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Vulnerabilities During and After Critical Illness:

Care-Seeking and Language-Concordant Care

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The COVID-19 pandemic brought critical care delivery to mainstream news cycles, with spotlights including nurse staffing, prone positioning, and the start of specialized post-COVID-19 clinics for recovery care. Although COVID-19 amplified public awareness of care delivery-related vulnerabilities during and after critical illness, these are well-known challenges within the critical care community. However, less explored are the relevance and implications of language-concordant care during and after critical illness.

In health care settings, language concordance is patient-centered care via the patient's preferred language for effective communication and dialog central to symptom identification, treatment decisions, and overall care delivery. Operationalized in most critical care research to date as the reverse, definitions of limited English proficiency include speaking English less than very well, choosing non-English formats when offered, documentation of a preferred language different from English, or a request for a translator.¹⁻³ The absence of language-concordant care during and after hospitalization is associated with negative consequences. During hospitalization, suboptimal communication has consequences associated with incomplete assessment of patient-reported history, delayed timelines for goals-of-care decisions, and a negative impact on patient autonomy and care-related expectations.⁴ Research is emerging in examining language concordance influencing intrahospital processes of care at the shift level. In an examination of ICU nurse-patient dyads, language-concordant care delivery was associated with differences in use of restraints and the odds of agitation and delirium.⁵ After hospitalization, limited English proficiency is linked to worse access to care attributed to health insurance status, varied thresholds for care-seeking for medical problems, delayed care, or a combination thereof, particularly during the COVID-19 pandemic.^{6,7} In sum, limited English proficiency represents a systematic disparity and structural barrier in critical care, with central solutions via language access services (eg, interpretation) to address language barriers for language-concordant care.

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In the June 2024 issue of *CHEST Critical Care*, Huang et al⁸ evaluated the intersectionality of race, ethnicity, and language as they relate to care seeking after COVID-19 critical illness. Their retrospective observational analysis of primary care and post-COVID-19 clinic use explored an association of limited English proficiency with care-seeking activities in 478 patients who survived an ICU stay in the Boston metropolitan area of the United States. Symptoms of post-intensive care syndrome are markedly present in 80% of patients with COVID-19 who survived an ICU stay, representing physical (74%), neuropsychiatric (40%), and cognitive (20%) sequelae. Primary care and post-COVID-19 clinic referrals and use were drawn from combined electronic health records for an 18-month period after hospital discharge and represent the first two surges of COVID-19 infections in the region. Their analysis examined language and ethnicity separately and suggested that limited English proficiency may be distinctly predictive of disparate post-COVID-19 clinic follow-up use.

In the context of COVID-19 critical illness, Huang et al⁸ contribute the first investigation of limited English proficiency and care seeking specific to ICU recovery care to our knowledge. They operationalized the interagency US government definition of “speaking English less than very well”¹ as “translator needed.” The validity and reliability of the designation of *translator needed* can be debated, because it is unclear if it underrepresents or overrepresents limited English proficiency. For example, when limited English proficiency was examined in 126,891 ICU admissions in Australia, the prevalence was 8%, composed of “English not preferred” (3%) and “interpreter required” (5%) responses.² Beyond language preference and translation documentation in electronic health records, other teams have turned to leveraging metadata. In a secondary analysis of a smoking cessation clinical trial, language preference was defined by language menu selections embedded in automated phone calls for research data collection.³ The comparison of *English not preferred* documentation in participant’s electronic health records (6.3%) was higher than the same participant’s self-selection of a non-English language during automated phone calls (5.1%). These are examples of threats to validity and reliability in measuring language in care delivery settings. Despite these challenges, measures of preferred language, translator required, or both represent language diversity classifications that are both agnostic to a specific language and have clinical, operational, and health policy relevance.

The practice implications of considering ICU recovery care seeking in the context of language preference spans environments before, during, and after the pandemic. This analysis by Huang et al⁸ is positioned to spark investigations in broader geographic diversity, given that linguistic diversity in the Boston metropolitan area differs from that of other areas. For example, the prevalence of *English not preferred* in Massachusetts (9%) is higher than the bordering state of Vermont (< 2%), which contrasts with California (19%) and Montana (< 1%).¹ Beyond language diversity of the general population, the care-seeking prevalence within ICU environments varies. For example, in an academic medical center in Miami, Florida, the prevalence of patients in the ICU reporting *English not preferred* (49%) has near equivalence to *English preferred*.⁵ Investigations into geographically diverse regions represent important areas for future research, to better examine how language is tracked and recorded, and investigate equity in ICU recovery care.

Overall, by presenting the care-seeking disparities of patients who have survived ICU stays with findings that disambiguate limited English proficiency from ethnicity, we can be challenged as a critical care community to examine better how language is recorded and accounted for in equitable care delivery along the critical care continuum. This analysis is relevant to health services researchers, policy analysts, and health system administrators to expand the evidence base on the organization of care delivery for patients during the vulnerable period after hospital discharge.

Investigations into vulnerabilities from explicit and implicit biases in health care delivery associated with sex, race, and ethnicity are continuing to guide the critical care community, and language perhaps has been underconsidered in ICU care delivery research. Huang et al.⁸ illustrate that when a translator was needed during hospitalization for COVID-19 critical illness, patients who survived ICU stays with a high burden of sequelae from critical illness were less likely to be seen in a post-COVID-19 clinic and showed higher rates of ED visits and death after hospital discharge compared with English-proficient counterparts. As a systematic disparity and structural barrier in access to care, language preference is an essential if not foundational element of patient-centered and family-centered care and one that warrants closer scrutiny during and after critical illness.

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