



WHITE PAPER

Pharmacy Language Access is a Code-Red Problem

Why unverified prescription translation has become
a patient safety issue

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RxTran, a division of Language Scientific, provides pharmacist-verified translation of prescription labels and directions for use.

01 Why We Published This Report

Years ago, I learned of a patient who ended up in the hospital because he didn't speak English and couldn't read the English-only instructions on his pill bottle. No one did anything wrong. A pharmacist counseled him, a relative tried to help, and a man still went home with a medication he had no reliable way to take correctly.

That case has stayed with me ever since, because this is how the problem usually looks. Nothing seems wrong while it's happening. The harm shows up later, at home, where no one is watching.

Over my career, I've watched language access move from a nice-to-have, to a legal requirement, to a patient-safety obligation nobody can credibly ignore. The states writing law today are setting the standard everyone will be held to tomorrow. My hope is that the industry comes to treat a verified label as ordinary equipment, expected and funded, well before the next mandate arrives.

Every patient should be able to read what is handed to them.

Sharon Blank
Chief Executive Officer, RxTran and Language Scientific

KEY FINDINGS

- 01 At least 28 million people in the United States have limited English proficiency, about one in twelve pharmacy patients.
- 02 Patients who can't read their directions face 33% higher odds of readmission and 12% higher odds of returning to the ER within 72 hours.
- 03 Poor comprehension of prescription directions has been a documented cause of medication errors since 2006. The label still hasn't changed.
- 04 Five states regulate prescription language access, no two alike, and four translate only when a patient asks.
- 05 Washington's 2027 rule sets no language limit, so a fixed list of languages does not comply.
- 06 Across RxTran's network, patients have requested labels in 18 languages, more than any state requires, and the fastest-growing are the least served.

02

How Language Access Became a Patient Safety Issue

At least 28 million people in the United States have limited English proficiency (LEP).¹ That's about one in every twelve patients a pharmacy serves who is unable to reliably read the label it prints.

Four points in the dispensing process put instructions in front of an LEP patient:

Counseling	The label	Refills	Transitions of care
Delivered verbally and often through an interpreter	The only instruction that goes home	Where no counseling encounter happens	Where a prescriber changes the dose or schedule, sometimes by phone, and the label the patient already has is outdated

When these are not understood, the patient improvises. A spouse translates, a child who learned English at school reads the dosing instructions to a parent who can't, or the patient uses a free translation app and trusts the answer it gives. Everyone is trying to help. No one is responsible for getting the instructions right.

A 2024 review of polypharmacy in primary care found that compounding illness, interacting medications, and complex circumstances leave patients managing several conditions with many times the instructions a single-condition patient receives.² The authors call directly for clearer information for those patients.

AHRQ names limited health literacy among the documented risk factors for adverse drug events, and notes patient-level risk is underrecognized in ambulatory care, where patients and caregivers make administration errors at high rates.³

When Patients Can't Read the Directions

As far back as 2006, the Institute of Medicine identified poor comprehension of prescription directions as a root cause of adverse drug events.⁴ Twenty years later, little has changed on the label.

In an analysis of nearly 49,000 California adults from the 2007 California Health Interview Survey, about 8 percent said they struggled to understand their prescriptions.

Limited English tripled those odds for Mexican, Central American, and Korean respondents, and quadrupled them for Chinese respondents.⁵ That figure counts only the patients who knew they were confused.

Among 1,126 Hispanic parents dosing liquid medication for young children, those with both limited health literacy and limited English erred on 28.8 percent of attempts, against 12.9 percent for parents with adequate literacy who were English proficient.⁶

A patient can be highly educated, literate in several languages, and still unable to read an English label.

SHE SPOKE FIVE LANGUAGES, NONE OF THEM WAS ENGLISH.

"One mother I visited had high health literacy and spoke four more languages than I do, but she did not speak English. She had escaped a war with five children and two nephews, and she explained that after a bomb went off near their home, all of the children developed asthma. Since arriving in our country, they had been in and out of the emergency room, and one had been hospitalized. When we went through the bags of medication in her house, we found several errors. One of the errors was that she had mixed up the maintenance inhalers with the rescue inhalers. She was horrified. Her children had suffered, and it wounded her dignity as a mother who had been so proud of getting them to safety."

Kristen Beiers-Jones, RN, MN
Assistant Professor of Clinical Nursing, OHSU School of Nursing

Among 424,745 adults discharged from New Jersey hospitals, patients with limited English proficiency had 33 percent higher odds of readmission within seven days than patients without LEP.⁷ Across 1.36 million patients seen in 64 New Jersey emergency departments, LEP patients had 12 percent higher odds of returning within 72 hours.⁸

The risk is not spread evenly. It concentrates in the languages fewest pharmacies can serve, where the fewest translations have been checked by anyone qualified to check them.

A pharmacy that dispensed without screening for drug interactions would be considered negligent. So would one that ignored an allergy alert. Both are on AHRQ's list of dispensing-stage safety strategies, and the same list recommends revising medication labels so patients can understand them.³ That last safeguard is the one still skipped for patients who don't read English.

03 Why Compliance Isn't Safety

Language access in healthcare already rests on federal law, chiefly Title VI of the Civil Rights Act and Section 1557 of the ACA, which reaches nearly every hospital and pharmacy in the country.^{9,10}

Five states go further and regulate prescription labels directly. No two require the same thing, and none of them guarantees the one outcome that matters: that the patient can read the label. Oregon mandates at least 14 languages, reviewed every 10 years by the state health authority using Medicaid and refugee data alongside Census figures.¹¹ Washington sets no fixed list and translates on request. California covers six languages, Nevada seven, New York four. A pharmacy can satisfy the letter of its state's law and still hand a patient a label they cannot read.

THE LAW PASSED. THE FUNDING DIDN'T.

"Since passing the Oregon law, every pharmacy and health system has approached the requirement differently. Some contract with outside translation services, others translate labels in-house, and the result is inconsistent implementation with no dedicated funding behind it. States that follow can learn from the Oregon experience by building the infrastructure and the funding from day one, rather than treating this as an unfunded mandate for pharmacies to solve alone. Pharmacists want all patients to understand how to take their medications, but the systems to support pharmacists in this are lacking."

Kristen Beiers-Jones
Assistant Professor of Clinical Nursing, OHSU School of Nursing

Oregon answered the verification worry with a specific protection: a pharmacy that uses a qualified third-party translation service in good faith is shielded from liability for that translation.¹¹

TABLE 1 — STATE PRESCRIPTION LABEL MANDATES

STATE	STATUTE	EFFECTIVE	REQUIRED LANGUAGES	WHO IS COVERED
Oregon ¹¹	ORS 689.564 (SB 698, 2019)	January 1, 2021	At least 14, set by most recent ACS and other data sets such as recent refugee arrivals. Dual-language label*	All pharmacies except institutional drug outlets
Washington ¹²	WAC 246-945-029 (ESHB 1852)	January 22, 2027	No limit. Translation upon request	In-state and nonresident licensed pharmacies
California ¹³	Bus. & Prof. Code § 4076.6; 16 CCR § 1707.5	Jan 1, 2016, amended Jan 1, 2025	6 published by the Board: Chinese, Farsi, Korean, Russian, Spanish, Vietnamese	All dispensers
New York ¹⁴	Educ. Law § 6829; 8 NYCRR § 63.11	Mar 30, 2013	Chinese, Italian, Russian, Spanish	Chains of 8 or more NY locations, plus mail order
Nevada ¹⁵	NRS 639.28013 (AB 177, 2021)	July 1, 2022	Spanish, Tagalog, Chinese, Amharic, Somali, Vietnamese, Korean	All pharmacies except institutional

Dual-language label: the English directions are printed on the label alongside the translated directions rather than being replaced by them, so the patient and anyone assisting them are reading the same instruction. Oregon's requirement is set out in ORS 689.564.

18 | 26

Eighteen of the 26 languages covered already logged.

RxTran's dispensing network, which has a total of 26 languages in the system, has logged label requests in 18 languages and counting. The fastest-growing are among the least commonly served.¹⁶

04

What Accountable Language Access Requires

Producing a translated label is the easy part, and the industry has done it for years. Accountable language access means a pharmacy can stand behind what it printed, clinically and legally, and can name who verified it. Success is measured by whether the patient understood the directions.

The goal isn't a translation. It's a translation an expert has verified, in the patient's own language, that they can follow.

Six Principles of Accountable Translation

01 Human clinical validation first. A qualified human reviews every translation before it reaches a patient. Machine output is never dispensed on its own.	02 Verified accuracy. A documented standard, measurable and auditable, rather than an assurance.
03 Coverage breadth. Language capacity built against the population a pharmacy serves, not the minimum a statute names.	04 System integration. Translation that lives inside pharmacy management systems, dispensing platforms, and drug information databases, generated in workflow rather than bolted onto it.
05 Care team coordination. Prescribers, nurses, community health workers, and care coordinators working from the same verified directions the patient holds, which requires the English directions to remain on the label alongside the translation.	06 Documented responsibility. A named party accountable for accuracy, which is what turns a translation into something defensible.

Questions Every Pharmacy Leader Should Ask

- 01 Who verified the translation on the label we dispensed yesterday, and can we produce that record?

- 02 How many languages do our patients speak, and how many can we serve?

- 03 Does our translation step run inside the dispensing workflow, or does it depend on someone remembering?

- 04 If a patient is harmed by a mistranslated direction, who in our organization owns that?

- 05 When we rely on machine-only translation, do we tell the patient it wasn't reviewed?

IN HER OWN WORDS

"Accountable language access means being able to defend a translation clinically and legally, not just produce one. That's the bar our industry should hold itself to. Human clinical validation first, verified accuracy, and documented responsibility for getting it right."

Sharon Blank
Chief Executive Officer, RxTran

05 Getting Ahead of the Next Wave of Regulation

A patient walks out of the pharmacy with a bottle and has to work out, alone, how to take what's inside it. Everything in this report is about that moment.

Kristen Beiers-Jones has spent much of her career with refugee and immigrant patients in Oregon. Two of the cases she describes end the same way.

WHEN DOING NOTHING FEELS SAFEST

"A young woman came home from the hospital after delivering her baby, carrying a bag of medications she couldn't read. Give the pharmacy the benefit of the doubt and assume an interpreter was called. By the time she got home she was exhausted and unwell, holding prescriptions for herself and for a newborn. She could not recall what the interpreter had said and could not read the English-only label so she did the safest thing she could think of. She disposed of them."

"A little girl was hit by a car and broke several bones. She was sent home from the hospital with pain medication prescriptions her mother couldn't read, so her mother gave her none of it. That child spent days in severe pain, with the drug that would have relieved it sitting in the house."

Kristen Beiers-Jones, RN, MN
Assistant Professor of Clinical Nursing, OHSU School of Nursing

In neither case did anyone misread a dose. The medication never got taken, because withholding felt safer than guessing. Neither case appears in a pharmacy's error log.

The exposure isn't only clinical. The Section 1557 compliance deadline has passed, and plaintiff's attorneys are already citing the 50 percent error rate as indefensible for populations pharmacies know they serve.¹⁷

Pharmacies that move before the next mandate can build this into workflow instead of retrofitting it under a deadline, and the work reaches past the counter to the nurses, prescribers, and care coordinators who see where directions get lost. The technology already exists; pharmacist-verified translation, generated inside the dispensing workflow, is available now. Start with the five questions in the previous section. Any pharmacy that can't answer who verified the translation on the label it dispensed already knows where to begin.

What this report has described is a patient safety problem that keeps being handled as paperwork. A label a patient cannot read is a direction that was never given, and the harm shows up later at home, in readmissions and in medication left in the bag, where no error log records it. Another patchwork of rules will not fix it. Five states now regulate prescription labels and no two agree, so a pharmacy can comply fully and still hand a patient something they cannot use.

Rather than wait to be told, the industry should settle on a standard of its own, one built on verified translation generated inside the dispensing workflow, with a named party accountable for accuracy. The states that do legislate should fund that infrastructure from day one instead of leaving pharmacies to solve it alone. That approach has to rest on human clinical validation, because unverified machine translation is an unreviewed instruction with no one behind it. Pharmacies can begin with the six principles and five questions in this report.

"None of this is about being only compliant with the law. That is too low of a standard. It's about whether a patient walks out of the pharmacy able to safely take the medicine we gave them. That's the only measure that has ever mattered to me, and it's the standard our team at RxTran is committed to push this industry toward, long after the current wave of mandates has passed."

Sharon Blank
Chief Executive Officer, RxTran

About the Contributors

Sharon Blank is the chief executive officer of Language Scientific, an intentionally human-scale provider of translation, localization, and linguistic validation services, primarily to the pharmaceutical, life sciences, clinical research, and regulatory sectors. RxTran is a wholly owned subsidiary of Language Scientific.

Kristen Beiers-Jones, M.N., R.N., is an Assistant Professor of Clinical Nursing at the Oregon Health and Science University School of Nursing, with a career rooted in population health nursing spanning college health, home health, hospice and refugee health. Her work focuses on health equity, language access in medication labeling, and the social drivers that shape care for underserved communities. She led a team of nursing students, community members and health providers to pass Oregon's prescription label translation law and was awarded Oregon Public Health Association Policy Champion award for 2019.

About RxTran

RxTran, a division of Language Scientific, provides pharmacist-verified translation of prescription labels and directions for use. Its software currently covers 26 languages, growing to 30 by the end of 2026, and integrates with pharmacy dispensing systems so translation happens in workflow rather than after the fact. Learn more at rxtran.com.



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