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MEDICAL EDUCATION

Should All U.S. Physicians Speak Spanish?

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Patients and physicians increasingly find they speak different languages. This is due largely to the growing number of people with limited English proficiency immigrating to the United States and seeking care from physicians, most of whom speak only English. Inadequate communication contributes heavily to disparities in health care quality, a point highlighted in the Institute of Medicine's (IOM's) 2002 "Unequal Treatment" report [1]. It has been found that 64 percent of U.S. patients with limited English speak Spanish [2], and a case could be made that all physicians in this country should learn Spanish to minimize the disparity.

Language concordance between patient and physician has been shown to reduce overall cost to the patient and minimize costs to the hospital [3]. In that light, we could look upon physicians' learning of Spanish as a type of medical intervention. As with any sound medical tool, it is designed to positively affect as many patients as possible with minimal investment of resources.

The Burden of Learning a New Language

Why should the burden of learning a new language fall to the physician rather than the patient? Just as it would help diabetics to control their blood sugar and overweight persons to lose weight, it would behoove foreign-language-speaking patients to learn English. We want all these patients to make the suggested lifestyle changes. The charge of a physician, however, is to treat disease given the reality of the patient, and for many patients that reality is lack of proficiency in English.

There are other reasons why having physicians learn a new language is more practical. There are fewer physicians than Spanish-speaking patients. According to the 2000 Census and the Bureau of Labor Statistics, the ratio of physicians to patients who speak English less than "very well" is approximately 22:1 [4-5]. In other words, fewer individuals would be responsible for learning a new language if we placed that responsibility on physicians. Second, physicians have better access to language programs and resources, including their universities or medical training facilities. Finally, physicians have a long preprofessional training period during which to learn another language, and many will have learned Spanish prior to studying medicine.

The Ethical Impetus

The ethical case for all doctors being proficient in Spanish is based on the idea that all patients should have control of their health care decisions. A recent article by Volandes and Paasche-Orlow in the *American Journal of Bioethics* maintains that the "autonomy of healthcare users with limited literacy is thwarted if the [consent] forms intended to preserve their individual autonomy are inaccessible" [6]. The autonomy of patients with limited English is similarly threatened: the lack of true informed consent has been confirmed in at least one study, which found that hospitalized patients with limited English were less likely than their English-speaking peers to have documented informed consent for common invasive procedures, even when given access to professional interpreters [7].

Volandes and Paasche-Orlow further cite the implications of language differences for the just distribution of health care services: "In Rawls' framework, decision-makers, who are behind a veil of ignorance and unaware of their positions in a society, would design a system in which the position of the least well-off is maximized regardless of the potentially negative impact on those better off" [6]. Many patients with limited English are, like English speakers with limited literacy, among the "least well-off," yet no one could argue that the health care system is designed with them in mind. One small step to closing this gap would be introducing Spanish, when appropriate, as a required part of the health care delivery system; it would largely benefit the least well-off patients and meet this standard of justice.

Medical Professionalism

Medical professionalism requires that the physician act as an advocate for the patient. In the most recent and widely accepted definition of medical professionalism—"The Physician Charter"—published in the *Annals of Internal Medicine*, two of the three fundamental principles—patient welfare and social justice—apply to patients with low English skills or literacy [8]. The IOM report suggests a rampant lack of social justice for patients with limited English language skills, and one of these principles is often compromised unless professional interpretation is provided [9]. For example, patients being seen by health professionals who speak only English were more likely to report less understanding of their diagnoses and treatment plans than patients with similarly limited English proficiency who were seen in the company of a Spanish-speaking caregiver [10].

Possible Solutions

We do not believe that the above arguments mandate the teaching of medical Spanish to all physicians; rather, we think they mandate that medical Spanish be a part of the standard of care. The distinction is an important one.

In reality, teaching *all* medical students Spanish would be nearly impossible and could actually prove detrimental to care. While bilingual doctors do have a positive impact on quality of care for patients who speak limited English [9], this outcome assumes that both parties are fluent in the same language. The addition of medical Spanish to the already overstuffed curriculum would probably not result in language

proficiency adequate for better care. Medical students with substandard Spanish skills might be recruited to serve as ad hoc interpreters for their health care teams, potentially compromising patient care and creating further confusion during the patient-physician interaction.

In the literature, an ad hoc interpreter is defined as any "untrained person who is called upon to interpret" [11]. The use of ad hoc interpreters was shown in a systematic review to have adverse effects on quality because the ad hoc interpreters in the study explained side effects of medication less frequently, distorted statements, and committed errors that could have clinical consequences [9].

Instead of teaching Spanish to all medical students, elective programs with incentives for enrollment should be made available to native Spanish-language speakers and those with extensive prior Spanish education. All medical students should, as part of the general curriculum, learn how to communicate properly with an interpreter who is a part of the interdisciplinary health care team.

The growing complexity of medicine has been the impetus for change from the model of the autonomous, solo practitioner to the interdisciplinary health care approach, in which patients receive care from a team trained in a variety of professional and nonprofessional disciplines. The value of the interdisciplinary model has been shown in several clinical settings [12-14], and integrating it into the existing medical school curriculum could start with building translation services into standardized patient stations. The experience and future plans of UT Southwestern offer an example of a practical approach to the challenge of caring for patients who have limited English skills.

An Example Curriculum

In 2005, 36 percent of Dallas County's population identified themselves as Latinos [15], and many had limited ability to speak English. For reasons explored above, the needs of this large, growing segment of the population should be accommodated in the health care setting.

In response, medical students at the UT Southwestern Medical School initiated an extracurricular translator apprenticeship program (TAP) designed to increase the number of students who could serve as competent medical interpreters. The program enlisted fluent or native Spanish-speaking students and students of intermediate-to-high Spanish proficiency because these are the students who are most likely to be recruited as ad hoc interpreters.

The students translated components of the medical and physical exam, practiced interactions between "doctor" and "patient" (played by fluent or native speakers), expanded their medical vocabularies, and learned about dynamics of the patient-provider-interpreter relationship. Then each intermediate-to-high proficiency student was paired with a fluent mentor to volunteer as translators at a community clinic serving a Spanish-speaking population. TAP has increased the numbers of available

and proficient translators and has facilitated better communication between patients and health care workers.

Eighteen of the 21 students involved in TAP expressed interest in having extended opportunities to improve their oral communication, and 19 were receptive to participating in more mock clinics. The TAP curriculum is being shaped to become an important extracurricular resource in future years and, if proven efficacious, to be integrated as an elective at UT Southwestern.

Future Challenges

The many obstacles to adding cultural proficiency to an already dense medical school curriculum have blunted medical schools' responses to the growing needs of patients with limited English. The best and most recent survey of medical schools found that "most U.S. and Canadian medical schools provide inadequate instruction on cultural issues, especially the specific cultural aspects of large minority groups" [16]. Only 26 percent of the schools in that study, for example, taught about aspects of Latino culture that could affect health care.

We have a long way to go before we reach the goal of ensuring that patients with limited English receive the care they deserve on ethical, professional, and legal grounds. The heightened awareness among medical educators and researchers of this shortcoming in our health system gives us hope for continued progress towards giving *all* patients the best possible care.

References

1. Smedley BD, Stith AY, Nelson AR, eds. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academies Press; 2003.
2. Shin HB, Bruno R. *Language Use and English Speaking Ability: 2000*. Washington, DC: US Department of Commerce, Economics and Statistics, US Census Bureau; 2003. http://www.census.gov/prod/2003pubs/c2kbr-29.pdf. Accessed January 26, 2008.
3. Jacobs EA, Sadowski LS, Rathouz PJ. The impact of an enhanced interpreter service intervention on hospital costs and patient satisfaction. *J Gen Intern Med.* 2007;22(Suppl 2):306-311.
4. US Bureau of the Census. Language use. http://www.census.gov/population/www/socdemo/lang_use.html. Accessed February 25, 2008.
5. US Department of Labor, Bureau of Labor Statistics. *Occupational Outlook Handbook*. http://www.bls.gov/oco/pdf/ocos074.pdf. Accessed February 25, 2008.
6. Volandes AE, Paasche-Orlow MK. Health literacy, health inequality and a just healthcare system. *Am J Bioeth.* 2007;7(11):5-10.
7. Schenker Y, Wang F, Selig SJ, Ng R, Fernandez A. The impact of language barriers on documentation of informed consent at a hospital with on-site interpreter services. *J Gen Intern Med.* 2007;22(suppl 2):294-299.

8. ABIM Foundation. American Board of Internal Medicine; ACP-ASIM Foundation. American College of Physicians-American Society of Internal Medicine; European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med.* 2002;136(3):243-246.
9. Flores G. The impact of medical interpreter service on the quality of health care: a systematic review. *Med Care Res Rev.* 2005;62(3):255-299.
10. Baker DW, Parker RM, Williams MV, Coates WC, Pitkin K. Use and effectiveness of interpreters in an emergency department. *JAMA.* 1996;275(10):783-788.
11. National Council on Interpreting in Health Care. *The Terminology of Health Care Interpreting: A Glossary of Terms.* Washington, DC: National Council on Interpreting in Health Care; 2001. http://www.hablamosjuntos.org/pdf_files/TheTerminologyofHealthCareInterpreting.pdf. Accessed March 5, 2008.
12. McAlister FA, Stewart S, Ferrua S, McMurray J. Multidisciplinary strategies for the management of heart failure patients at high risk for admission: a systematic review of randomized trials. *J Am Coll Cardiol*. 2004;44(4):810-819.
13. Counsell SR, Callahan CM, Clark DO, et al. Geriatric care management for low-income seniors: a randomized controlled trial. *JAMA.* 2007;298(22):2623-2633.
14. Diabetes Integrated Care Evaluation Team. Integrated care for diabetes: clinical, psychosocial, and economic evaluation. *BMJ.* 1994;308(6938):1208-1212.
15. US Census Bureau. State and county quickfacts. Dallas, Texas. http://quickfacts.census.gov/qfd/states/48/48113.html. Accessed November 26, 2007.
16. Flores G, Gee D, Kastner B. The teaching of cultural issues in U.S. and Canadian medical schools. *Acad Med*. 2000;75(5):451-455.

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