Appropriate Use of Non–English-Language Skills in Clinical Care

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An estimated 25 million US residents have limited English proficiency (LEP)[1] and in a 2006 national survey of 2022 internists, 54% reported encountering patients with LEP at least weekly, with many seeing LEP patients every day.[2] Legal guidance related to Title VI of the Civil Rights Act requires that physicians and hospitals take reasonable steps to ensure effective communication with these patients. Hence, when a patient with LEP presents for care, the encounter must either be conducted with a clinician who speaks the patient's language or indirectly through a trained interpreter. Untrained interpreters, such as patients' friends or family members, are sometimes used, although this practice is risky for reasons of competence and confidentiality.

While no national data are available on physicians' non–English-language skills, in some local surveys, more than 80 percent of physicians report some proficiency in 1 or more non-English languages.[3] Direct communication between language concordant patients and physicians is associated with improved quality, adherence and satisfaction, and reductions in emergency department utilization and costs.[4]

We recently worked with the Commission to End Health Care Disparities to develop a set of recommendations for policymakers, organizations, and clinicians to promote the appropriate use of physicians' non–English-language skills.[4] The recommendations were based in part on interviews with bilingual physicians in a variety of practice settings[5] and an expert panel review using a patient safety approach to care improvement.[6] The commission recognized that the responsibility for ensuring quality of communication ultimately rests with physicians and encouraged use of their non–English-language skills to interact in the patient's preferred language, but cautioned against relying on inadequate language skills.

The course of this work, however, revealed that language skills are often interpreted for practical purposes as a dichotomous construct—even modest skills are often deemed good enough to "get by."[7] In contrast, recommendations from leaders in the field have advocated for graduated measures of language proficiency.[8]

Physicians' non–English-language skills are extremely heterogeneous, ranging from those who speak just a few words of 1 or more non-English languages to those who are native speakers and received their medical training in another language. Similarly, the communication demands of certain clinical interactions are greater than others—conversations about end-of-life care or informed consent for surgery implicitly pose greater miscommunication risks compared with more routine encounters.

As a result of this variability, some physicians are probably always able to appropriately provide care to patients in languages other than English, others might be able to do so in some circumstances, and others have such limited skill that they never should attempt medical communication without an expert assistant (ie, a trained interpreter).

This more nuanced understanding of language proficiency makes it similar in nature to many other skills necessary for the appropriate and effective practice of medicine. Physicians commonly have some level of skill in specific areas (rheumatology, cardiology, surgery, etc) that usually is sufficient for many routine interactions, but they also are prepared to involve an expert consultant if the clinical situation evolves to exceed their skill level.

If bilingual physicians should consider trained interpreters as expert consultants, how should physicians decide whether their non–English-language skills are adequate to provide appropriate care in particular situations and when should they call for consultative assistance?

This turns out not to be an easy task. A qualitative study of 20 resident physicians found that most overestimated their ability to provide care in another language.[7] Another study of 25 physicians who provide care directly in a non-English language (most often Spanish) based on skills that are frequently inadequate (ie, skills obtained in high school or middle school, "medical Spanish" courses, or during short visits abroad and reinforced only by occasional medical or nonmedical use) found the physicians value direct communication with patients very highly, and believe patients do too.[5] However, these physicians might also underappreciate the value provided by using trained interpreters, and cli-

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Box. Encounters Potentially Needing Language Interpreters

High-Risk Encounters

Barring emergency situations, trained interpreters should always be used for the following types of encounters:

- Psychosocial issues predominate, including all encounters for mental or behavioral health or substance abuse
- End-of-life or advance-care planning conversations
- High-stakes genetic counseling
- Trauma, physical or sexual assault
- Team-based encounters in which not all members of the team speak the same language
- Other encounters that may be specialty specific (eg, acute stroke, family planning counseling, new diagnosis of cancer, surgical informed consent)

"Red Flags"

Indications that an encounter is becoming more complex and specialized interpreter services might be required:

- Word finding
  - The physician cannot think of a good word to describe a concept
- Rephrasing
  - The patient displays lack of understanding during a teach-back communication and the physician cannot rephrase the concept or instruction in a different way
- Emotional disconnect
  - The patient displays an emotional response that does not seem to match the content of the conversation
- Patient editing
  - The patient needs to edit what he or she says or speak noticeably more slowly than normal, to make it easier for the physician to understand
- Novel topic or issue
  - The encounter turns to a subject that is unusual, novel, or something the physician does not usually handle
- Confusing answer
  - The patient's description or answer to a question does not make sense and requires repeated clarifications
- Confusing question
  - The patient asks a question that is confusing or seems to be out of context

nicians with limited language skills might find it difficult to detect their own communication errors.

It is not easy or inexpensive for physicians to obtain a valid assessment of their language skills. Although formal assessments exist, they are proprietary and most hospitals and health systems have not adopted policies to provide (or require) these assessments for physicians who use their non–English-language skills in patient care.[4]

More important, even formal language assessments cannot guarantee proficiency for all situations, at least for those physicians in the broad middle range of proficiency. It is possible to be well versed in conversational use of a non–English language but to lack necessary skills for a discussion about psychiatric care or high-stakes medical/surgical treatment. For each specialty, some types of encounters pose such a substantial risk of communication errors that they should always require that a trained interpreter be present, unless the physician carrying out the interaction is fully bilingual and trained in medical use of the non–English-language (Box). The high-risk interactions listed in the box are not comprehensive, but can provide a starting point for discussion and elaboration within specific practices.

Clinicians should also consider ways to detect when a non–English-language encounter is becoming more likely to cause communication errors (Box). In particular, using teach-back, a National Quality Forum–endorsed practice in which clinicians explicitly state key points of instruction and ask patients to restate them to ensure clarity, is useful in many settings. This can be an especially important means for ongoing communication quality assurance for physicians using their non–English language skills in clinical practice.

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