Strengthening Communication Capacity: California's OB/GYNs Enhance Language Access for Limited English Proficient Patients

ABSTRACT

The American College of Obstetricians and Gynecologists (ACOG), District IX (California) initiated a project in 2004 to explore approaches employed by its physician members to communicate with patients who have limited (LEP) or no English language proficiency. The project conducted a series of focus groups of physicians and consumers and surveyed District IX's membership to catalogue physician language access strategies and attitudes across a variety of practice settings. The project also performed a literature search and elicited expert opinion to identify language access practices with demonstrated effectiveness.

Most survey respondents reported high and increasing levels of patient language diversity in their practices. They tend to invest in language access through recruitment of bilingual staff, use of pay differentials for language skills, and contracting with professional interpreters. Additionally, responding physicians tended to:

1. Value accuracy in inter-language communication, but rate availability and cost as the most important factors in selecting language access measures.
2. Promote language access capacity within their practices more often than use external professional interpreters, especially in solo and group practices.
3. In some circumstances, continue inappropriate practices such as the use of children, spouses, other family members, or friends of patients as interpreters.

The project generated practice and policy recommendations to encourage use of language access practices that ensure accurate interpretation, confidentiality, and adherence to medical ethics standards, while discouraging use of inappropriate methods.

INTRODUCTION

The Importance of Language Access

Effective communication and patient confidentiality are core values of medical practice in the United States, especially among physicians providing reproductive health services to women. Effective communication is essential for delivery of quality health care and to ensure patient safety. Communication between physicians and their patients about the most sensitive issues in health care can be very difficult, even when they both are fluent in the same language. When communication must also bridge cultural and language differences, the critical elements of effective communication – rapport, accuracy, sensitivity, and respect –

> Effective physician-patient communication requires <u>mutual understanding.</u> It is more than one-way transmission of information.

become more difficult to achieve and the consequences of miscommunication are often more severe. An un-bridged language gap between patients and their physicians negatively affects all aspects of the health care experience. Poor inter-language communication has been associated with:

- Health disparities between Hispanic and white, non-Hispanic populations[1].
- Lower levels of patient comprehension of health care information for LEP patients than English speaking patients[2].
- Lower levels of satisfaction with health care services[3,4].
- Lower quality of care[5].
- More costly health care encounters[6].
- Lower access rates to primary and preventive services[7].

Low patient ratings of satisfaction and other quality measures used in pay-for-performance programs may affect physician compensation and increase risk of malpractice litigation.

Physician respondents confirmed these observations. More than half reported that they had observed how poor communication compromised healthcare through patient misunderstanding of diagnoses and treatment, noncompliance with prescribed medications, and delayed access to care.

California's Growing Linguistic Diversity

While immigrants have enriched California's economy and cultural landscape, the language diversity they present creates substantial challenges to a health care system that, until recently, operated almost entirely in English. Forty percent of Californians speak a language other than English at home, with Spanish spoken by 26%. The 2000 Census also reports that 11,000,000 California households are "linguistically isolated"[8], including 26% of Spanish-speaking and 31% of Asian and Pacific Islander language-speaking

[1] Fiscella K, Franks P, Doescher MP, Saver BG. Disparities in health care by race, ethnicity, and language among the insured. Medical Care. 2002;40:52-59.
[2] Crane JA. Patient comprehension of doctor-patient communication on discharge from the emergency department. Journal of Emergency Medicine. 1997;15(1):1-7.
[3] Ibid.
[4] Morales LS, Cunningham WE, Brown JA, Liu H, Hays RD. Are Latinos less satisfied with communication by health care providers? Journal of General Internal Medicine. 1999;14:409-417.
[5] Ghandi TK, Burstin HR, Cook EF, et al. Drug complications in outpatients. Journal of General Internal Medicine. 2000;15:149-154.
[6] Hampers LC, McNulty JE. Professional interpreters and bilingual physicians in a pediatric emergency department. Archives of Pediatric Adolescent Medicine. 2002;156(11):1108-1113.
[7] 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. Journal of General Internal Medicine. 2001;16:468-474.
[8] Linguistic isolation is defined by the U.S. Census Bureau as a household having no member over the age of 14 who 1) speaks only English or 2) speaks a non-English language and speaks English "very well".

households.[9] Ten per cent of HMO members statewide speak solely a language other than English[10].

ACOG Members Face Increasing Language Diversity

Survey respondents confirmed the impact of California's linguistic diversity on their practices. More than a third of respondents reported that 10% or more of their patients were LEP. Half of the respondents reported contact with three or more LEP patients in a month while almost all (98%) respondents reported contact with at least one.

Survey Highlight: ACOG member respondent practices experience growing language diversity, high percentages of LEP patients, and multiple languages within their patient populations.	
Change in % LEP patients over past 5 years:	Higher: 38% Lower: 7% Same: 55%
% Patients who are LEP:	> 10% reported by 34% of respondents > 25% reported by 25% of respondents

Survey Highlight: Collectively, responding physicians served patients who spoke all of California's major languages.
Nine of ten physician respondents identified Spanish as among the three non-English languages most frequently spoken by their patients. Chinese (including Mandarin, Cantonese, and Taiwanese) was second and identified by 39% of respondents.
Other patient languages, and the percentage of respondents who mentioned them, include: Filipino (18%), Vietnamese (16%), Asian Indian dialects (15%), Farsi (9%), and Hmong (8%).

[9] Lopez, Alejandra. "Californians' Use of English and Other Languages: Census 2000 Summary", Center for Comparative Studies in Race and Ethnicity, Stanford University, 2003. Available at http://www.stanford.edu/dept/csre/reports/report_14.pdf.

[10] GF Kominski, PL Davidson, CL Keeler, N Razack, LM Becerra, R Sen. *Profile of California's HMO Enrollees: Findings from the 2001 California Health Interview Survey.* A Report for the California Office of the Patient Advocate. Los Angeles: UCLA Center for Health Policy Research, 2003. Summary available at http://www.healthpolicy.ucla.edu/pubs/files/OPA_summaryfindings_022703.pdf.

LANGUAGE ACCESS STRATEGIES

Introduction

Interpreters play a variety of roles[11]

- Message Converter
- Message Clarifier
- Cultural Clarifier
- Patient Advocate

Physicians reported employing a variety of strategies to promote language access for their patients. Their choices reflect a variety of factors including: their own language skills and cultural background, the skills and background of their staff, accessibility of language resources, the language diversity of their patient population, the size of their practice, and, not least, their attitude toward language diversity and patient responsibility.

Survey respondents used the following language access strategies in their practices:

- Trained professional interpreters for both face-to-face and telephone interpreting sessions.
- Bilingual non-physician office staff.
- The physician's own language skills.
- Untrained external interpreters including friends, family members, or children of patients.
- Other strategies to improve overall access to services and information for LEP patients.

Recommendations for communicating effectively with LEP patients:

- Use qualified and effective interpreters.
- Show respect to the patient.
- Listen attentively.
- Encourage elaboration[12]
- Speak slowly and distinctly.
- Use short simple sentences.
- Repeat and confirm information.[13]

Trained professional interpreters

Benefits of trained professional interpreters

Published research shows that trained interpreters are more likely than untrained interpreters to possess the skills required to ensure accurate and confidential communication between physicians and patients who do not speak the same language. Physicians rate the quality of interpretations using trained interpreters as significantly higher than with untrained interpreters and family members.[14] The use of untrained interpreters has been associated with more hospital admissions, longer visit times, and

[11] California Healthcare Interpreters Association (2002). *California Standards for Healthcare Interpreters: Ethical Principles, Protocols, and Guidance on Roles & Intervention.* Woodland Hills: The California Endowment.
[12] Enzinger, S. Communication between Spanish-speaking patients and their doctors in medical encounters. Culture, Medicine, and Psychiatry. 1991;15:91-110.
1991)
[13] (Elderkin-Thompson 2001)
[14] Hornberger J, Itakura H, Wilson SR. Bridging language and cultural barriers between physicians and patients. Public Health Reports. 1997;112: 410-417.

more ordered tests than the use of trained interpreters.[15] Professional interpreters may also be more cost effective than diverting bilingual staff from their usual duties.[16]

Trained professional interpreters are required to demonstrate proficiency in:[17]

- Basic language skills in English and the non-English language.
- Ethics, including confidentiality.
- Cultural issues.
- Health care terminology.
- Integrated interpreting skills to ensure accurate interpretation, correction of error, and recognition of incomplete understanding.
- Written translation of simple instructions.

Ethics Standards of Trained Interpretation[18]

- Confidentiality
- Impartiality
- Respect for individuals and their communities
- Professionalism and integrity
- Accuracy and completeness
- Cultural responsiveness

Appendix D.1, below, provides advice for working effectively with professional interpreters.

Barriers to the use of trained interpreters

Notwithstanding the documented efficacy of trained interpreters and the high value survey respondents placed on accurate interpretation, responding physicians tended to use bilingual office staff, their own language abilities, and even the family and friends of patients more frequently. Nearly two-thirds (65%) reported that the use of professional interpreters was too time consuming; 39% that they were too expensive; and, 38% that they did not know whom to call to access their services. Only 30% knew that some managed care organizations include interpreter services as a covered benefit. About one-fourth (24%) noted that patients did not like telephone interpreters.

Respondent use of trained interpreters varied according to the type and size of their practice with group and solo practice settings rating their preference for professional interpreters at substantially lower levels than did physicians from institutional practice settings.

Community sources of trained interpreters

Many communities in California have organizations that provide interpreters on a voluntary or not-for-profit basis. Some services are tied to patient eligibility requirements such as income level, Medi-Cal enrollment, or refugee status. Examples of organizations that may be sources of interpreters include: Catholic and Lutheran Social

[15] (Hampers 2002)
[16] Rader GS. Management decisions: Do we really need interpreters? Nursing Management. 1988;19:46-48.
[17] Hablamos Juntos (2002). *Language Testing Options.* Claremont: Robert Wood Johnson Foundation.
[18] California Healthcare Interpreters Association (2002). *California Standards for Healthcare Interpreters: Ethical Principles, Protocols, and Guidance on Roles & Intervention.* Woodland Hills: The California Endowment.

Services, American Red Cross, and ethnic community organizations. Sources of information about these resources include patients, the local Medical Society, and other health care providers.

Bilingual office staff

Significant reliance on bilingual office staff

Bilingual office staff is the most frequently employed method for providing language access to LEP patients among survey respondents in all practice settings. Focus group participants and survey respondents described bilingual staff as a known and trusted resource that is immediately available. Depending on the practice, circumstance, and confidence of the physician, bilingual office personnel play a significant communication role with LEP patients in every aspect of the patient visit. Their tasks include communicating directly with patients to schedule appointments, complete paperwork, and prepare for examinations, and interpreting in clinical encounters for languages not spoken fluently by the physician.

Survey Highlight: Physicians rely on and value bilingual office staff for bridging communication with LEP patients.
79% employ bilingual staff that spoke at least one of the three most frequently encountered languages in their practice.
74% identified bilingual office staff as their preferred resource for communicating with LEP patients.
Bilingual office staff were rated (4.34)[19] highest on measures of quality and availability[20].
Only respondents from hospital practice settings preferred another language service (professional interpreters) over bilingual office staff.
Even respondents who rated themselves as proficient or fluent in a non-English language preferred using bilingual staff to interpret.

While the survey did not distinguish use of bilingual staff for direct communication from their use as interpreters for clinical encounters, the interpreter role requires a much higher skill level with potentially serious consequences of interpreter error and miscommunication. Appendix B provides information on the different requirements for direct communication and interpreted communication.

Physicians invest in development of bilingual office staff resource

Survey respondents have made substantial investments to recruit, retain, and enhance the effectiveness of their bilingual non-physician staff. Overall, about half (49%) reported that applicant language skill was a strong consideration or a requirement for hiring. Three-fourths (75%) indicated their practices provide extra pay for the language skill of their bilingual staff. About one-third of respondents, who reported frequent use of

[19] All ratings are presented as weighted averages of respondent scores on a scale of 1 to 5 with 5 = best, highest, etc. depending on the particular measure.
[20] The survey elicited a combined rating of quality and availability.

bilingual staff as interpreters, provide them with interpreter training. Almost two-thirds of all respondents indicated they would be interested in interpreter training for their bilingual staff.

Survey Highlight: Bilingual staff coverage varies by language (% of practices with bilingual staff that speaks a language identified as one of the three most frequently encountered).
Spanish: 80% coverage
Filipino: 60% coverage
Coverage of Chinese, Vietnamese, Farsi, and Asian Indian dialects: between 30% and 40% of practices.

Survey responses revealed substantial variation in bilingual staff development practices across practice settings[21]. Fewer small group (30%) and large group (39%) practices used language skills as a significant hiring factor when compared to institutional practice settings such as Kaiser (48%) and hospitals (80%). However, more than half (54%) of small group practices used language skills as a significant hiring criterion.

Limitations in the effectiveness of bilingual staff interpreters

Physician participants of focus groups reported using a variety of office staff to communicate with LEP patients including: bilingual receptionists, medical assistants, maintenance personnel, nurses, and in some instances, physician colleagues. While the survey did not assess the qualifications or language skills of office staff, focus group participants reported that bilingual staff sometimes inaccurately interpreted communications or were unwilling to deliver unpleasant information. These reports reflect research findings that untrained bilingual staff interpreters frequently omit, condense, or add information in a way that compromises the accuracy of the interpretation, even if they are medically-skilled personnel.[22] Focus group physicians reported that bilingual staff interpretation skills improved over time, especially with coaching from the physician.

Focus group physicians reported that they attempted to assess the accuracy and overall quality of interpretations by office staff by observing body language, asking questions in different ways to confirm results, and asking the patient to repeat information previously provided. However, none reported conducting a formal assessment of the English and other language skills of bilingual staff using tools or services such as those identified by Hablamos Juntos[23] or the California Academy of Family Practice Physicians[24]. Appendix

[21] Practice settings are broadly grouped as "institutional settings" which include community clinics, hospitals, Kaiser Permanente, and county facilities and "solo and group settings" which include solo and small and medium/large group practices.
[22] Elderkin-Thompson V, Silver RC, Waitzkin H. When nurses double as interpreters: A study of Spanish-speaking patients in a U.S. primary care setting. Social Science and Medicine. 2001;52:1343-1358.
[23] Hablamos Juntos. *Language Testing Options.* Available at: www.hablamosjuntos.org/resourcecenter/pdf/Language_Testing_Options.pdf
[24] Groat, pp. 9 and 27-28.

D.2 contains advice for working with untrained interpreters when other options are limited.

Physician's own language skills

Communication and quality of care tend to be enhanced when physicians and their patients speak the same language. Physician-patient language concordance generates significantly higher levels of patient satisfaction than when interpretation is provided by patient family members or other ad hoc interpreters.[26] Spanish-speaking patients with ethnic and language concordant physicians report better well-being and functioning on health status measures than Latino patients with non-language concordant physicians.[27]

Physicians may acquire their language skills from the family and community in which they were raised; through formal training or overseas living and practice; and, especially with Spanish, through frequent interaction and practice with LEP patients and bilingual staff. Consequently, bi-lingual physicians represent a very wide range of language proficiency.

The communication value derived from physician-patient language concordance is compromised if the physician's command of the patient's language is insufficient for complex medical communications. Almost all survey respondents, regardless of the level of their language skills, reported communicating with their LEP patients in a language other than English. In self-assessing their language skills, more than two-thirds (68%) reported they are

Assessing One's Own Language Proficiency[25]

Physicians should ask themselves, "Should I use my own language skills for this visit or employ a trained interpreter?"

Q: Where did the physician learn the patient's language? Where does s/he speak and hear the language?

A: If only at school or home or in the United States and without extensive formal training, the physician's language skills may be too limited for complex and sensitive medical communications.

Q: What will the physician be discussing during this visit?

A: Regardless of the original purpose of the visit, the physician must be prepared for highly nuanced communication for complex and sensitive issues.

Q: Have the physician's language skills been formally assessed?

A: There are numerous tools and programs for objective assessment of language capability. Physicians whose language skills seem adequate in non-medical settings should confirm their capacity for communicating effectively with patients.

[25] Groat, p.9.
[26] Lee LJ, Batal HA, Maselli JH, Kutner JS. Effect of Spanish interpretation method on patient satisfaction in an urban walk-in clinic. Journal of General Internal Medicine. 2002;17:640-645.
[27] Perez-Stable EJ, Napoles-Springer A, Miramontes JM. The effects of ethnicity and language on medical outcomes of patients with hypertension or diabetes. Medical Care. 1997;35:1212-1219.

proficient[28] in a non-English language, while almost half (49%) reported they are fluent[29]. An additional 21% of respondents, who did not claim proficiency or fluency, reported that they "make do" with their own language skills, at least some of the time, to communicate with their LEP patients. Ten per cent of survey respondents, who indicated they were not proficient or fluent in a language other than English, rated "making do" with their own language skills as the preferred method of communicating with LEP patients. Neither survey respondents nor focus group participants indicated the method they used to assess their own language skills.

Physician focus group participants provided insights on how physicians gain and employ their language skills. While recognizing the limitations of their language training and proficiency, they tended to use their language skills to (in order of increasing proficiency):

- Speak simple greetings and engage in social conversation in the language of the patient to build rapport and increase patient comfort.
- Monitor the interpretation of bilingual staff and patients by looking for language cues that the interpretation is accurate and understood by the patient.
- Conduct less critical or complicated aspects of an examination in the language of the patient and ending the visit with an interpreter to confirm patient understanding of instructions.
- Conduct the full exam without an interpreter, if physician language skills allow.

Untrained ad hoc interpreters including friends, family members, and children of patients

Untrained interpreters, also known as "ad hoc" interpreters, speak both English and the language of the patient, but are not professional or dedicated interpreters. They frequently have limited fluency in English, the patient's language, or both and that fluency is rarely assessed and documented. They are also less likely to understand medical terminology. Untrained interpreters may be drawn from the family or friends who accompany a patient to the physician's office or from bilingual staff at a health facility who do not usually have patient contact. Numerous studies and anecdotal reports document the limitations of, and harm that may result from, the use of untrained interpreters.[30,31]

For example, a study of language services for Chinese and Vietnamese patients reported that they had a strong preference for professional interpreters over their family members for language interpretation at health care visits. They feared that adults may compromise

[28] Language proficiency was defined in the survey as the ability to "carry out basic medical conversation about new diagnosis, or instruct patient on how to take a medication".
[29] Language fluency included the ability to "carry out nuanced discussion of informed consent".
[30] Flores G, Barton Laws M, Mayo SJ, et al. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. Pediatrics. 2003;111(1):6-14.
[31] (Hornberger 1997)

confidentiality while the use of children violated traditional values of respect for elders and resulted in miscommunication of symptoms.[32]

Physician focus group participants confirmed problems with untrained ad hoc interpreters, including inaccurate interpretation, reticence of patients to be fully forthcoming with critical information, violations of patient confidentiality, exposure of minor children to traumatizing information, and others. They reported examples of women who withheld critical information because their visit with the physician was interpreted by their husbands or by a friend who may violate confidentiality. They also reported miscommunication of physician instructions because the untrained interpreter could not communicate even relatively simple medical concepts, terminology, or instructions.

Survey respondents recognized the problems with using untrained interpreters, especially children, who were the least preferred alternative for providing language services (9%). However, family and friends of patients ranked fourth in preference on the list of options (26%). While preference for professional interpreters was ranked third at 38%, their frequency of use was rated (2.14) lower than the frequency of use of family/friends (3.33) and children (2.19). Respondents also rated the availability/quality of family and friends (3.19) higher than professional interpreters (2.92).

Other communication strategies

Survey respondents reported other actions to strengthen their capacity to communicate with LEP patients. More than half (54%) reported that their practice tracks the language of their patients, while 27% provide interpreter training to bilingual staff.

Respondents also reported their steps to increase access to health care and information for their LEP patients. More than 80% provide patients with bilingual materials, 57% accept Medi-Cal, and 43% encourage their patients to make referrals to their practice. About one in four practices advertise in ethnic media, sought referrals from other physicians, or reached out to community organizations.

Factors related to use of communications strategies

Practice Settings

Survey responses revealed sharp distinctions between solo and group practices and institutional practice settings. About 2/3 of respondents (68%) work in solo and small and large group settings with the remaining 32% working in "institutional" settings, i.e., community clinics, hospitals, Kaiser Permanente, and county facilities.

Survey Highlight: Institutional settings were substantially more likely than solo and group practices to:

[32] Ngo-Metzger Q,. Massagli M, Clarridge BR, et al. Linguistic and Cultural Barriers to Care: Perspectives of Chinese and Vietnamese immigrants. Journal of General Internal Medicine. 2003; 18: 44-52.

Have patient populations with more than 25% LEP (40% vs. 18%).
Encounter four or more languages in a given month (45% vs. 21%).
Provide extra pay for interpreters (38% vs. 12%), train interpreters (53% vs. 16%) and track languages (73% vs. 47%).
State higher preference for using professional interpreters (63% vs. 27%) and lower preference for making do with own language skills (4% vs. 12%), or using a patient's family or friend (13% vs. 33%) or a child (7% vs. 10%) as interpreters.

These comparisons likely reflect differences in the size, ethnic diversity, type of practice, and available language support resources of institutional settings compared to solo and group practices.

Physician Attitudes

Survey respondents have diverse opinions about who has primary responsibility for ensuring effective communications between physicians and LEP patients. Almost half (49%) indicated that the patient has this responsibility, while 39% identified the practice setting, and 19% the physician. Only 12% identified either government or insurance companies as responsible parties.

Eighty-five physicians provided responses to the survey item that elicited their "creative solutions" for communicating with their patients in an open ended format. Their responses reflected both the strategies they employ, and to some extent, underlying attitudes toward language access. A representative sample of their responses is provided below.

Selected Respondent Comments
We have obtained great funding for a part time Spanish interpreter, who is excellent, better than our bilingual staff, and frees up our staff for their regular duties.
Making do with less than perfect Spanish is common practice among many physicians in California. I have seen too many mistakes because of this. Physician education in this area is essential.
Provide educational and instructional materials in Spanish, provide interpreters for patients in multiple languages.
In Alameda County our Medi-Cal managed care & clinic consortium have done great while supporting interpreter services- you can't do this alone!
Use speakerphone interpreter (ATT) for patients, 1) not to use family as interpreters a) privacy violation, b) quality of interpretation
The majority of our patients bring family (spouse, adult children, or friends) to interpret if they have limited English skills.
Advise patients that understanding their care is their responsibility, irrespective of language. The

latter is not the only obstacle.

ASSESSMENT AND RECOMMENDATIONS: THE CHALLENGE

The state of language access strategies

The survey of California's ACOG physician members provided a useful snapshot of language access attitudes and practices across a wide variety of practice settings. While the survey may not fully represent California's physician population, it does reveal the wide range of physician language access efforts along with their strengths and limitations. Some of the patterns the survey revealed are:

1. The importance of bilingual staff as a language resource.
2. The importance of the physician's own language skills as a resource.
3. Underutilization of trained interpreters.
4. Over-utilization of the children, family members, friends of patients.
5. The importance of immediate availability, and to a lesser extent of cost, of interpreting resources to physicians.
6. The lack of language access tools, information, and other resources available to solo and group practices.
7. The lack of quality control measures to assess and improve language access strategies in physician practice.

Survey responses and focus group discussion also reveal factors that encourage the development of effective language access strategies. These factors include:

1. Physician recognition of the importance of accurate communications with LEP patients.
2. Continuing growth in the numbers of LEP patients served by ACOG members.
3. Physician investment in language access through recruitment of bilingual staff and use of pay differentials.
4. Strong physician interest in providing interpreter training to bilingual staff.
5. Growth in the number of organizations and resources that provide interpreter services, training for interpreters, tools for language assessment, and other resources.
6. Increasing policy advocacy for public and insurance support for interpreter services by organized medicine and community health advocacy organizations.

Recommendations

The recommendations that follow address the limitations described above while building on the facilitating factors. They are developed from an analysis of the physician responses to the survey, the input of focus group members and other experts, and the project's review of the literature.

<u>Practice Recommendations</u>

The following recommendations address reducing inappropriate practices, strengthening the skills of resources (such as bilingual staff interpreters) physicians are likely to use, and encouraging the use of professional interpreters. They also include administrative practices that can increase the efficiency of language access measures.

1. Eliminate use of children as interpreters.
2. Strongly discourage use of family members as interpreters except in emergencies or if the patient insists against advice of physician.
3. Assess language skills of bilingual physicians, particularly those who have not had formal language instruction and who grew up in the United States.
4. Test language and interpreting skills of bilingual staff who are serving as interpreters for clinical information.
5. Provide interpreter training for bilingual staff used as interpreters and for physicians who work through interpreters.
6. Develop language access policies and procedures that foster routine use of professional interpreters and includes:
    a. Tracking patient language on an individual patient basis (for appointment purposes) as well as clinic basis (for planning purposes).
    b. Clear and easy-to-use procedures for accessing trained interpreters.
    c. Scheduling use of interpreters prior to visit.

Policy Recommendations

The policy and practice decisions of government legislatures and agencies and insurance companies strongly affects all aspects of physician practice, including language access. These recommendations are designed to make high quality language access resources available to patients and physicians, especially those in solo and group practices.

1. Develop reimbursement for interpreter services through Medi-Cal.
2. Support standards for professional health care interpreters.
3. Encourage health plans to enhance support for language access measures.
4. Increase low-cost or subsidized opportunities for interpreter training for office staff and physicians.
5. Accelerate development of low-cost (to users) technologies that expand rapid access to trained interpreters.

CONCLUSION

ACOG District IX's member physicians recognize the importance of accurate communications with their LEP patients and have invested in bilingual staff, professional interpreters, and other strategies to bridge inter-language communication. The challenge remains, however, to ensure the accuracy, confidentiality, and adherence to ethics. Achieving this goal requires avoiding use of ad hoc interpreters while increasing access to trained and tested professional interpreters and bilingual staff and physicians.

APPENDICES

Appendix A: Language Access Tools and Resources

Interpretation Terminology[33]

Limited English proficiency (LEP) a legal concept referring to a level of English proficiency that is insufficient to ensure equal access to public services without an interpreter [ASTM] This is a term used in the Policy Guidance of August 29, 2000 published in the Federal Register, by the Office for Civil Rights (OCR) of the US Department of Health and Human Services.

interpreting (noun) the process of understanding and analyzing a spoken or signed message and re-expressing that message faithfully, accurately and objectively in another language, taking the cultural and social context into account. [ASTM] The purpose of interpreting is to enable communication between two or more individuals who do not speak each other's languages. (adjective) concerning or involved with interpreting. Examples*: interpreting services, interpreting issues*.

proficiency thorough language competence derived from training and practice.

translation the conversion of a written text into a corresponding written text in a different language.
[Within the language professions, **translation** is distinguished from **interpreting** according to whether the message is produced *orally* (or manually) or *in writing*. In popular usage, the terms "translator" and "translation" are frequently used for conversion of either oral or written communications.]

Steps in Developing Language Access Program

Determine patient need:

1. Ask your patient which language she prefers to use when receiving medical care.
2. Note your patient's preference in her medical chart. Color code the chart by the preferred language of the patient.
3. Assess patient language needs for your practice.

Assess resources available to your practice:

1. Inventory language resources available to you, including: your language skills, language skills of staff, professional interpreters in your facility or community, telephone interpreters, and others.
2. Determine if health plan or other source will cover costs for interpreters.
3. Objectively, assess your language skills and the language skills of your bilingual staff.
4. Acquire training for bilingual staff in medical interpreting terminology, ethics, and techniques.
5. If needed, develop contract with agencies that provide face-to-face or telephonic interpretation.

[33] National Council for Interpreting in Health Care. *The Terminology of Health Care Interpreting.* 2001. Available at http://www.ncihc.org/NCIHC_PDF/TheTerminologyofHealthCareInterpreting.pdf

Appendix B: Comparison of Requirements for Effective Direct and Interpreting Communications

	Direct Communications	**Interpreting Communications**
Type of Information	Scheduling appointments. Greeting patients. Obtaining patient contact and insurance information.	Medical information including: medical history, medication use, diagnosis and treatment, and prognosis. Collecting informed consent from patient. Discussing sensitive information including family relationships, sexual activity, and domestic violence.
Skills required	Language fluency. Understanding of forms and practice procedures.	English and other language fluency. Medical terminology in English and other language. Memory skills. Interpretation accuracy. Understanding of interpreter procedures and ethics.

Appendix C: Summary Assessment of Alternative Language Access Strategies

Method	Benefits	Cautions	Recommendations
Bilingual MD	Direct communication with patient.	May overestimate language skills if not a native speaker.	Physician should undertake a formal assessment of language capability and employ a variety of communications strategies to augment language capability.
Bilingual staff	Quickly available. Likely to know patients. May understand medical terminology. Helps patients to feel more comfortable.	May be untrained in interpretation techniques and ethics. May interject information and edit responses.	Physician should receive training in managing interpreted communications. Staff language skills should be assessed. Staff should receive training in medical terminology and interpreter ethics and skills.
Professional face-to-face interpreter	Likely to be skilled, accurate, certified, and trained in medical terminology.	High cost, if not subsidized or reimbursed. May not be immediately available. May not be available in needed language.	Ensure skill level of interpreter and quality of agency. Physician should receive training in managing interpreter sessions.
Telephone interpreter	Skilled in language. Readily available. Neutral interpreter.	May be costly if low volume. Perhaps difficult to access. Not able to view non-verbal cues.	Establish an account. Use a high quality speakerphone or dual headsets. Direct remarks to the patient, not to the telephone. Monitor patient facial expressions and body language.
Family/friend	Convenient and readily available. Low cost to physician. Patient may know and be comfortable with interpreter.	Inaccurate interpretation. May violate patient confidentiality.	Should not be used, except: To schedule or reschedule appointments; If expressly requested by the patient; In an emergency when no other alternative is available.
Patient's child or other child.	None	Violates confidentiality. Inaccurate interpretations. Opens practice to financial liability. Potentially traumatizing to child.	Should not be used, except: To schedule reschedule an appointment; If expressly requested by the patient against the advice of the physician; In an emergency when no other alternative is available.

Appendix D: Working with interpreters

Appendix D.1: Working with trained interpreters, on-site[34]

- Greet the patient first, not the interpreter.
- During the medical interview, speak directly to the patient, not to the interpreter.
- Note that a professional interpreter will use the first person in interpreting, reflecting exactly what the patient said.
- Speak at an even pace in relatively short segments; pause often to allow the interpreter to interpret. You do not need to speak especially slowly.
- Don't say anything you do not want interpreted.
- If you must address the interpreter about an issue of communication or culture, let the patient know first what you are going to discussing with the interpreter.
- Speak in: Standard English (avoid slang)
  Layman's terms (avoid medical terminology and jargon)
  Straightforward sentence structure
  Complete sentences and ideas
- Ask one question at a time.
- Ask the interpreter to point out potential cultural misunderstandings that may arise.
- Respect the interpreter's judgment that a question is culturally inappropriate and either rephrase the question or ask the interpreter's help in eliciting the information in a more appropriate way.
- Do not hold the interpreter responsible for what the patient says or doesn't say.
- Avoid interrupting the interpretation. Many concepts have no linguistic or conceptual equivalent in other languages. The interpreter may have to paint word pictures of many terms you use. This may take longer than your original speech.
- Don't make assumptions about your patient's educational level. An inability to speak English does not necessarily indicate a lack of education.
- Acknowledge the interpreter as a professional in communication. Respect his or her role.

[34] Roat, Cynthia E. *Addressing Language Issues in Your Practice: A Toolkit for Physicians and Their Staff Members.* California Association of Family Practice: 2005. p 11. Available at: http://www.calendow.org/reference/publications/pdf/cultural/CAFP%20Language%20Access%20Toolkit.pdf

Appendix D.2: Working with untrained interpreters, on-site[35]

- Refer to tips for working with trained interpreters.
- Introduce yourself to the patient, then to the interpreter.
- Gauge the interpreter's level of English skills and professional training.
- Remind the interpreter that you expect everything that you say and the patient says to be interpreted accurately and completely. Direct the interpreter to avoid paraphrasing or answering for the patient, and to let you know if you need to repeat yourself, explain something, or slow down.
- Introduce the interpreter to the patient (if they do not know one another) and explain the interpreter's role.
- Speak directly to the patient and ask the patient to speak to you directly.
- Position the interpreter next to and a bit behind the patient. (By getting the interpreter out of the line of sight of the patient, there is a greater possibility that you can engage the patient instead of having the patient talk to the interpreter.)
- If you are concerned that the interpreter has not interpreted everything, ask the interpreter to do so.
- In the interpreter and the patient get into a conversation that is not interpreted for you, interrupt and ask the interpreter to let you know everything that is being said.
- Check in frequently with the patient; use the "teach back" method ("Please tell me everything I just told you").
- Speak simply, pausing between sentences.
- Remember to speak to the patient, not to the interpreter.
- Be prepared to interrupt if you sense the interpreter is getting sidetracked or is not being complete.

[35] Ibid, p. 13

Appendix E: Methodology Notes

During 2004, ACOG District IX implemented a project to examine challenges, attitudes, and practices related to the delivery of services by its members to LEP patients. District IX conducted four focus groups (2 of physicians and 2 of consumers / consumer advocates) to define the key issues to be addressed by the surveys. These focus groups generated a comprehensive list of concerns of physicians and consumers about cross-language communications and provided information about physician and consumer communications related attitudes, needs, and practices.

Survey content was reviewed by the Project Steering Committee and revised. The final survey was administered on-line and ACOG District IX provided incentives to encourage response by its members. Two hundred ninety (290) ACOG members completed the survey, a response rate consistent with a similar effort conducted over a multi-county area of California by the California Academy of Family Physicians. While the 290 respondents were not randomly drawn and cannot be considered fully representative of California's more than 4,000 obstetricians and gynecologists, they do represent a wide range of practice types and sizes, non-English communications capabilities, and physician experiences working with LEP patients.

Respondents to the survey, as a whole, may represent a subset of California's obstetricians and gynecologists who are most interested in issues related to communication with LEP patients. Sixty- seven per cent of respondents identified themselves as proficient in a non-English language; 49% identified themselves as fluent. The response group likely over-represents physicians who have high levels of interest in language issues.

The survey did not request identifying information from the respondents and this analysis does not distinguish respondents from the same practice setting.

Respondent Demographic and Practice Characteristics

The tables below display the responses to survey questions about respondent demographic and practice setting characteristics. Although data are not available to determine if the respondent group is representative of ACOG District IX membership, the responses do demonstrate that respondents are ethnically and linguistically diverse, practice in a variety of settings, and serve a variety of communities. About half of the respondents rate themselves as fluent in a language other than English and two-thirds work in solo or group practices.

Physician Ethnicity (self-identified)	
African American	3%
All Asians and Pacific Islanders	16%
Biracial	3%
Latino	7%
Unknown	4%
White	69%

Practice Setting		
	#	%
No Answer	4	1
Solo	84	29
Small Group	56	19
Large Group	55	19
Clinic	15	5
County	13	4
Kaiser	41	14
Hospital	22	8

Type of Community Served		
	#	%
Urban	111	38
Suburban	130	45
Inner City	22	8
Rural	20	7
No Answer	7	2

Number of Patients Seen in a Week		
Range of # of Patients	**#**	**%**
0	1	0
1-25:	8	3
26-50:	39	13
51-75:	53	18
76-100:	73	25
101-150:	41	14
151-200:	12	4
>200:	4	1
No Answer:	59	20

Respondent Language Skills

Proficient:	#	%
Yes	193	67
No	95	31
Blank	2	1

Fluent	#	%
Yes	143	49
No	143	49
Blank	4	1

Fluent No and Proficient Yes	53
Fluent Yes and Proficient Yes	140
Fluent Yes or Proficient Yes	196

References and Resources

1. California Healthcare Interpreters Association (CHIA) http://www.chia.ws/pages/resources_tools.php

2. Diversity Rx. *Overview of Models and Strategies for Overcoming Linguistic and Cultural Barriers to Health Care.* Available at http://www.diversityrx.org/HTML/MOVERA.htm#abibi

3. Grantmakers in Health. *In the Right Words: Addressing Language and Culture in Providing Health Care.* Issue Brief No. 18, 2003. Available at http://www.calendow.org/reference/publications/pdf/cultural/TCE0811-2002_In_the_Right_W.pdf

4. National Council for Interpreting in Health Care. *National Standards of Practice for Interpreters in Health Care.* 2005 available at http://www.calendow.org/reference/publications/pdf/cultural/National_Standards_of_Practice_for_Interpreters_in_Health_Care.pdf

5. Roat, Cynthia E. *Addressing Language Issues in Your Practice: A Toolkit for Physicians and Their Staff Members.* California Association of Family Practice: 2005. http://www.calendow.org/reference/publications/pdf/cultural/CAFP%20Language%20Access%20Toolkit.pdf

6. Roat, Cynthia E. How to Choose and Use a Language Agency: A Guide for Health and Social Service Providers Who Wish to Contract With Language Agencies (2003). Available at http://www.calendow.org/reference/publications/pdf/cultural/TCE0220-2003_How_To_Choose_.pdf

7. The California Endowment. Bridging Language Barriers in Health Care: Public Opinion Survey of California Immigrants from Latin America, Asia and the Middle East http://www.calendow.org/news/press_releases/2003/special/ncm_poll072903/NCMEXECSummary.pdf

8. Hablamos Juntos. *Language Testing Options.* Available at: www.hablamosjuntos.org/resourcecenter/pdf/Language_Testing_Options.pdf