Provider Language Proficiency and Decision-Making When Caring for Limited English Proficiency Children and Families

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Abstract: Objective: To examine associations between self-assessed language ability and provision of clinical care without professional interpretation.

Methods: We conducted an anonymous web-based survey of pediatric residents at a large pediatric training program. Respondents self-rated their language ability, and then reported on their willingness to deliver clinical care without professional interpretation in standardized clinical scenarios.

Results: All pediatric residents completed the survey (n=81; 100%). Many residents (58 of the total sample) indicated at least rudimentary skills in a second language, and seven (9%) indicated they were proficient in Spanish. Eight-five percent had sometimes relied upon friends or family to communicate with parents. Most (69%) reported occasional use of Spanish-language skills to take a history or provide medical advice without the use of a professional interpreter. In contrast, in clinical scenarios where a child was believed to have a complex medical history, few residents (2.5%) felt comfortable using their language skills in the clinical encounter. Residents were willing to have their language ability assessed.

Conclusions: Residents still face circumstances in which care proceeds without an interpreter. Discomfort with providing care in a second language grows with the perceived complexity of care, and yet a complex condition may not be apparent when communication barriers exist. Overcoming barriers to the use of professional interpretation may improve care for LEP children.

Keywords: Llimited English proficiency■Interpreter■Language skills■Resident physician

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INTRODUCTION

Caring for a linguistically diverse patient population is of growing importance for healthcare providers. One-fifth of all US residents speak a language other than English at home.[1] By 2050, it is projected that Hispanic individuals will comprise over 26% of the US population,[2] with significant growth in language diversity.[3] This language diversity has a profound impact on care for limited English-proficient (LEP) patients. Compared to English-proficient patients, LEP patients are less likely to have a primary care provider or to receive preventive care, have higher rates of dissatisfaction, longer perceived wait times at emergency room visits, disparities in pain management or disability care, and less medication adherence.[4–9] US Federal law and the Joint Commission require that US health care organizations offer and provide language assistance services at no cost to patients with LEP at all points of contact.[10,11] Yet in practice, health care providers and institutions do not consistently meet the guidelines for the use of professionally interpreted care.[12]

Past studies have asked medical students and residents about self-reported language use and interpreter services; however, these studies found that providers often rely on less than adequate language skills or *ad hoc* interpreters such as family members or untrained staff to provide care.[12–15] This behavior may be due to a lack of training on how to effectively use interpreters during medical training.[16,17] Little is known about provider fluency or the use of rudimentary language skills in clinical encounters, and medical school curricula are only beginning to address the challenge of language barriers. Use of family members and untrained staff to interpret for LEP patients can result in significant errors and assessment of healthcare staff language abilities is not a standard practice.[18–20]

Our objectives were to explore self-reported language proficiency, reasons for not using professional interpretation, language proficiency, willingness to initiate care without professional interpretation in the setting of increasingly complex clinical scenarios, and interest in the assessment of language proficiency for accuracy and desire for improvement. We hypothesized that residents would initiate care without a professional interpreter if they were concerned about a delay in care, if the family requested the use of a relative, and that a resident would be more likely to initiate care using Spanish language skills in straightforward clinical scenarios.

METHODS

Study design

We designed a cross-sectional anonymous web-based survey to measure self-reported language proficiency and clinical decision-making in standardized clinical scenarios.

Study participants

Participants were pediatric residents in a large residency program, the sole training program providing pediatric tertiary care for four Northwest states. All pediatric residents were invited to take an anonymous web-based survey using SurveyMonkey©. Residents completed the survey during a two-week period in 2007. An automatically generated reminder email was sent to all pediatric residents one week after the initial emailing of the survey. All residents received a coffee card as a token of appreciation for participation.

Survey design

The standardized clinical scenarios were designed by the authors based on commonly encountered cases, and included frequently managed conditions (e.g. wheezing) as well as cases for which history and exam findings were important in a treatment plan (e.g. wheezing caused by heart failure). Surveys were pilot-tested by three chief residents and revised to improved clarity. Survey content was approved by the Seattle Children's Hospital Human Subjects Review Board.

Outcomes of interest included reported clinical use of Spanish, comfort using second language skills to provide care, use of professional interpretation, and decision-making in choice of communication with families in three hypothetical clinical scenarios. If a resident chose to speak Spanish in the encounter, they were asked their reason for not seeking professional interpretation. These scenarios were designed to illustrate perceived trade-offs between good communication, prompt care, and provision of professionally interpreted care.

The primary outcome was a willingness to provide clinical care without professional interpretation. Explanatory variables were self-reported proficiency in a second language, race/ethnicity, gender, and year of training. Residents were asked to identify themselves as proficient in a language other than English and/or a native speaker of a language other than English. Residents who were native speakers of another language were asked whether they completed university training in that language.

Data analysis

Study data were imported from SurveyMonkey© and analyzed using STATA Version 9.0 (College Station, TX). Typed responses were coded into binary variables of language proficiency (yes or no) and native language presence (yes or no). The primary outcome of interest, resident use of language skills, was assessed using a Likert scale from "never" to "always". We examined associations between the outcomes (e.g. willingness to use language skills without professional interpretation) and explanatory variables (e.g. perceived clinical complexity) using logistic regression.

RESULTS & DISCUSSION

Resident language proficiency

All 81 pediatric residents responded to the survey (100% response rate). Respondents represented a diverse group of physicians with 18 (22%) reporting proficiency in at least one language other than English. Of those, 9 (11%) reported they were native speakers of at least one additional

Table 1. Characteristics of study participants.

Characteristic	Total N = 81
Average Age	31 years
Race/Ethnicity	
White	61 (75%)
Other (includes those residents who were Hispanic and/or listed a race other than White as their first choice)	14 (17%)
No Answer on race/ethnicity	6 (7%)
Female Gender by year of training	
First Year (R1)	82%
Second Year (R2)	67%
Third Year (R3)	74%
Self-Reported Language Proficiency	
No self assessed language proficiency other than English	63 (78%)
[a]Native speaker of a language other than English	9 (11%)
[a]Proficient in a language other than English	18 (22%)
Native Speaker (language other than Spanish)	3 (4%)
Native Spanish	1 (1%)
Non – native, non Spanish	8 (10%)
Non –native, Spanish	6 (7%)

[a]*Participants were allowed multiple responses. Some native speakers did not report being proficient in a language other than English, so total does not equal 100%.*