



The American College of Obstetricians and Gynecologists
District IX California

Language Access Solutions for OB/GYN Medical Practices



INTRODUCTION

Background

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 with limited (LEP) or no English language proficiency. The project employed a series of focus groups of physicians and consumers and a survey of District IX's membership to catalogue physician language access strategies and attitudes across a variety of practice settings.

Focus group and survey findings and the results of a literature search were analyzed by the project's Advisory Panel. The Panel then generated practice and policy recommendations to promote use of language access practices that ensure accurate interpretation, confidentiality, and adherence to medical ethics standards, while discouraging use of inappropriate methods.

Importance of Language Access

Effective physician-patient communication requires mutual understanding; not just the one-way transmission of information.

Effective communication and patient confidentiality are core values of medical practice, 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 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** – 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 populationsⁱ.
- Lower levels of patient comprehension of health care information for LEP patients than English speaking patients^{iv}.
- Lower levels of satisfaction with health care services^{v,vi}.
- Lower quality of care^{vii}.
- More costly health care encounters^{viii}.
- Lower access rates to primary and preventive services^{ix}.



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

Recommendations for communicating effectively with LEP patients:

- Use qualified and effective interpreters.
- Show respect to the patient.
- Listen attentively.
- Encourage elaboration.
- Speak slowly and distinctly.
- Use short simple sentences.
- Repeat and confirm information.ⁱⁱⁱ
- When using an interpreter, look at and speak to patient.

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.

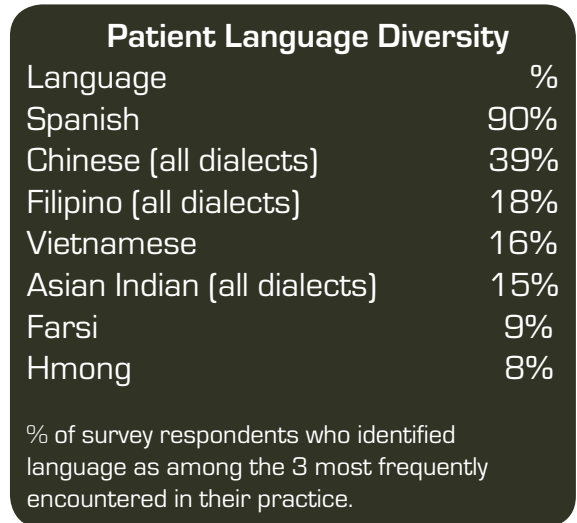
Forty percent of Californians speak a language other than English at home, with Spanish spoken by 26%.

The 2000 Census also reports that 11,000,000 California households are "linguistically isolated"^x, including 26% of Spanish-speaking and 31% of Asian and Pacific Islander language-speaking households^{xi}. Ten percent of HMO members statewide speak solely a language other than English^{vii}.

ACOG Members Face Increasing Language Diversity

The physician respondents and focus group participants confirmed the impact of California's linguistic diversity on their practices. Twenty-five percent reported that more than a quarter of their patients were LEP and 38% reported that the number of LEP patients has increased over the past five years, while only 7% reported a decrease.

“Ten percent of HMO members statewide speak solely a language other than English.”



LANGUAGE ACCESS STRATEGIES

Communication Methods

Survey responses revealed broad diversity in physician approaches to ensuring 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.

Physicians relied primarily on bilingual office staff and their own language skills (49% self-rated as fluent in a non-English language) reflecting the high priority they gave for low cost and immediately available interpreter solutions. Almost 70% of respondents gave some consideration to language skills in hiring. Smaller numbers provide extra pay for language skills (20%) and provide interpreter training (27%).

Survey responses also reveal under-utilization of professional interpreters and over-reliance on untrained interpreters including the children of patients. Numerous studies and anecdotal reports document the limitations of, and harm that frequently results from, the use of untrained interpreters.^{xiv,xv} Use of children, other family members, patient friends, and other untrained bilingual interpreters often results in inaccurate and incomplete interpretations and violations of confidentiality.

Approaches to Language Access (ranked by reported frequency of use in physician practices)

- Bilingual office staff
- Own language skills
- Interpretation by patient's family member
- Making do with own language skills
- Interpretation by patient's child
- Professional interpreter
- Telephone interpreter
- Teleconference / Videophone
- Other

Ethics Standards of Trained Interpretation^{xiii}

- Confidentiality
- Impartiality
- Respect for individuals and their communities
- Professionalism and integrity
- Accuracy and completeness including idiomatic correctness.
- Cultural responsiveness



SUMMARY ASSESSMENT OF ALTERNATIVE LANGUAGE ACCESS STRATEGIES^{XVI}

Interpreter	Benefits	Cautions	Recommendations
Bilingual MD	<ul style="list-style-type: none"> • Direct communication with patient. • May have cultural concordance. 	<ul style="list-style-type: none"> • May overestimate language skills if not a native speaker. 	<ul style="list-style-type: none"> • Formally assess physician language skills. • Learn and employ effective communications strategies to augment language capability.
Bilingual staff	<ul style="list-style-type: none"> • Quickly available. • Likely to know patients. • Cultural interpreters. • May understand medical terminology. 	<ul style="list-style-type: none"> • May be untrained in interpretation techniques and ethics. • May interject information and edit responses. 	<ul style="list-style-type: none"> • Train physician in managing interpreted communications. • Assess staff language skills. • Train staff in medical terminology and interpreter ethics and skills.
Professional face-to-face interpreter	<ul style="list-style-type: none"> • Likely to be skilled, accurate, certified, and trained in medical terminology. 	<ul style="list-style-type: none"> • High cost, if not subsidized or reimbursed. • May not be immediately available. Needed language may be unavailable. 	<ul style="list-style-type: none"> • Ensure skill level of interpreter and quality of agency. • Train physician in managing interpreted communications.
Telephone interpreter	<ul style="list-style-type: none"> • Skilled in language. Readily available. • Neutral interpreter. 	<ul style="list-style-type: none"> • May be difficult to access and costly if low volume. • Not able to view non-verbal cues. • Patient may be uncomfortable until familiar with system. 	<ul style="list-style-type: none"> • Establish an account. • Use a high quality speakerphone or dual headsets. • Train physician in managing interpreted communications. • Direct remarks to the patient, not to the telephone. • Monitor patient facial expressions and body language.
Patient's spouse, other family member or friend	<ul style="list-style-type: none"> • Convenient and readily available. • Low cost to physician. • Patient may know and be comfortable with interpreter. 	<ul style="list-style-type: none"> • Inaccurate interpretation through additions, edits, misinterpretations. • May violate patient confidentiality. • Unlikely to know medical terminology. 	<p>Should not be used, except:</p> <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Violates confidentiality. • Inaccurate interpretations. • Opens practice to financial liability. 	<p>Should not be used, except:</p> <ul style="list-style-type: none"> • To schedule reschedule an appointment; • If expressly requested by the patient against the advice of the physician;

BUILDING A COMPREHENSIVE LANGUAGE ACCESS PROGRAM

More than half of the survey respondents reported tracking the primary language spoken by their patients. This is a key element of an overall language access program that provides an efficient strategy for improving service to LEP patients. These steps include:

Determine patient needs:

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.

ASSESSMENT AND RECOMMENDATIONS: THE CHALLENGE

Summary of medical practice 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. Physicians view bilingual staff as a valuable language resource.
2. Physicians frequently rely on their own language skills to communicate with LEP patients.
3. Medical practices underutilize trained interpreters.
4. Medical practices over-utilized the children, family members, and friends of patients as interpreters.
5. Physicians strongly prefer low-cost and immediately available interpreting resources.
6. There is a shortage of language access tools, information, and other resources accessible to solo and group practices.
7. There are few resources to assess and improve the quality of language access strategies in physician practice.

Survey responses and focus group discussion also reveal factors that support further 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 encouraging trends. They are developed from an analysis of the physician responses to the survey, the input of focus group members and the project's Expert Advisory Panel, and the project's review of the literature.

Practice Recommendations

The following recommendations aim to eliminate inappropriate practices, strengthen the skills of existing linguistic resources (such as bilingual staff interpreters) that physicians are likely to use, and encourage the use of professional interpreters. They also address administrative practices that can increase the efficiency of language access measures.

The highest priority recommendations are:

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. Validate 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 include:
 - a. Tracking patient language on an individual patient basis (for appointment purposes) as well as clinic basis (for planning purposes).
 - b. Developing clear and easy-to-use procedures for accessing trained interpreters.
 - c. Scheduling use of interpreters prior to visit.

Policy Recommendations

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

The highest priority recommendations are:

1. Develop and implement reimbursement programs for interpreter services through Medi-Cal.
2. Implement standards for professional health care interpreters.
3. Encourage private 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.

To access the full report, please go to www.acog.org/acog_districts/dist_web.cfm?recno=13.

RESOURCES AND REFERENCES

1. California Healthcare Interpreters Association (CHIA)
http://www.chia.ws/pages/resources_tools.ph
 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_WV.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
- ⁱFiscella 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.
- ⁱⁱEnzinger, S. Communication between Spanish-speaking patients and their doctors in medical encounters. *Culture, Medicine, and Psychiatry*. 1991;15:91-110.1991]
- ⁱⁱⁱ[Elderkin-Thompson 2001]
- ^{iv}Crane JA. Patient comprehension of doctor-patient communication on discharge from the emergency department. *Journal of Emergency Medicine*. 1997;15(1):1-7.
- ^vIbid.
- ^{vi}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.
- ^{vii}Ghandi TK, Burstin HR, Cook EF, et al. Drug complications in outpatients. *Journal of General Internal Medicine*. 2000;15:149-154.
- ^{viii}Hampers LC, McNulty JE. Professional interpreters and bilingual physicians in a pediatric emergency department. *Archives of Pediatric Adolescent Medicine*. 2002;156(11):1108-1113.
- ^{ix}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.
- ^xLinguistic 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".
- ^{xi}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.
- ^{xii}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.
- ^{xiii}California Healthcare Interpreters Association (2002). *California Standards for Healthcare Interpreters: Ethical Principles, Protocols, and Guidance on Roles & Intervention*. Woodland Hills: The California Endowment.
- ^{xiv}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.
- ^{xv}[Hornberger 1997]
- ^{xvi}Groat p. 18.

ACKNOWLEDGEMENTS

ACOG, District IX LEP Advisory Panel

Elizabeth Lyster, MD - Chair
Bruce B. Ettinger, MD, MPH
David Priver, MD
Christopher Bencomo, MD

Josephine Von Herzen, MD
Nathana Lurvey, MD
Alicia Barela, MD
Alice Chen, MD

Calvin Freeman - Researcher/Consultant
Margaret Merritt - Executive Director
Diana Cowan - Program Director, Editor

A special thank you to the California Endowment for providing the grant that made this project possible.

