make decisions, and interact with veterinary professionals. Cultural perspectives influence human–animal relationships, views on appropriate medical interventions, end-of-life decision-making, financial priorities for pet care, and expectations for the veterinary team–client relationship.[5]

Cultural variations in medical decision-making are particularly relevant in practice. Some clients make decisions individually; others involve the family or community. Some defer to authority figures; others expect shared decision-making. Time orientation, risk tolerance, and attitudes toward preventive care also vary across cultures. Adapting to these differences requires clarifying who should be involved in decisions, allowing time for family consultation when appropriate, respecting hierarchical communication when present, and balancing cultural sensitivity with patient welfare.[5]

Cultural humility, recognizing the limits of one's cultural knowledge, and approaching each client as an individual rather than a representative of a group are as important as cultural knowledge. Avoiding assumptions, asking open-ended questions, and finding common ground in animal welfare are starting points.[5]

STANDARDIZING ACCESS

Implementation varies according to clinic size (**BOX 3**).

- **Small practices with 1 to 3 veterinarians** should start with a telephone interpretation service, focus on the top 1 or 2 languages in their community, translate the 5 to 10 most critical documents, and create simple visual aids for common procedures.
- **Medium practices with 4 to 10 veterinarians** can designate a language access coordinator, contract with in-person interpreters for commonly encountered languages, and integrate technology solutions into the practice workflow.
- **Large practices and specialty hospitals** are positioned to develop formal language access programs, maintain on-site interpreters for common languages, and build comprehensive multilingual materials libraries.[3]

Regardless of practice size, veterinary nurses/technicians should ask every client which language they prefer, document language barriers when they occur, and request professional interpretation rather than defaulting to whoever is available.

SUMMARY

Language diversity in the United States will continue to grow. The practices best positioned to meet this reality are the ones building multilingual communication systems now. Addressing language access is not a courtesy extended to underserved communities; it is a clinical obligation rooted in the same principles that guide every other aspect of patient care. Every client who walks through the door deserves complete, accurate information about their pet's condition and care, regardless of the language they speak. The investment required to provide that is far smaller than the cost of the alternative. **TVN**

BOX 3

The Do's and Don'ts of Consistent Language Access

Do:

- Ask every client which language they prefer for medical information
- Document language preference and interpreter use in the medical record
- Use professional interpreters for medical discussions when available
- Translate critical safety documents professionally
- Verify understanding through teach-back methods
- Use visual aids to supplement verbal and written communication

Don't:

- Assume English proficiency based on conversational ability
- Skip informed consent verification because interpretation takes time
- Rely solely on machine translation for medical documents
- Provide less thorough discharge instructions because communication is more difficult
- Document "client verbalized understanding" without actual verification
- Assume the problem is resolved because a translated document was provided

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