Let's Not Contribute to Disparities: The Best Methods for Teaching Clinicians How to Overcome Language Barriers to Health Care

Lisa C. Diamond, MD, MPH[1] *and Elizabeth A. Jacobs, MD, MPP*[2]

[1]Palo Alto Medical Foundation Research Institute, Palo Alto, CA, USA; [2]Division of General Internal Medicine and Rush Institute for Healthy Aging, John H. Stroger Hospital of Cook County & Rush University Medical Center, Chicago, IL, USA.

Clinicians should be educated about how language barriers contribute to disparities for patients with limited English proficiency (LEP). However, educators must avoid developing educational interventions that increase health disparities for LEP patients. For example, studies suggest that teaching "Medical Spanish" or related courses may actually contribute to health care disparities if clinicians begin using these non-English language skills inappropriately with patients. We discuss the risks and benefits of teaching specific cultural competence skills and make evidence-based recommendations for the teaching content and methods for educational interventions focused on overcoming language barriers in health care. At minimum, we suggest such interventions include: (1) the role of language barriers in health disparities, (2) means of overcoming language barriers, (3) how to work with interpreters, (4) identifying and fixing problems in interpreted encounters, and (5) appropriate and safe use of one's own limited non-English language skills.

KEY WORDS: communication barriers; doctor-patient relationships; medical education; health disparities.
J Gen Intern Med 25(Suppl 2):189–93
DOI: 10.1007/s11606-009-1201-8

INTRODUCTION

Language barriers are increasingly present in health care in the US. According to the US Census, an estimated 47 million people in the US speak a language other than English at home, and the proportion of people who speak English "not well" or "not at all" almost doubled, from 4.8% in 1980 to 8.1% in 2000.[1] Having limited English proficiency (LEP) is a risk factor for health disparities—it can result in decreased access to preventive health services,[2] decreased satisfaction with care,[3] poor understanding of instructions or medications,[4] longer hospital stays,[5] and an increased risk of medical errors and misdiagnoses.[6,7] However, the risk of these disparities can be reduced and/or eliminated when physicians use professional interpreters or communicate proficiently with patients in their preferred language. The use of professional interpreters improves the quality of care for patients with LEP, resulting in higher patient satisfaction,[8] fewer errors in communication,[9] reduced disparities in utilization of services,[10] and improved clinical outcomes.[11] Despite this fact, studies have shown that physicians underuse professional interpreters,[11–14] frequently substituting their own limited non-English language skills during clinical encounters, even when they are aware of their non-English language limitations and their potential impact on quality of care.[15] Patients also recognize when interpreters are underused. In one study, almost one quarter of patients with LEP felt that an interpreter should have been used, especially when the clinician used his or her own limited Spanish to communicate.[11]

The Institute of Medicine, in their report entitled "Unequal Treatment—Confronting Racial and Ethnic Disparities in Healthcare" recommended that cross-cultural education be incorporated into the training of all health professionals, including how to address language barriers in clinical practice.[16] In order to reduce the risk of health disparities that LEP patients face, it is essential that clinicians be educated as to how language barriers contribute to disparities. These courses may include information about which methods of surmounting language barriers are the most effective at reducing disparities, and how some methods, such as use of family and friends as interpreters, can contribute to this risk. In doing so, however, medical educators must take care not to develop educational interventions that may actually increase the likelihood that LEP patients will experience disparities, such as teaching clinicians minimal language skills that then supplant the use of professional trained interpreters.

THE EVIDENCE FOR AND AGAINST DIFFERENT METHODS OF TEACHING ABOUT LANGUAGE BARRIERS IN HEALTH CARE

Courses focused on teaching clinicians about language barriers in health care, and how and when to use an interpreter have been shown to be beneficial. They increase the likelihood that physicians will choose to access and use appropriate interpreters when they encounter LEP patients. One study showed that physicians who had received such training reported both increased use of professional interpreters and satisfaction with the medical care they provided.[17] A systematic review of cultural competence interventions showed that those targeting language barriers helped improve the knowledge, attitudes, and skills of health professionals.[18] Cultural competence interventions have been shown to improve participants' understanding of: racial/ethnic differences in disease burdens,[19,20] traditional cultural practices,[21,22] influences of patient culture on providers' own behaviors,[21] best interpreter practices, immigration demographics, and legal issues surrounding language barriers.[23] Other benefits of educational programs about cultural and language disparities have shown

improvements in participants' self-perceived cultural competence skills and attitudes, potentially resulting in more culturally sensitive care of LEP patients.[23–25] In addition, a national survey of resident physicians found that physicians who had received prior instruction on cultural competence, appropriate interpreter use, and the legal rights of LEP patients were more likely to use professional interpreters and less likely to use children as interpreters.[26]

In contrast, while several studies have demonstrated that interventions to improve non-English language skills of clinicians result in improvements in tested language skills,[20,27–29] there have been some negative outcomes of these interventions. Studies have demonstrated that brief, intense language training in groups of medical trainees with some proficiency in Spanish led to diminished interpreter use, despite the limited nature of the trainees' proficiency after the course.[27,28] One of these studies identified significant communication errors in the post-intervention period when trainees used their improved, yet non-fluent, language skills instead of interpreters.[28] Another intervention to teach medical students how to communicate better with non-English-speaking patients improved students' inquiry skills and attitudes, but not their ability to convey empathy and use simple language.[30] These studies suggest that teaching health-care professionals "medical Spanish" or other limited language skills may actually contribute to health-care disparities in the LEP population. In the case of language, a little proficiency can be a dangerous thing.

RECOMMENDATIONS FOR CURRICULUM

Education intended to reduce language barriers can also potentially contribute to disparities among LEP patients. Accordingly, institutions and/or individuals who develop and teach these courses need to take care to avoid contributing to the problem they are intending to address. This can be done by making sure that teaching interventions are of high quality and that their impact on use of interpreters and on physician's own limited non-English language skills is monitored.

Based on our experience and review of the literature,[31] we have identified five teaching topics that should be included in any high-quality educational intervention that focuses on overcoming language barriers to health care: (1) the role language barriers play in contributing to health disparities, (2) what the best interventions are for reducing the risk of disparities when caring for LEP patient populations, (3) how to work with an interpreter, (4) how to recognize when an

Table 1. Recommended Curriculum Modules for Teaching Clinicians How to Overcome Language Barriers in Health Care

Module	Content	Suggested teaching methods[a]
Contributing role of language barriers in health disparities	● Review of literature of impact of language barriers on health and health care ● Description of salient cases ● Review of laws regulating the provision of adequate interpreters (Title VI and state laws)	● Didactic lecture ● Reading and discussion of salient cases/ first person accounts
Effective means of overcoming language barriers	● Review of issues that arise when ad hoc interpreters are used ● Description of qualified interpreter and what they bring to the role of professional interpreting	● Didactic lecture ● Video vignettes of problematic encounters in which ad hoc interpreters are used ● Video vignettes of professionally interpreted encounters
How to work with interpreters	● Need for introduction and debriefing with interpreters ● Positioning of interpreter ● Use of jargon-free, easily translated amounts of information ● Keeping eyes on the patient, not the interpreter ● Asking the interpreter for help with cultural issues that arise ● What to do if you have to use an ad hoc interpreter ● Never use a child as an interpreter	● Didactic lecture ● Role-modeling in simulated encounter ● Video vignettes of professionally interpreted encounters ● Role-playing working with interpreters
How to identify problems in interpreted encounters and what to do about them	● Interpreted information does not match the patient's tone and/or demeanor ● More is said by the patient or clinician than appears to be interpreted ● The interpreter takes control in the encounter ● How to politely guide the interpreter to use best interpreting practices	● Didactic lecture ● Video vignettes of problematic interpreted encounters ● Role-modeling ● Role-playing
Should clinicians use their own limited language skills?	● Description of how limited fluency inhibits accurate communication ● Review the literature documenting how limited language skills inhibit appropriate use of interpreters ● Encourage use of these limited language skills for rapport building	● Didactic lecture ● Discussion

[a]*One or more may be used for teaching content in each module*

interpretation is not going well and what to do about it, and (5) when it is appropriate and safe to use one's own non-English language skills. In Table 1, we outline what should be taught under each of these topics and recommend methods for teaching them. We elaborate on each of these recommendations below. Of note, we do not recommend the course duration or minimum number of individual sessions. We believe that the content and quality of the teaching are more important than the absolute amount of time devoted to it.

For the first topic, there is plenty of evidence in the literature that language barriers or use of inappropriate interpreters leads to worse quality of care and outcomes[2,32–34] and increases the risk of adverse events.[5,6] The use of ad-hoc interpreters, including family members or untrained bilingual staff, can lead to misunderstandings, misdiagnoses, and medical errors.[6,7] In addition, anecdotes or first person accounts in the literature of how lack of or poor interpretation can lead to poor outcomes are very powerful and should also be included in this teaching module.

The second module on the best methods of overcoming language barriers should include teaching on how non-professional or ad hoc interpreters (e.g., family, friends, untrained staff, etc.) can impair adequate communication and how professional interpreters are the best solution. In this module, the ability of professional interpreters to provide accurate, neutral, and complete information should be the focus. It is important to discuss how ad hoc interpreters likely do not have the skill or ability to provide accurate complete interpretation and that their relationship to the patient may interfere with communication and negate the confidentiality of the encounter. For example, a daughter interpreting for her father, upon hearing a cancer diagnosis, could decide not to interpret everything the physician says because she believes she is protecting him. Then the focus should be on how use of professional interpreters (via any method: in person, telephonic, or video) reduces the likelihood of this potential problem.

The third module should focus on how best to work with interpreters, including role-modeling either in person or on video vignettes and role-playing to practice this skill. Clinicians should be taught to position the interpreter next to and somewhat behind the patient, so that patient-clinician eye contact, rapport-building, and relationship are not disrupted.[35] In this module, it is also a good idea to teach clinicians what to do in a situation in which they have no choice but to use an ad hoc interpreter. The focus should be on maximizing the quality of the interpretation using a non-professional interpreter. This can include making sure the clinician speaks as simply as possible to increase the likelihood that their words can be interpreted and giving the ad hoc interpreter permission to stop at any point to clarify vocabulary (in either language) or discuss any discomfort from being in the interpreter role. It should be acknowledged that there are times when ad hoc interpreters must be used, but students should be reminded why this should be avoided and that the use of children as interpreters is unethical and should never be done.[36]

Addressing the potential use of ad hoc interpreters highlights the importance of the fourth module, in which students are taught how to recognize when an interpreted encounter is not going well. This is most important in the context of using an ad hoc interpreter when problems of communication most likely will arise. This includes attending carefully to what is happening with the patient and the flow of information. The clinician must always attend to whether or not the patient's expression, voice, and/or demeanor match what the interpreter is saying and if the amount of information the physician or the patient is giving is matched by what the interpreter is saying. In addition, the clinician needs to make sure that the interpreter is not interjecting his or her own opinion or agenda. If any of these happen, then the clinician should stop and clarify the interpreter's role—to provide accurate, neutral information.

In the final module, there should be a discussion of what to do when the clinician speaks the patient's language, but not fluently. Unfortunately, there is no research available to know how fluent a clinician needs to be to be able to safely provide care in a language other than English, and, as a result, there are no current standards for when it should be allowable.[37] It is known, however, that care provided by non-fluent physicians can be as problematic as care provided by using ad hoc interpreters.[11,15] So, unless a physician is fluent in the patient's language, they should consider using a professional interpreter. However, they should always be encouraged to use their non-fluent second language skills to establish rapport and conduct a simple physical exam, but not for more complicated interactions.

WHAT ABOUT TEACHING OTHER LANGUAGE SKILLS?

The question of whether or not clinicians should be taught languages other than English to help promote communication with their LEP patients is a difficult one. The intention of these interventions is noble—to enhance communication with LEP patients—but it can also have the unintended effect of impairing communication and potentially contributing to health disparities among LEP patients. We believe that if these language skills are taught in addition to the curricular components we have outlined, they could potentially benefit communication. However, great care must be taken to emphasize that these skills should be used in conjunction with professional interpreters and not in place of them. In addition, the impact of this teaching on appropriate use of interpreters and inappropriate use of limited non-English language skills must be carefully tracked and evaluated to make sure they are not having the unintended effect of impeding appropriate linguistic access services. In the absence of specific guidelines for non-English language use by clinicians, those enrolled in medical Spanish or similar courses should be taught to recognize their own limitations in the non-English language and to call for professional interpreters when needed.

REDUCING DISPARITIES THROUGH EDUCATION

Teaching clinicians and trainees about how to avoid contributing to health-care disparities in the context of language barriers should be an essential component of clinical education. The literature tells us that using the best methods for communicating with LEP patients (e.g., professional interpreters) can reduce health disparities,[8–11] so increasing the use of these best methods through education is therefore likely to reduce disparities in this vulnerable population.

Ideally, these types of educational interventions should be introduced early in the career of health professionals, reinforced close to the commencement of clinical experiences (e.g., ward rotations for medical students), and continued throughout clinical training. Introducing them early lays the foundation for good clinical practice in training and beyond, and reinforcement is critical to any teaching. In our experience, educational interventions that include interactive sessions, student problem-solving, and role-playing work best.[31] Practicing these skills during a structured intervention is not only skill-building, it can empower clinicians to better address challenging clinical situations and make them feel less anxious and intimidated when caring for patients with LEP. In addition, it is useful to have interpreters be part of the teaching faculty; they are the most experienced with what physicians do right and wrong in interpreted encounters and bring a unique and important perspective to the teaching. Finally, the quality and reinforcement schedule of the teaching is more important than the quantity of teaching. A handful of high-quality 1- to 2-hour sessions that address the topics we have outlined, placed strategically throughout medical or nursing school, for example, will go farther towards establishing and maintaining knowledge and skills than one or two longer sessions.

The disparities that result from language barriers, like other health disparities, partially result from clinicians' lack of knowledge of their import, attitudes towards them, and behaviors. Interventions to increase knowledge, change attitudes, and encourage the right behaviors can therefore be one of the solutions to reducing the disparities that arise from language barriers in the health-care setting. They need not be extensive or complex, just strategically placed throughout clinicians' training, targeted to enhance knowledge and encourage facilitative attitudes towards communicating with patients in a language that the patient can understand as well as skill-building in how to access and work with the right interpreter services to facilitate accurate communication.

Acknowledgements: *Dr. Diamond was supported during this research by The California Endowment. Dr. Jacobs was supported during this research by The California HealthCare Foundation.*

Conflict of Interest: *None*

Corresponding Author: *Lisa C. Diamond, MD, MPH, Palo Alto Medical Foundation Research Institute, Ames Building, 795 El Camino Real, Palo Alto, CA 94301, USA (e-mail: diamondl@pamfri.org).*

REFERENCES

1. **Shin HB, Bruno R.** Language Use and English-Speaking Ability: 2000. October 2003; http://www.census.gov/prod/2003pubs/c2kbr-29.pdf. Accessed October 23, 2006.
2. **Woloshin S, Schwartz LM, Katz SJ, Welch HG.** Is language a barrier to the use of preventive services? J Gen Intern Med. 1997;12(8):472–7.
3. **Morales LS, Cunningham WE, Brown JA, Liu H, Hays RD.** Are Latinos less satisfied with communication by health care providers? J Gen Intern Med. 1999;14(7):409–17.
4. **Wilson E, Chen AHM, Grumbach K, Wang F, Fernandez A.** Effects of limited English proficiency and physician language on health care comprehension. J Gen Intern Med. 2005;20(9):800–6.
5. **John-Baptiste A, Naglie G, Tomlinson G, et al.** The effect of English language proficiency on length of stay and in-hospital mortality.[see comment]. J Gen Intern Med. 2004;19(3):221–8.
6. **Divi C, Koss RG, Schmaltz SP, Loeb JM.** Language proficiency and adverse events in US hospitals: a pilot study. Int J Qual Health Care. 2007;19(2):60–7.
7. **Flores G, Laws MB, Mayo SJ, et al.** Errors in medical interpretation and their potential clinical consequences in pediatric encounters. Pediatrics. 2003;111(1):6–14.
8. **Baker DW, Hayes R, Fortier JP.** Interpreter use and satisfaction with interpersonal aspects of care for Spanish-speaking patients. Med Care. 1998;36(10):1461–70.
9. **Jacobs EA, Lauderdale DS, Meltzer D, Shorey JM, Levinson W, Thisted RA.** Impact of interpreter services on delivery of health care to limited-English-proficient patients. J Gen Intern Med. 2001;16(7):468–74.
10. **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(2):727–54.
11. **Baker DW, Parker RM, Williams MV, Coates WC, Pitkin K.** Use and effectiveness of interpreters in an emergency department. JAMA. 1996;275(10):783–8.
12. **Burbano O'Leary SC, Federico S, Hampers LC.** The truth about language barriers: one residency program's experience. Pediatrics. 2003;111(5 Pt 1):e569–73.
13. **Yawman D, McIntosh S, Fernandez D, Auinger P, Allan M, Weitzman M.** The use of Spanish by medical students and residents at one university hospital. Acad Med. 2006;81(5):468–73.
14. **Schenker Y, Wang F, Selig SJ, Ng R, Fernandez A.** The Impact of Language Barriers on Documentation of Informed Consent at a Hospital with On-Site Interpreter Services. J Gen Intern Med. 2007;22(S2):294–9.
15. **Diamond L, Schenker Y, Bradley E, Curry L, Fernandez A.** Getting By: Underuse of Interpreters by Resident Physicians. J Gen Intern Med. 2009;24(2):256–62.
16. **Institute of Medicine, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care.** Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington: National Academies Press; 2003.
17. **Karliner LS, Perez-Stable EJ, Gildengorin G.** The language divide. The importance of training in the use of interpreters for outpatient practice. J Gen Intern Med. 2004;19(2):175–83.
18. **Beach M, Price E, Gary T, et al.** Cultural Competence: A systematic review of health care provider educational interventions. Med Care. 2005;43:356–73.
19. **Copeman R.** Medical students, Aborigines and migrants: evaluation of a teaching programme. Med J Aust. 1989;150:84–7.
20. **Nora L, Daugherty S, Mattis-Peterson A, Stevenson L, Goodman L.** Improving crosscultural skills of medical students through medical school-community partnerships. West J Med. 1994;161:144–7.
21. **Culhane-Pera K, Reif C, Egli E, Baker N, Kassekert R.** A curriculum for multicultural education in family medicine. Fam Med. 1997;29:719–23.
22. **Godkin M, Savageau J.** The effect of a global multiculturalism track on cultural competence of preclinical medical students. Fam Med. 2001;33:178–86.
23. **Kalet A, Mukherjee D, Felix K, et al.** Can a web-based curriculum improve students' knowledge of, and attitudes about, the interpreted medical interview? J Gen Intern Med. 2005;20(10):929–34.
24. **Napholz L.** A comparison of self-reported cultural competency skills among two groups of nursing students: implications for nursing education. J Nurs Educ. 1999;38:81–3.
25. **Gany F, de Bocanegra H.** Maternal-child immigrant health training: changing knowledge and attitudes to improve health care delivery. Patient Educ Couns. 1996;27:23–31.
26. **Lee KC, Winickoff JP, Kim MK, et al.** Resident physicians' use of professional and nonprofessional interpreters: a national survey. JAMA. 2006;296(9):1050–3.
27. **Mazor S, Hampers L, Chande V, Krug S.** Teaching Spanish to pediatric emergency physicians: effects on patient satisfaction. Arch Pediatr Adolesc Med. 2002;156(7):693–5.
28. **Prince D, Nelson M.** Teaching Spanish to emergency medicine residents. Acad Emerg Med. 1995;2(1):32–6.

29. **Reuland D, Frasier P, Slatt L, Aleman M.** A longitudinal medical Spanish program at one US medical school. J Gen Intern Med. 2008;23 (7):1033–7.
30. **Farnill D, Todisco J, Hayes S, Bartlett D.** Videotaped interviewing of non-English speakers: training for medical students with volunteer clients. Med Educ. 1997;31:87–93.
31. **Jacobs, EA, Diamond, LC, Stevak, L.** The Importance of Teaching Clinicians When and How to Work With Interpreters. Patient Educ Couns., In Press.
32. **Cheng EM, Chen A, Cunningham W.** Primary Language and Receipt of Recommended Health Care Among Hispanics in the United States. J Gen Intern Med. 2007;22(S2):283–8.
33. **Diehl A, Westwick T, Badgett R, Sugarek N, Todd K.** Clinical and sociocultural determinants of gallstone treatment. Am J Med Sci. 1993;305(6):383–6.
34. **Todd KH, Samaroo N, Hoffman JR.** Ethnicity as a risk factor for inadequate emergency department analgesia.[see comment]. JAMA. 1993;269(12):1537–9.
35. **National Committee on Interpreting in Health Care.** Guide to Interpreter Positioning in Health Care Settings. (November 2003). Available at: http://data.memberclicks.com/site/ncihc/NCIHC Working Paper — Guide to Interpreter Positioning in Health Care Settings.pdf. Accessed November 8, 2009.
36. Downing, B. and Roat, CE. Models for the Provision of Language Access in Health Care Settings (March 2002). Available at: http://data.memberclicks.com/site/ncihc/NCIHC Working Paper — Models for Provision of Language Access.pdf. Accessed November 8, 2009.
37. **Diamond L, Reuland D.** Describing Physician Language Fluency: Deconstructing Medical Spanish. JAMA. 2009;301(4):426–8.