

English as a second language and outcomes of patients presenting with acute coronary syndromes: results from the CONCORDANCE registry

Ben Gray

University of Otago Wellington, Wellington, New Zealand.

ben.gray@otago.ac.nz

Competing interests: No relevant disclosures. ■

doi: [10.5694/mja16.00483](https://doi.org/10.5694/mja16.00483)

TO THE EDITOR: The retrospective observational study by Juergens and colleagues¹ raises some concerning questions. They chose the variable of English either as first language (EFL) or second language (ESL) and measured significant inferiority of care and outcome for people with ESL. This variable has the advantage of being reasonably easy to collect in a standardised way, but the effect that is being measured is likely to be a proxy for limited English proficiency. We do not need a large trial to know that a patient who is unable to communicate with his or her doctor will have inferior care and outcomes. To be able to provide clinical care, we need to know the language proficiency of the patient. To assess the outcome of the clinical care using an EFL or ESL variable, we need to know whether an interpreter was used and if the interpreter was professional or ad hoc. The authors acknowledge this omission, but they make the contentious statement that “using non-professional interpreters can be expedient”. I would argue that in the setting of an admission for acute coronary syndrome, where vital issues of informed consent and patient understanding of the condition are involved, the use of non-professional interpreters is unethical.² This is particularly true in Australia where, as Phillips notes, “the Translating and Interpreting Service offers the most extensive telephone interpreting system in the world, providing doctors and pharmacists with rapid, 24-hour access to interpreters”.³

Although, as the authors point out, we cannot know how much of this adverse outcome in correlation with ESL is related to poor communication and how much is related to a higher prevalence of cardiovascular risk factors, it is inconceivable that poor communication is not part of the explanation. A professional interpreter should be used routinely in the setting of an admission for acute coronary syndrome because this will almost certainly improve outcomes⁴ and is likely to decrease costs,⁵ and it is a basic right for a patient to be able to communicate fully with clinicians when suffering from a potentially fatal illness.

© 2016 AMPCo Pty Ltd. Produced with Elsevier B.V. All rights reserved.

References are available online at www.mja.com.au.

- 1 Juergens CP, Dabin B, French JK, et al. English as a second language and outcomes of patients presenting with acute coronary syndromes: results from the CONCORDANCE registry. *Med J Aust* 2016; 204: 239. <https://www.mja.com.au/journal/2016/204/6/english-second-language-and-outcomes-patients-presenting-acute-coronary-syndromes>
- 2 Gray B. Informed consent in patients with limited English proficiency. *NZ Health Hospital* 2011; 63: 16.
- 3 Phillips CB. Improving health outcomes for linguistically diverse patients. *Med J Aust* 2016; 204: 209-210. <https://www.mja.com.au/journal/2016/204/6/improving-health-outcomes-linguistically-diverse-patients>
- 4 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; 42: 727-754.
- 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: 1294-1299. ■