CASE REPORT

Defining an Ethical Response to the Medically and Linguistically Vulnerable Patient: A Case Report

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ABSTRACT

Despite advancements in professional interpretation services, several imitations remain prevalent in the care of hospitalized patients with limited English proficiency. This case report describes a middle-aged patient who presented with a foot infection in the setting of poorly controlled type 2 diabetes and end-stage renal disease. Of note, the patient was also considerably hard-of-hearing precluding the use of standard virtual interpretation software. During the hospital stay, the patient was found to be in acute heart failure and found to have chronic limb-threatening ischemia demanding the input of numerous consultants in addition to the primary inpatient team. In addition to highlighting potential pitfalls of relying on ad-hoc interpretation via family members, the purpose of this case report is to point out alternative communication styles among healthcare professionals that seek to reduce emotional burden by addressing gaps in patient and/or caregiver understanding.

INTRODUCTION

Professional interpreters, whether utilized in-person or virtually, represent one of our most innovative approaches to caring for patients with limited English proficiency (LEP).[1-3] Nevertheless, many practical limitations of professional interpretation exist including in-person availability and technological difficulties. Additionally, patient-based factors may be at play including limited ability to communicate when confronted with auditory, visual, and/or speech deficits as well as patient preference to utilize ad-hoc interpretation via family members. These limitations create a dilemma for the inpatient clinician, especially the one assuming primary responsibility of LEP patients in the face of a medically complex presentation. This case analysis concerns an exclusively Spanish-speaking patient with numerous medical concerns who is also considerably hard-of-hearing who was hospitalized for a diabetic foot infection and subsequently found to be in systolic heart failure with chronic limb-threatening ischemia. The discussion to follow will attempt to critically examine this case from an ethical lens in assessing whether the

primary inpatient team took adequate steps to ensure understanding on the part of the patient and their family.

CASE REPORT

A middle-aged patient with poorly controlled type 2 diabetes and end-stage renal disease (ESRD) requiring daily peritoneal dialysis presented to care with left foot swelling, chest pain, and worsening difficulty with ambulation. History was obtained primarily from the patient's daughter at the bedside, as the patient was considerably hard of hearing and primarily Spanish speaking with limited English proficiency. Virtual professional interpretation was attempted with standard hospital software but ultimately failed given the patient's significant hearing difficulty.
Vital signs were unremarkable with the exception of hypotension which would persist throughout the patient's hospital course. Physical exam findings included skin necrosis, discoloration, and ulceration of the left foot consistent with infection. MRI findings demonstrated osteomyelitis of the affected foot. An EKG was obtained and revealed a new left bundle branch block which was further investigated with transthoracic echocardiogram at the recommendation of the cardiology service. Estimated ejection fraction (EF) on the echocardiogram was ten percent, consistent with severely reduced systolic function.

CT angiography recommended by the vascular surgery service to assess the extent of vascular damage demonstrated changes of chronic limb-threatening ischemia. Angiogram with possible revascularization was subsequently recomm ended and tentatively scheduled for later that week pending preprocedural clearance.

The infectious disease service was consulted given the MRI findings and advised against antibiotics given the presumed chronic course of infection and lack of fever. The nephrology team was also consulted for provision of nightly peritoneal dialysis as well as for input regarding treatment in the setting of ESRD.

Daily rounds by the primary inpatient team were preceded by independent evaluation by both a medical student and a resident. Given the complexity of the case, the medical student generally initiated interviews with open-ended questions to calibrate patient understanding such as "What is your understanding of what is going on?" These open-ended questions were generally received with confusion leading to apparent emotional distress for both the patient and their daughter. On several occasions, the patient stated they were not receiving sufficient information about what was going on from medical staff and posed concerns about potential lower-extremity amputation. The patient's daughter voiced concerns that it was difficult to organize the isolated recommendations of the numerous clinicians entering the room as well as confusion as to which clinicians were from which service.

The student frequently attempted to redirect the patient and family members, in plain language, stating there was no plan to proceed with amputation, but that given concerns about blood flow in the affected extremity, the vascular surgery team had proposed a procedure to look at the affected blood vessels which would possibly include intervention. Following these encounters, the patient voiced willingness to proceed as recommended by the team.

The attending physician on the primary inpatient team was made aware and provided further clarification to the patient and their daughter during rounds reiterating they had a foot infection, poor blood supply, and a failing heart. Therefore, the next steps in management would depend on the input of the "heart doctors." Although teach-back was frequently attempted to ensure

understanding, in-person professional interpretation was not utilized throughout the first several days of hospitalization.

The cardiology team eventually evaluated the patient, deeming them high-risk. Further, they explained the proposed procedure would be associated with a fifteen percent 30-day risk of death, MI, or cardiac arrest.

By the sixth day of hospitalization, the patient was now accompanied by their spouse instead of their daughter. At that time, both the patient and their spouse continued to endorse significant gaps in understanding including why the cardiology team was involved or whether there were "still plans to proceed with amputation." A decision was made at that time by the primary inpatient team to utilize an in-person Spanish interpreter.

Prior to meeting with an in-person interpreter, a multi-disciplinary meeting was arranged. Although the vascular surgeon was hesitant to perform an angiogram, they stated it could be performed if this was aligned with the patient's wishes under the condition they demonstrated adequate decision-making capacity. The cardiology and nephrology teams expressed agreement with this proposal, adding that they would be more comfortable with an angiogram once the patient's blood pressure improved enough to initiate goal-directed medical therapy (GDMT) for heart failure. The infectious disease physician recommended proceeding with a six-week course of antibiotics, stating while this would not be curative, it would serve as a temporizing measure.

With the help of an in-person interpreter, the attending physician on the primary team explained to the patient and the patient's spouse that the arteries in the patient's leg were damaged in the setting of diabetes, and that the vascular surgery team has proposed a procedure to restore blood flow to the leg. It was also explained that the patient's heart was discovered to have been failing, which confers higher risk to the proposed procedure. After teach-back was used by the interpreter to assess understanding, two choices were proposed to the patient.

Choice 1: Proceed with endovascular intervention as planned with the understanding the procedure is associated with a significant chance of death, cardiac arrest, or MI.

Choice 2: Postpone endovascular intervention for the time-being until a later date, with a plan to improve the patient's blood pressure such that they can tolerate heart failure medication and have the procedure performed at a time when it is potentially lower-risk.

The patient elected to proceed with ***Choice 2***.

The patient was discharged the following day on metoprolol, amoxicillin/clavulanate doxycycline, and their regularly scheduled home medications. Outpatient follow-up was arranged with nephrology, cardiology, infectious disease, and vascular surgery.

DISCUSSION

This case illustrates numerous patient-based factors coalescing to result in a deviation from standard of care use of a professional medical interpreter. While the use of a virtual interpreter proved to be of little utility given the patient's hearing deficits, several days went by before an in-person interpreter was contacted. The American Academy of Family Physicians advocates against the use of ad hoc nonprofessional medical interpreters.[4] Among other reasons, unfamiliarity with medical terminology may lead to misunderstanding and errors in

interpretation, a dilemma made glaringly obvious in this case.

In a strictly practical sense, several potential problems can be traced to the use of ad hoc nonprofessional medical interpreters including higher risk of longer hospital stays and readmission as well as limited scope of inquiry when considering certain topics such as intimate or sexual issues.[4,5] Conversely, the benefits of professional interpreters have been well-documented for decades and include a significantly lower likelihood of communication errors and significantly shorter hospital stays and reduced 30-day readmission rates.[6]

Adequate patient *understanding*, however, extends beyond sufficient linguistic interpretation. In this context, the specific dialogue chosen by the clinician will drastically affect how information is processed by the patient. Perhaps, most importantly, the way in which this information is framed to the patient informs how medical decisions are made. This focus on the interaction between doctor and patient concerns the field of microethics, initially introduced in 1995 by physician and philosopher Paul Komesaroff.[7,8]

More recently, the Situation, Task, Intent, Concern Calibrate (STICC) framework has been proposed to guide clinicians in their discussion with individual patients (*Table 1*).[9,10] Not surprisingly, inclusion of a greater number of STICC elements in team discussions has been associated with fewer complications and shorter hospital stays.[11] However, the sequence of steps in this framework is perhaps underappreciated as premature calibration on the part of the clinician (e.g., asking "What is your understanding of what is going on?" to begin the interview) may amplify the emotional burden on the part of the patient and their caregivers when gaps in understanding are revealed, as seen in this case.

Once an in-person interpreter was recruited to the bedside, several (but not all) of the STICC criteria were satisfied. First, the situation was explained in plain language (arterial damage secondary to diabetes). Next, the task (endovascular intervention) as well as the concerns (death, cardiac arrest, and MI) were described. Using this initial discussion as a launchpad, the ensuing plan was explored in the context of *a choice.*

This exchange highlights the effect of framing on how patients arrive at uncertain decisions, known formally as behavioral economics.[12] Earlier in the patient's hospital course, the proposed task (endovascular intervention) had been recommended and tentatively scheduled. At that time, the patient had "opted in." However, once given more complete information related to the risks, and given a *choice,* they chose not to proceed with the procedure. In short, the patient's decision frame was biased in the absence of full information regarding their choices. This development corroborates earlier data in the medical communication space that a "choice" frame, wherein all treatment options are explicit, is less likely to bias preferences.[13]

While the team's explanation of the patient's clinical presentation was coherent and factual, what was missing were consistent and clear recommendations – *why are we pursuing this plan in the first place?* Neglecting this piece of the STICC framework resulted in increased emotional distress for the patient and their family, a longer hospitalization and notable gaps in understanding.

This case offers several potent teaching points for anyone tasked with working with the medical and/or linguistically vulnerable patient. First, LEP patients requiring professional interpretation

Table 1: STICC elements and definitions	
Situation	*What are we dealing with?*
	What is going on?
Task	*What are we going to do about this situation?*
	What is the plan?
Intent	*Why are we pursuing this plan?*
	Are we all on the same page with our thinking?
Concern	*What could go wrong?*
	What are we worried about?
	What complications or side effects do we need to look out for?
Calibrate	Discussion regarding what the team might be missing, what is unclear or not yet understood

will almost certainly require extra time and attention on the part of the inpatient physician – *especially* those such as this patient who are considerably complex from a medical standpoint. Second, when a multidisciplinary approach is utilized in the case of the medically complex patient, professional interpretation should be utilized for every consultant who enters the patient's room. While there are practical limitations to this, it is undoubtedly the ethical thing to do. Ways around this could include specialized multi-disciplinary rounds or a specialized team that focuses on LEP patients depending on the patient population of the institution. Beyond this, special attention is required not only to the clinical content of dialogue with the patient, but how it is framed. When the clinical benefit of a proposed intervention is uncertain, we owe it to our patients to take a more directive approach in navigating the next steps.

CONCLUSION

In his widely acclaimed memoir *When Breath Becomes Air,* the late neurosurgeon and writer Paul Kalanithi writes of the modern physician, "You can't ever reach perfection, but you can believe in an asymptote toward which you are ceaselessly striving." Indeed, perfection in medicine is unattainable. Communication is no exception, especially with those who do not share our native tongue. However, we owe it to our patients as clinicians to ceaselessly strive for common understanding. This case elucidates the critical role professional interpreters play in that mission, and the necessity to make use of them even when it is not practically ideal. This is the bare minimum. Ensuring *understanding*, however, surpasses mere translation and is concerned with the specific protocol in which we convey not only *what* we plan to do, but *why.*

Notes
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REFERENCES

1. Karliner LS, Jacobs EA, Chen AH, and Mutha S. Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health Services Research.* 2007;42: 727-754. doi:10.1111/j.1475-6773.2006.00629.
2. Morten Health, Hvass AM, Wejse CM. Interpreter services and effect on healthcare – a systematic review of the impact of different types of interpreters on patient outcome. *Journal of Migration and*

Health. 2023;7. doi:10.1016/j.jmh.2023.100162

3. Al Shamsi H, Almutairi AG, Al Mashrafi S, Al Kalbani T. Implications of language barriers for healthcare: A systematic review. *Oman Med J.* 2020 Apr 30;35(2):e122. doi: 10.5001/omj.2020.40
4. Juckett G, Unger K. Appropriate use of medical interpreters. *American Family Physician.* 2014; Oct 1;90(7); https://www.aafp.org/pubs/afp/issues/2014/1001/p476.pdf. Accessed January 21, 2025.
5. Lindholm M, Hargraves JL, Ferguson WJ, Reed G. Professional language interpretation and inpatient length of stay and readmission rates. *J Gen Intern Med.* 2012;27(10):1294-1299. doi: 10.1007/s11606-012-2041-5.
6. Flores G, Abreu M, Barone CP, Bachur R, Lin H. Errors of medical interpretation and their potential clinical consequences: a comparison of professional versus ad hoc versus no interpreters. *Ann Emerg Med.* 2012 Nov;60(5):545-53. doi: 10.1016/j.annemergmed.2012.01.025.
7. Sisk BA, Baker JN. Microethics of communication—Hidden roles of bias and heuristics in the words we choose. *JAMA Pediatr.* 2018;172(12):1115–1116. doi:10.1001/jamapediatrics.2018.3111
8. Komesaroff PA. Bioethics to Microethics. In: Komesaroff PA, ed. *Troubled Bodies: Critical Perspectives on Postmodernism, Medical Ethics, and the Body.* Durham, NC: Duke University Press; 1995.
9. Leykum LK, Lanham HJ, Provost SM, McDaniel RR, Pugh J. Improving outcomes of hospitalized patients: The physician relationships, improvising, and sensemaking intervention protocol. *Implement Sci*. 2014; Nov 26;9:171. doi: 10.1186/s13012-014-0171-3.
10. Leykum LK, O'Leary K. Web Exclusives. Annals for hospitalists inpatient notes -sensemaking- fostering a shared understanding in clinical teams. *Ann Intern Med.* 2017 Aug 15;167(4):HO2-HO3. doi: 10.7326/M17-1829.
11. Leykum LK, Chesser H, Lanham HJ, et al. The association between sensemaking during physician team rounds and hospitalized patients' outcomes. *J Gen Intern Med.* 2015 Dec;30(12):1821-7. doi: 10.1007/s11606-015-3377-4.
12. Tversky A, & Kahneman D. The framing of decisions and the psychology of choice. *Science,* 1981;*211*(4481), 453–458. doi:10.1126/science.7455683
13. Abhyankar P, Summers BA, Velikova G, Bekker HL. Framing options as choice or opportunity: Does the frame influence decisions? *Med Decis Making.* 2014 Jul;34(5):567-82. doi: 10.1177/0272989X14529624.