

**National Advisory Committee**  
**Concept Paper: Language Access Services**

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***Scope and Purpose:***

The aim of this paper is to provide input to the National Advisory Committee for the design and definition of curriculum modules on culturally competent care based on the corresponding subset of National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) Standards (Office of Minority Health, 2001). It focuses on the core knowledge and competencies of working with limited English proficient (LEP) persons that family physicians should be able to demonstrate. It outlines these competencies and the range of possible educational approaches to teaching family physicians how to develop and maintain their skills in addressing the needs of their LEP patients. It also includes references to research supporting the inclusion of this type of curriculum into medical education and training. There have been no studies that directly demonstrate the impact for this type of curricular intervention, but there is an abundance of literature documenting the importance of overcoming language barriers to access to medical care and the urgent need for this type of curricular intervention.

***Culturally and Linguistically Appropriate Services in Health Care Standards***

Culturally and linguistically appropriate services are defined in the CLAS standard as Health care services that are respectful of and responsive to cultural and linguistic needs (Office of Minority Health, 2001). The CLAS standards that specifically address the provision of language access services will guide the recommendations for designing and defining curriculum modules on language access services described in this paper. These standards are

- Standard 4: Health Care Organizations Must Offer and Provide Language Assistance Services, Including Bilingual Staff and Interpreter Services, at No Cost to Each Patient/Consumer With Limited English Proficiency at All Points of Contact, in a Timely Manner During All Hours of Operation.
- Standard 5: Health Care Organizations Must Provide to Patients/Consumers in Their Preferred Language Both Verbal Offers and Written Notices Informing Them of Their Right To Receive Language Assistance Services.
- Standard 6: Health Care Organizations Must Assure the Competence of Language Assistance Provided to Limited English Proficient Patients/Consumers by Interpreters and Bilingual Staff. Family and Friends Should Not Be Used To Provide Interpretation Services (Except on Request by the Patient/ Consumer).
- Standard 7: Health Care Organizations Must Make Available Easily Understood Patient-Related Materials and Post Signage in the Languages of the Commonly Encountered Groups and/or Groups Represented in the Service Area.

## ***I. Core concepts and content knowledge about language access services that family physicians should know.***

Family physicians should be knowledgeable of the research, laws and federal guidance that motivated the development of the CLAS standards by the Office of Minority Health. Knowledge in these areas will motivate their acquisition of skills to help overcome language barriers in their practice and inform them of how to care for these patients in a legal and ethical manner. They should also be knowledgeable of the different methods of providing language access in health care settings and the rationale behind CLAS Standard 6. This information is key to understanding the importance of acquiring the core skills outlined in Section II of this paper. They should understand that increasing language access is a crucial step to enhancing cross-cultural communication, but only one component of providing culturally competent care. Finally, they should be able to assess the adequacy of translated materials.

### **a) Research on the importance of language access to the health of LEP patients**

Family physicians should be aware of the fact that language barriers to access to medical care are a large and growing problem in the United States. According to the 1990 Census, nearly 32 million people living in the United States do not speak English as their primary language (U.S Census, 1993). They represent 14% of the total US population and up to 36% of the population of some states (U.S. Census 1993). Final 2000 census figures are expected to show a dramatic increase in the size of this population over the past 10 years.

An abundance of research has demonstrated that patients who cannot speak English well receive less than optimal health care. Many studies have shown that people whose main spoken language is not English are less likely to receive preventive care (Woloshin et al., 1997; Hu et al., 1998), to have a regular source of primary care (Kirkman-Liff et al., 1991; Weinick RM et al., 2001) or to receive timely eye, dental, and physical examinations. (Kirkman-Liff et al., 1991) Patients whose primary language is not English may also be at increased risk of experiencing medical errors (Gandhi JK et al., 1998). Other studies have found patients have fewer physician visits (Pitkin Derose K et al., 2000) and are less likely to return for follow-up visits after being seen in the Emergency Department when compared to patients with better English proficiency (Sarver J et al., 2000). LEP patients are also less satisfied with their health care. Latinos who speak Spanish have been shown to be less satisfied with their communication with health care providers (Morales LS et al., 1999) (Carrasquillo O et al., 1999), the care they receive (Carrasquillo O et al., 1999), and more likely to report overall problems with care (Carrasquillo O et al., 1999) than are English speakers.

Research has also shown that use of unskilled interpreters can have negative and sometimes dangerous consequences and that improving language access can improve outcomes. In many instances the person enlisted to help LEP patients communicate with health care providers is a not trained interpreter, but rather another patient, family member (including small children), friend, untrained non-clinical employee or non-fluent health care professional. (Ginsberg et al., 1995; Schmidt et al., 1995; Robert Wood Johnson Foundation Media Release, 2001) Use of these ad hoc services appears to have many negative clinical consequences including reduced trust in physicians (Putsch, 1985; Robert Wood Johnson Foundation Media Release, 2001), lower patient satisfaction (Baker et al., 1998) (Haffner, 1992) breach of patient confidentiality (Haffner, 1992), inaccurate communication (Marcos LR, 1979; Ebden et al., 1988), misdiagnosis (Vasquez et al., 1991), inadequate or inaccurate treatment (Putsch, 1985), and reduced quality of care (Woloshin et al., 1997). Communicating to patients in their own language has been shown to improve patient compliance and understanding of their disease, (Baker et al., 1998) (Manson, 1988) patient self-reported well-being and

functioning,(Perez-Stable EJ et al., 1997) access to primary care and preventive services,(Jacobs EA et al., 2001) and that the quality of interpretation correlates with patient understanding and satisfaction with the encounter.(Baker et al., 1996; Baker et al., 1998) charges.

Taken together, this body of research makes a great case for the importance of reducing language barriers to access to health care in physician practices. It indicates that speaking a language other than English puts persons at increased risk of poorer health and reduced access to care and that traditional approaches to using unskilled interpreters places these patients at even greater risk. It also highlights how physicians might make dangerous or even fatal errors in provision of care if they do not address these barriers appropriately. Family physicians should be aware of this “evidence-base” behind the CLAS standards.

## **b) Laws and Federal Guidelines that Pertain to the Provision of Language Access Services**

Family physicians should be aware of the federal and state laws that govern the provision of adequate interpreter services. They include Title VI of the Civil Rights Act of 1964, state laws and regulations and the CLAS standards. Title VI requires all entities receiving Federal financial assistance, including physicians accepting Medicare or Medicaid, payments, to ensure that LEP persons have meaningful linguistic access to the health services that they provide (Office of Civil Rights, 2001).

The OCR Policy Guidance: Title VI Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency provides a clear and comprehensive explanation of Title VI, the basis of its interpretation in case law, and what health care providers can do to be in compliance with the law (Office of Civil Rights, 2001). Family physicians should be given a copy of this guidance as one of their materials in a Language Access Curriculum so that they can fully understand what the law means and how to assure that their practice is in compliance with the law. In addition, several states have laws and regulations that apply to provision of health care to LEP persons.

Family physicians and residency directors in these states should also make themselves aware of these laws and regulations and include them in the curriculum (Perkins J et al., 1998). Finally the CLAS standards and the rationale behind them should be included in the curriculum as well (Office of Minority Health, 2001). They serve as further guidance on how they can be in compliance with Title VI and optimize the quality of care they deliver to LEP persons.

## **c) Models for the Provision of Language Access in Health Care Settings**

Family physicians will encounter many methods for overcoming language barriers throughout their career. They will most frequently encounter a multifaceted model in which multiple complementary approaches to overcoming language barriers are employed. They should know how to recognize these different models and the advantages and disadvantages of each. This knowledge will help them recognize when an interpretation may be going badly and require their intervention (Roat CE et al., 2002).

Briefly, the models include bilingual-bicultural providers, bilingual providers, bilingual clinic or hospital staff (such as nurses), trained interpreters (including staff interpreters, agency interpreters, volunteer interpreters or telephone interpreters), and ad hoc interpreters (including use of untrained family, friends, non-professional staff, other patients, or other convenient person). A bilingual-bicultural provider is considered the ideal interpreter because they are both fluent in the patient’s language and culture. Providers who are fluent in the patient’s language are also advantageous as it removes the

need for triadic communication (communication through three people, the physician, the interpreter and the patient). These types of language access models are rare however.

Limited English-speaking persons are most commonly cared for by a health care provider who communicates through a bilingual staff person, trained interpreter or ad hoc interpreter. The advantage of using a bilingual staff person is that they are convenient, may be viewed as trustworthy by the patient, and have knowledge of medical terminology. The disadvantages are that they may not have adequate time to interpret because of other pressing duties and they may not be fluent in both languages. Without testing, there is no way that the physician can know that this staff member is fluent in both English and the target language. The advantage of using a trained interpreter is that they have good knowledge of medical terminology in both English and the patient's language, they understand the importance of confidentiality, and they know how to manage triadic communication. The disadvantages are that the provider may have to wait for them and they may be costly.

Finally, the advantages to using ad hoc interpreters are that they are convenient, they are cheap in the short run, and the patient may prefer them, especially when the interpreter is a family member. However, there are many disadvantages to using such interpreters. They often make errors in interpretation because of language limitations, they reduce patient confidentiality and their presence may alter the communication. For example they may withhold information in order to protect the family member or the family from shame. Alternatively the patient may not share information they do not want the interpreter/family member to know. It may also strain family relations as in the case of burdening a minor child with the responsibility of communicating for their parent. Family physicians should know that it is unethical to use minor children as interpreters for this and other reasons.

#### **d) Culture and Interpretation**

Family physicians should understand that language is a necessary but not sufficient step towards improving cross-cultural communication. Clearly being able to speak to a patient in a language s/he understands is critical to establishing communication, but there are many cultural variables in communication that may need interpretation as well. This curriculum should be part of a larger curriculum in which principles of cross-cultural communication and cultural awareness and sensitivity are taught.

#### **e) Translated Materials:**

Family physicians should be able to assess the adequacy of translated materials and signage that they make available in their practices. This does not require knowledge of the language, but knowledge of the best method by which to assure adequate translation of English into the target language. This method is called back-translation. It requires two translators. One translates the document from English into the target language. The second translates it from the target language back into English. The original English version and the translated English version are then compared. If the meaning and intent are the same, then the translation is adequate. If not then the translators change the initial translation to more accurately capture the original English version. Ideally back translation should be conducted again. If a family practitioner used materials or consent forms developed by another organization or health care provider, they can get an idea of the quality of the translation by asking how they were translated and if back translation was used.

## ***II. Core skills associated with language access services that family physicians should be able to apply.***

- a) Family physicians should be able to recognize when their patients have a language barrier that requires intervention. Physician may think that the patient understands them because the patient speaks some English, but in reality the patient has little comprehension of English. Some patients with a command of English may also revert back to their primary language in a stressful health care situation. As with English speaking patients, family physicians should learn how to check for comprehension.
- b) Family physicians should know how to access adequate interpretation either through a staff member they know to be bilingual or through a trained interpreter. If such an interpreter is not available or the patient insists on use of an ad hoc interpreter or family member, family physicians should know how to optimize communication in this less than optimal situation (see C and D below).
- c) Family physicians should be able to work effectively with interpreters. This includes the principles of triadic communication, how to brief an interpreter prior to an encounter and how to debrief after the encounter. They should know to always direct questions to the patient and observe the patient throughout the encounter when an interpreter is present. This establishes the doctor-patient relationship and allows the physician to pick up important non-verbal cues. They should know to speak succinctly, using minimal jargon so as to enhance the interpretation. They should know how to give the interpreter permission to indicate when they do not know how to translate information in either language or are uncomfortable with the information being communicated. In the initial briefing they should give the interpreter information about what is going to happen in the encounter, its expected duration, and if the physician has any concerns about the encounter. The physician should also be open to getting feedback from the interpreter. The interpreter may sense an issue or identify a cultural issue that they do not think the physician is aware of and bring it to the physician's attention. Finally, they should be able to identify when an encounter is not going well, either because the patient is uncomfortable with the interpreter or the interpretation is not adequate.
- d) Family physicians should know how to address commonly encountered problems that arise in interpreted in encounters. Problems commonly occur when an interpreter is culturally unacceptable to a patient due to age, gender or relationship to the patient or when the relationship between the interpreter and patient prevents full disclosure of important information (e.g. husband interpreting for women who is a victim of domestic violence). They also occur when the interpreter takes over for the patient or physician or when it becomes clear that the interpreter is not able to speak English and the patient's language fluently.
- e) Family physicians should be able to assess the adequacy of translated materials. (See I-e).

### ***III. Pedagogical strategies that are appropriate for the teaching of these concepts and skills.***

Several pedagogical strategies can be used to teach these concepts and skills. They include directed readings, lecturing, case-based discussions, trigger videotapes, and role-playing. Directed readings should include articles documenting the importance of language barriers to access to care, articles describing how to work with interpreters, and information on federal and state laws pertaining to provision of language services in the health care setting. Lecturing should include the same topics and may be supplemented by readings. Teaching using case-based discussions is a more interactive learning process in which cases are used as discussion triggers. The cases should raise issues of that will allow the teacher or learner to identify and discuss the core concepts, knowledge, and skills outlined above. Trigger videotapes can be used to display both problematic and ideal interpreted patient encounters. They can trigger discussion of what constitutes good and bad interpreting. They also allow for skill demonstration of how to effectively work with an interpreter or identify problems in the interpreted encounter. Role-playing can be used to give the learner an idea of what it is like to be an LEP patients, an interpreter or a physician working with an interpreter. They are excellent for promoting self-awareness, patient empathy, and skill acquisition as well as for assessing a physician's skill.

Language access curriculum is best taught using a combination of these strategies over a period of time. Optimally, such a curriculum should be taught in three to four modules lasting two to three hours each. It should include readings, case-based discussions, trigger videotapes, and role-playing. Ideally it should be part of a larger curriculum on culturally competency so that the learning in this particular curriculum is reinforced over time in the other teaching modules. Teachers should include physicians, interpreters, and if possible patients or community members who can directly address the issue of what it is like to be an LEP patient who faces language access issues.

### ***IV. Implications for general medical education and residency training of family physicians.***

Language barriers to access to medical care are a large and growing problem that should be addressed in physicians' education. It is important to teach future physicians both about the ethical and quality care arguments for reducing these language barriers as well as their legal responsibility to do so. This paper outlines a set of core concepts, content knowledge, and skills that should be included in a Language Access Curriculum, a number of teaching strategies and a brief outline of a 6 to 8 hour curriculum. It also makes the case that a Language Access Curriculum should be one component of a larger cultural competency curriculum. Since most medical schools and residencies currently do not include this type of educational module in their curriculum (Louden, et al., 1999) medical educators and residency directors will need to find the time and resources to include this curriculum into their current programs.

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