



# **Physician Perspectives on Communication Barriers**

**Insights from Focus Groups with Physicians Who Treat  
Non-English Proficient and Limited English Proficient Patients**

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## Introduction

*Hablamos Juntos* and The Robert Wood Johnson Foundation sponsored this focus group study with physicians to better understand communication barriers to health care for minority patients. *Hablamos Juntos* is a project funded by the Robert Wood Johnson Foundation to improve communication between healthcare providers and their patients with limited or no English proficiency. Lake Snell Perry & Associates, a research firm in Washington, DC, conducted the six focus groups in four sites across the country May through July, 2003.

The purpose of this project is to hear directly from physicians who treat a growing number of patients who are non-English proficient (NEP) or limited English proficient (LEP). Physicians with Latino patients were particularly encouraged to participate in this study since Hispanics represent both the largest and fastest growing minority population in the United States. The focus groups explored physicians' experiences with their NEP/LEP patients, the kinds of challenges these patients pose, some of the strategies and actions they have taken to address these challenges, and their reactions to messages and information created to engage physicians on this topic. In order to hear a variety of experiences, a mix of physicians participated in this study from internists, pediatricians, OBGYNs to specialists such as surgeons, ENTs, urologists and Nephrologists.

## The Challenge

A growing body of research on health disparities between ethnic groups shows that being a member of a minority group in the United States, in and of itself, can be a barrier to health care. And though socioeconomic status and ethnicity are only two elements in the larger picture of access to care, statistically they have shown themselves to be critically important. The inability to speak English, in particular, has been empirically associated with less care-seeking and access to care.

Language barriers create problems for both patients and providers. For patients, language and communication influence how and if NEP/LEP patients access and experience health care. Because of language barriers, these patients often encounter the following basic types of problems:

- Lack of awareness of existing services and how to access them;
- Difficulty in making appointments and accessing basic information about the visit when they do seek care;

- Inability to communicate adequately with health care support staff, providers, and ancillary staff at all points within the healthcare delivery system;
- Low patient satisfaction in situations where language is a barrier, which may lead to reluctance to return to the health care setting.

Furthermore, research shows that even when NEP/LEP patients are able to access health care, health care quality may be diminished and health outcomes may be poorer for them than for other patients. Specifically:

- These patients receive less information about the therapeutic regimen, and understand less of the instructions related to their medication;<sup>1</sup>
- After cross-language encounters, patients are less likely to keep subsequent appointments and are more likely to make emergency room visits than are patients in same-language encounters;<sup>2</sup>
- Non-English speakers are less likely to receive preventive services;<sup>3</sup>
- Latino parents, in one study, cited language barriers as the cause of misdiagnoses, poor medical care and inappropriate medications and/or hospitalizations of their children.<sup>4</sup>

Language barriers also pose many challenges to the healthcare providers who treat NEP/LEP patients. Because of language barriers, providers often encounter difficulties in:

- Making an accurate diagnosis;
- Meeting informed consent responsibilities (e.g., HIPPA);
- Explaining care options to NEP/LEP patients;
- Undertaking health education and awareness efforts;

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<sup>1</sup> Shapiro J and Saltzer E (1981). Cross-cultural aspects of physician-patient communication patterns. *Urban Health*. Vol 10, 10-15.

<sup>2</sup> Manson A. (1988). Language concordance as a determinant of patient compliance and emergency room visits in patients with asthma. *Medical Care*. Vol. 26. 1119-1128.

<sup>3</sup> Woloshin S, Schwartz LM, Katz SJ, and Welch HG. (1997). Is language a barrier to the use of preventive services? *Journal of General Internal Medicine*. Vol. 12, 472-477.

<sup>4</sup> Flores G, Abreau M, Olivar M, and Kastner B. (1998). Access barriers to health care for Latino children. *Archives of Pediatric and Adolescent Medicine*. Vol. 152, 119-1125.

- Convincing NEP/LEP patients to comply with a treatment regimen they may not understand.

The study seeks to highlight the challenges facing physicians who treat NEP/LEP patients and better understand how to engage more physicians on this topic.

## Methodology

In May-July, 2003, Lake Snell Perry & Associates (LSPA) conducted six focus groups in four sites: Olympia, WA; Falls Church, VA; Atlanta, GA; and Columbus, OH. One focus group was held in Olympia and Columbus, while two groups each were held in Atlanta and Falls Church.

To qualify for this study, 5 percent or more of the physicians' patient population had to be NEP/LEP patients. Most providers reported much higher levels of NEP/LEP patients, particularly of Hispanic patients. LSPA further separated the groups by two categories: generalists and specialists. Based on the existing data, LSPA used this framework to explore potential differences on this issue based on their specialty. For ease of reporting, the generalists in this study are referred to throughout the report as PCPs (primary care physicians) but, in reality, they represent a range of types of physicians. Table 1 below shows the organization of the focus groups and the providers who participated.

**Table 1: Description of Provider Focus Groups**

Group #	Location	Date	Time	Type of Group	Providers in Group
1	Falls Church, VA	June 5	6:00-7:30pm	Generalists (PCPs)	OB/GYN (2); Family Practice (2) Internal Medicine (2); Pediatrics (1) Naturopathic (1)
2			7:45-9:15pm	Specialists	Ophthalmology (2); Psychiatry (2); Surgery (2); Allergist (1); Gastroenterology (1)
3	Atlanta, GA	July 15	6:00-7:30pm	Specialists	Cardiology (2); ENT (1); Nephrology (1); Surgery (1); Ophthalmology (1); Oncology (1); Endocrinology (1)
4			7:45-9:15pm	Specialists	Neurology; Plastic Surgery (1); Endocrinology (1); Podiatry (1); Nephrology (1); Orthopedic Surgery (1); ER (1); Eye (1); Ophthalmology;
5	Columbus, OH	July 17	6:00-7:30pm	Mix	Pediatrics (4); ENT (1); Pulmonary/Critical Care (1); Podiatry (1); Ophthalmology (1)
6	Olympia, WA	July 29	6:00-7:30pm	Generalists (PCPs)	Family Practice (2); Pediatrics (2); Urology (1);

Since we wanted to hear from “mainstream” physicians – and not those who are particularly in-tune with this specific issue – extra care was taken to find physicians who may be struggling with this issue with limited time and resources. In each location, LSPA used a multi-tiered recruitment strategy. To avoid recruiting those who are already onboard with this issue, LSPA dug deeper to find those who are farther removed from this topic. LSPA worked closely with local organizations – from local hospitals to health care coalitions – as well as used traditional recruitment methods (such as referrals of referrals) to find providers for whom this is not a top-of-mind issue.

As a result, providers who serve high numbers of non-English speaking Hispanic patients, and those providers who speak Spanish were limited or excluded from participating in this study. Each focus group discussion lasted 90 minutes, included an average of 8 participants, and was conducted in a professional focus group facility. Each discussion was audio taped and transcribed. Physicians were paid to attend the group discussion.

# Findings

## I. The Changing Environment

The physicians in this study are facing a growing population of patients who are non-English proficient (NEP) or limited English proficient (LEP). They are in urban and rural locations that are experiencing an influx of diverse ethnic and racial populations, many of whom do not speak English. These physicians talk at great length about the changing demographics of their communities and their practices. Based on their remarks, some seem to be taking these demographic changes in stride, welcoming the growing diversity of their practice, and slowly evolving to meet a wide range of needs. Other physicians seem overwhelmed by their increasingly diverse patients and are being seriously challenged by the communication barriers they face to treating NEP/LEP patients. A handful of physicians even seem resentful of NEP/LEP patients and the perceived burden they place on providers. Insights into these issues follow.

### **Physicians say their communities – and their patient populations – are becoming more diverse.**

All physicians say the shift in their patient population has been dramatic in recent years. Many of the physicians in the focus groups can easily list six or seven different ethnic groups represented among their patient population. “My patient population is about 10 percent African Americans and about 15 percent Spanish-speaking and about 25 to 30 percent Korean, Japanese, Chinese, [and] Vietnamese,” said a PCP from Falls Church. In particular, physicians say the number of Hispanic patients they treat has sharply increased. “I can clearly tell you that there has been an increase in the population in the Hispanic community,” explained an Atlanta specialist.

Based on physicians’ comments, immigration patterns vary among the sites selected for this study and the overall affect of these patterns is unclear from the focus groups. For example, in Olympia, WA and Columbus, OH, physicians talk about the recent influx of particular ethnic groups, leading to a sizable population of that ethnic group in those locations. For example, a physician from Columbus noted, “I see a large number of immigrants that is increasing very rapidly over the last five to six years. There’s been a huge influx [of] Somalians, Hispanics, South African[s], Chinese, Japanese, [and] South Koreans.” This still seems to be a new phenomenon to these physicians. Indeed, the effect of these rapidly increasing minority populations has caught their attention and affected how they practice.

However, in the larger metropolitan sites (Falls Church, VA and Atlanta, GA), physicians are more likely to describe a steady and varying stream of diverse

ethnic populations that has been occurring for a while. The specific ethnic groups coming to their communities – other than Hispanic – seem indistinguishable because of the sheer number of minorities that arrive daily. These physicians just seem to take their changing communities for granted, simply a part of living in an international city and not necessarily a new occurrence.

### **Most say their NEP/LEP patients find them through word-of-mouth.**

*"The referrals, they are booming."*

*-Falls Church PCP*

When asked how they attract their NEP/LEP patients, most physicians say that it is through word-of-mouth rather than intentional marketing. "The vast majority of our patients choose us," explained a Falls Church physician. Many physicians say that if a NEP/LEP patient likes them and feels they are well-cared for, they will tell their friends. The result is that these physicians begin to notice an increase among patients from that specific racial and ethnic group based on that positive referral.

Some say their diverse patient population is more the result of insurance coverage or convenience than marketing. "Some doctors don't accept certain insurances...more people come to me [as a result]," explained a Falls Church PCP. Others say they are located near minority neighborhoods, which explains their growing minority patient population. A few physicians, particularly women, say their gender affects their patient mix. Specifically, they say that many women prefer to see a female provider regardless of ethnic background.

### **Some physicians do not necessarily welcome the idea of caring for more NEP/LEP patients.**

Some physicians in this study reveal that they do not actively seek minority or immigrant patients. While they say they do not turn these patients away, they acknowledge that they do not seek to attract them either. Rather, the NEP/LEP patients they see tend to come from referrals from other patients. It should be noted that this is not a universal opinion in any of the focus groups – rather, many other physicians diverge from this view and instead describe the many benefits of treating a multi-ethnic patient population.

The reasons that some physicians give for not wanting to increase their NEP/LEP patients are varied – everything from cost concerns to inconvenience to the basic challenge of communication. In terms of costs, a number of physicians talk about paying for interpreters and the delays associated with treating NEP/LEP patients. A few physicians say that time is money for them and are frustrated that they have to spend twice as much time treating NEP/LEP patients because of language barriers (e.g., repeating what they say, drawing pictures, speaking slower, using an interpreter, etc).

*"I don't [market]. I can't speak the language. I'm sure they are more frustrated with their inability to communicate with me than I am with my ability to communicate with them. I don't actively seek it [Hispanic clients]."*

*-Atlanta Specialist*

Others physicians say there are many “hassles” when treating NEP/LEP patients. A specialist from Falls Church explained, “[M]ost of the surgical cases that we have are in and out local anesthesia and so the patient is basically awake when we are operating. You have patients from one of the nationalities and... they don't speak the language and they start moving their head, and you have to call someone to tell them don't move your head or don't squeeze your eyes, or don't do this. It's a big challenge.” A specialist from Atlanta cited that her NEP/LEP patients are less reliable. She said, “If they [non-English speaking Hispanic patients] are that bad off they will show up unexpectedly. They won't keep their appointments, but they will knock on the door. It is more like that, they won't follow the schedules.”

Finally, a PCP from Olympia stated that it is difficult to form a relationship with NEP/LEP patients, especially when you rely on an interpreter to help communicate. She commented, “It's really hard to get a rapport with a patient because you are having to go through a translator the whole time...people have to develop a trust in you and you have to kind of develop a feel for them of what they'll take and how much they understand...That is really hard to do when you have to do it though a translator.”

The result is that some physicians in this study acknowledge that they do not really want to care for more NEP/LEP patients – they are only doing so because they feel they cannot turn away a patient in need.

### **Specialists in this study seem to be struggling with the challenges of NEP/LEP patients more so than general practitioners.**

Comparing the focus groups with specialists and those with PCPs (internal medicine, pediatricians, OB/GYN, etc) suggests that PCPs may be more comfortable with this topic and with treating NEP/LEP patients. This may reflect the long-term nature of the patient-doctor relationship with PCPs that could make them more responsive to the needs of these patients. In contrast, some of the specialists in the focus groups describe intermittent relationships with their patients which may provide less incentive for them to take steps to improve communication with NEP/LEP patient.

### **A handful of physicians in this study seem resentful of NEP/LEP patients.**

Comments made by a few physicians in this study suggest an underlying resentment of their NEP/LEP patients. These physicians feel it is not their responsibility to address language barriers. As one specialist from Atlanta said, “I think the responsibility is not with the medical community. We have more problems than you could possibly comprehend.” Another specialist from Atlanta made the following comment, “I feel very strongly that when you come to the United States you should learn English...I believe that the patient should make certain that they come equipped to be able to receive the care that I am going to give to them. I

cannot tailor my practice to fit any particular patient population.” An Atlanta specialist made the point that NEP/LEP patients often have multiple needs that go beyond medical care. She said, “We pamper people too much. We don’t let them be adults. I can’t, every time I turn around, put out another fire and be another social worker for someone else. I am social worked to death.” And a Falls Church specialist went so far as to explain, “I chose not to deal with serving this type of population, serving immigrants or non-English speaking in my private practice because of the cost issues,” although he does see them at a hospital-affiliated health clinic that is also part of his practice.

**In contrast, many physicians appreciate their NEP/LEP patients and accept the shifts in their patient populations as inevitable.**

The more typical attitude of physicians in this study is one of acceptance when it comes to their NEP/LEP patients. They see their communities becoming more diverse and believe it is inevitable that their patients will reflect this change. These physicians seem to believe that they must “keep up with the times or be left behind,” and so are sanguine in their approach to NEP/LEP patients. This does not mean that they have made substantial adjustments in their practices to accommodate patients with no or only limited English-speaking ability, however many have made small changes and others are considering changes in the future.

A subset of this large group of physicians is more positive in their discussion of NEP/LEP patients. Their feelings go beyond mere acceptance and they assert that they reap many rewards from treating ethnically and linguistically diverse patients. As one Atlanta specialist said,

“From what I hear from all the other surgeons, to them it is an inconvenience and a problem for them to have to deal with non-English speaking minorities. It takes a little extra energy here and there but this is the world we live in. I feel like to the extent that I can, if I try to create a positive situation for them then it is going to come back around and I think that is what needs to be done. That is the world we live in now and it is not going to change. It is not going to go back the other way so I feel like this is what I need to do. I have enjoyed every minute of it. They are some of the best patients I can have.”

One specialist from Atlanta described his perspective on treating NEP/LEP patients, “It’s very rewarding to see somebody come to this country, who doesn’t speak English and suddenly see [a doctor] that can listen to them and can understand them and can see their needs are met.” A few of these physicians even empathize with the challenges facing NEP/LEP patients and therefore go out of their way to be helpful. “[They are] lost in the system. People aren’t that helpful. They [physicians] point down the hall and the person will follow, and then they get to another person and it is like ‘follow the dots’ and hope you get where you need to go, and then get back to me. It is a nightmare for these poor people,” explained an Atlanta specialist.

**A few physicians say they actively market to minority patients and feel it is the best way to grow their practice.**

A few physicians in this study say they are actively marketing to NEP/LEP populations because it is economically advantageous. They see a surge in minority populations in their communities and want to be their provider of choice. These physicians say they have taken out ads, hired bilingual staff, and provided free seminars to attract NEP/LEP patients. “Yeah, either through advertising or maybe going out [to their community]. I go out into communities and I’ll give talks. I do that several times a month, so I try to go different place where I think people may need care or someone will say I want you to come to my church or something like that,” described a Falls Church PCP. A few have used other techniques, such as hiring bilingual staff so that word is spread that they can accommodate different languages. As one Atlanta specialist said, “We have not done any marketing, but we actually hired a Latin physician and a medical assistant and a scheduler. They are Latin culturally so we can reach out to that community by word of mouth that we provide that service.”

The result of this discussion is that all physicians in this study acknowledge their communities are changing and so are their patients. Some are taking steps to address the needs of this population. A few resent they have to accommodate NEP/LEP patients and feel the patient themselves should take more responsibility for their care. Many just feel there is no choice – it is part of their responsibility to serve all patients who come to them. And some see this as an opportunity to grow their business and reach more diverse patients.

## II. How Physicians Are Responding

Most physicians in the focus groups believe that their practices will continue to diversify, leading to even more NEP/LEP patients in the future. While many physicians acknowledge that these patients can have unique needs and pose some communication challenges, most appear to feel that changes in their practice are not really necessary to address the increase in NEP/LEP patients. Rather, the majority of physicians in the focus groups seem to feel that the communication techniques they already use with English-speaking patients can overcome most of the language barriers that may exist. They also strongly assert that clear communication with *all* of their patients is a top priority and are proud of their ability to connect with their patients regardless of racial and ethnic background and their English proficiency.

Given this feeling, it is not surprising that the majority of these physicians are not making big changes in their practices or looking to outside expertise – such as professional medical interpreters – to assist communication with NEP/LEP patients. Rather, their approach seems more ad hoc and usually in reaction to an individual patient’s specific need. For example, most rely on communication techniques they already use, or they pull in family members or staff to help interpret during an appointment when there is a communication problem. Most seem to believe these informal and improvised steps are sufficient to ensure that key information is being transmitted between doctor and patient.

This section addresses the specific steps physicians in the focus groups say they are taking to improve communication with NEP/LEP patients. But first, this section underscores the importance that physicians place on clear communication with their patients.

**First and foremost, physicians in this study say clear communication with all their patients – regardless of race, ethnic background, or language – is the goal.**

“[T]he most important thing in medicine is communication. If you tell the patient what to take, what to do, they have to understand that. If they don’t then there is no point in seeing the best doctor,” commented a PCP from Falls Church. A PCP from Olympia points out that obtaining a full medical history from a patient is a key part of treating them, and this relies on clear communication. She said, “[Medical] history, they say, is the majority of your diagnosis and if you can’t get an accurate history then you are not going to be able to do your job.” Virtually all of the physicians in this study say they work hard at clear communication with their patients and use a range of techniques – speaking slowly, having the patient repeat after them, writing down the information or handing out pre-printed materials, non-verbal communication, visual images and diagrams, and speaking with other family members to ensure they understand.

Most physicians say they take these steps with all their patients, not just the NEP/LEP patients. Some physicians assert that treating patients with a low education level (even though they speak English) can be just as challenging as treating NEP/LEP when it comes to explaining complicated medical conditions, treatment options, or when providing care instructions. For this reason, these physicians say they are careful in their communication with all patients and take extra steps and time, if needed, to ensure there is a clear understanding. Some resist singling out NEP/LEP patients as being particularly challenging in terms of communication and say they prefer to treat all their patients the same.

Clear communication is also mandated, these physicians point out, since they are required to obtain “informed consent” before surgical medical procedures on their patients due to HIPPA regulations. This requirement means they must explain the procedure to the patient and have confidence that the patient fully understands the procedure and its possible benefits and consequences. According to many physicians in this study, therefore, clear communication is not only a personal and professional priority, but it is a legal requirement also.

### **Steps Most Physicians Are Taking:**

Following are the specific steps physicians say they are taking to improve communication with their NEP/LEP patients. They are in descending order – i.e., those steps that most or many physicians are taking come first, while those steps only a few or a handful of physicians are taking come last. Note: few say they do all of the following instead most rely on one or two individual efforts.

#### **❖ Family Members/Friends**

The preferred approach of physicians in this study to overcoming language barriers is using bilingual family and friends of NEP/LEP patients who can speak English to act as interpreters. A few physicians say they actually encourage patients to bring English-speaking family members and friends to appointments, however, many say that their NEP/LEP simply know to bring these family members and friends with them. “I tell them to bring somebody even children who talk English. They can talk to their parents and they come here to interpret. They even come to the operating room to interpret for us,” explained a Falls Church specialist. An Atlanta specialist said,

“I don’t usually see somebody that comes in by himself or herself who doesn’t speak English. They usually bring somebody with them. It is usually somebody else that will call to make the appointment for them and that person will be insightful enough to tell my secretary that they don’t speak English and the secretary will ask them to bring an interpreter or someone who can help with that. That generally occurs before I ever see the patient the first time.”

*“I always say the most important thing you can do is to bring someone who speaks English with you.”*

*-Atlanta Specialist*

While this is the typical way physicians in this study appear to deal with communication barriers with NEP/LEP patients, it is not without its flaws (which are explored fully in the next section of the report). Many acknowledge problems using family members and friends who are not trained to be interpreters – for example, they tell stories about miscommunication stemming from a family member or friend that detrimentally affected the patient’s health. Despite this, it seems likely that physicians in this study will continue to rely on family members and friends for interpretation in the foreseeable future.

### ❖ **Traditional Communication Techniques**

Most physicians say they use the following techniques with their NEP/LEP patients: non-verbal gestures/signals, charts and visual aids, videos, a few words in their language (Spanish mostly), simple English terms the patient might know, repetition and slower speech, and extra time during appointments. They reveal that they use these techniques with all their patients, but assert they can be particularly helpful with NEP/LEP patients. Some comments from physicians on these techniques include:

“[I] speak very slowly, use simple words... Explain [things] to them. Take more time explaining so you don’t rush them.”  
*-Falls Church Specialist*

“Every exam room has a blackboard like this and we have colored magic markers. We do a lot of drawing. It really helps to be visual in showing patients exactly what is involved and what we plan on doing.”  
*-Atlanta Specialist*

“Instructional videos, every patient who comes through the door sees an instructional video.”  
*-Atlanta Specialist*

Despite their reliance on these techniques, a number of physicians acknowledge that these communication methods do not always guarantee a clear understanding between doctor and patient. A number of physicians say that despite taking these steps, they are sometimes unsure how much the patient understands.

### ❖ **Printed Materials in Various Languages**

Fewer physicians – but still a significant number of focus group participants – say they obtain and disseminate print materials in the appropriate languages (usually Spanish) to their NEP/LEP patients. They find these materials from different sources – their medical associations, from colleagues, from websites, from vendors – and use them as a backup

to their own verbal instructions. These materials cover a range of topics – some explain common medical conditions, others describe treatment options, and still others pertain to prescription medication and dosage schedules. “I’ve got a supply of Spanish material for like diabetes and hypertension, cholesterol,” said an Olympia PCP. An Atlanta specialist described his use of pre-printed materials this way:

“I have handouts for the various operations that I do in different languages like Spanish, so that they can go home and read about their potential hernia repair or gall bladder surgery in their own language. It’s hard enough to fully inform an English-speaking patient of all the risks and benefits of their operation, but reaching across not only the language barrier, but also the jargon barrier between conversational language and our medical jargon – there are three or four barriers there to get across. The pamphlets in their language help a lot.”

Another specialist from Atlanta also relies heavily on printed materials: “I also have brochures on trying to explain the side affects of chemotherapy in Spanish, pain management, nausea and vomiting and diarrhea all in Spanish. Even in English sometimes it is difficult. The difficulty I have is because I don’t speak fluent Spanish if they call me and they don’t have an interpreter then I think that is difficult for someone who is not English speaking.”

Some physicians in the focus groups point out that there are some flaws in relying too much on printed materials. Literacy is one concern. “Some of our Spanish population doesn’t read, so they speak it and they don’t read it, so [written information] may or may not be helpful,” said an Olympia PCP. Another PCP from Olympia also pointed out that the language level of some of the printed materials is too high for many NEP/LEP patients. She said,

“What is available isn’t always appropriate either because I know there was some information they had at the hospital and I had a translator in for sending somebody home and she said, ‘This is high school level.’ She says, ‘You need something that is fourth to sixth grade level reading material.’ It was perfectly good Spanish, she said, but it probably wasn’t appropriate for the population they were serving. There are quite a few illiterate people who can’t read anything.”

Finally, it is unclear that physicians can assess the quality of the written materials they use with NEP/LEP patients – i.e., whether it is a good translation and at the appropriate level. Many seem unaware of good sources of written materials on various medical conditions and most seem open to hearing about other sources of this kind of information (as long as they do not have to find them).

*"We have Spanish [speaking] employees who translate for me, if I don't understand what they are saying."*

*-Falls Church PCP*

## ❖ **Bi-lingual Staff**

Some physicians (usually about three or four in every focus group) say they have purposely hired bilingual staff, almost always Spanish-speaking, to assist with communication with NEP/LEP patients. This is, by far, the biggest investment that physicians in this study have made to address the needs of NEP/LEP patients. In many cases, these appear to be administrative and front office staff rather than medical professionals. Physicians say they use these staff members to act as interpreters during office visits or to answer phone calls from NEP/LEP patients. "In our offices we have at least two people in every office [that] speaks Spanish, so it's not a problem," said a PCP from Falls Church. A physician from Columbus commented, "[I] have bilingual staff. I do [and] have done a little sensitivity training with them in trying to make sure that they understand that when these people [call] don't roll your eyes and take the time and listen to them."

It is noteworthy that most of these physicians appear proud of having taken the step to hire bilingual staff. To them, it shows how seriously they take this issue and their willingness to make an investment in better communications with NEP/LEP patients. However, many seem to stop at this step and may not be looking for other ways to enhance communication. In other words, with this investment in staff, many physicians appear to feel they have gone a long way in improving communications with NEP/LEP patients.

Another issue emerging from the groups is that these physicians acknowledge that one or two bilingual staff members can sometimes be too few to accommodate the patient demand. Indeed, since these staff members usually only speak one other language – Spanish – they are not helpful with patients who speak other languages. Some reveal that at times, their bilingual staff member can be spread too thin – dealing with many NEP/LEP patients at one time. Also, based on physician comments, many of these bilingual staff members are not medically trained nor are most professional medical interpreters, which means that may not be qualified to serve as interpreters for NEP/LEP patients.

## ❖ **Professional Medical Interpreters**

Few physicians in this study say they have experience using professional medical interpreters. The exception is that some physicians have used professional interpreters in a hospital and emergency room setting, where the interpreter was on site or easily accessible. In these circumstances,

physicians say the interpreter is provided by the hospital and at no cost to themselves.

*"We're assuming they [professional medical interpreters] are competent."*

*-Columbus Physician*

However, in terms of their private practices, most physicians in this study report that they know little about professional interpreters (such as where to find these services, their training and credentials, and how much they cost). "I would have no way of knowing [their credentials]," commented a Columbus physician. Despite their lack of experience using professional interpreters, most physicians in this study resist taking this step. Most cite cost as the reason. As a PCP from Olympia said, "We can't afford [to provide an interpreter]. A solo practice can't afford it." Many others say it is inconvenient and too time consuming to use professional medical interpreters. And still others believe bringing in an outside interpreter (as opposed to a family member) can cause a disruption to the doctor-patient relationship.

It should be noted that a few physicians are confused about whether they are legally required to provide a professional interpreter for their NEP/LEP patients. While most seem to know that the Americans with Disabilities Act (ADA) requires them to provide sign language services to their deaf patients who need this kind of assistance, a few are confused about whether this pertains to NEP/LEP patients as well. "It's a law," asserted a physician from Columbus. Another specialist from that focus group added, "We have to pay for [interpreters or] they'll get hold of the ACLU and have you for discrimination."

What is clear from this study is that the majority of physicians resist the idea of mandating the use of professional interpretation services for NEP/LEP patients. They cite the extra costs they would absorb and the potential for litigation as just two of the reasons they oppose this idea. One PCP from Olympia expressed this fear when she said,

"So us using family members, using volunteers that are not certified and things like that, I bet you a few years down the road all that is going to be because the legal system will get a hold of that. If there is something that goes to court, that person can say 'Oh that's not what the interpreter told me.' And if you don't have a certified interpreter who has gone through training or whatever, then basically you don't have a leg to stand on."

It is worth mentioning that requiring the use of professional interpreter services may be a lightning rod issue for physicians when it comes to the topic of communication with NEP/LEP patients. For all the reasons they cite in the groups – cost, inconvenience, fear of legal mandates – they express strong opposition to taking this step.

### ❖ **Language Lines (Interpreters By Phone)**

A few physicians have experience using “language lines” in a hospital and emergency room setting to access a professional interpreter by phone. A PCP from Falls Church explains how it works: “It’s a phone that has two pieces. You dial. You ask for an interpreter and...the patient has one [phone]...and you have the other phone.” Once again, the reason these physicians say they used this service is that it was provided by the hospital free of charge to them. They explain that this method can be helpful when a NEP/LEP patient is in the emergency room, needing a medical procedure, and there is no family present. However, one or two physicians say that language lines are inconvenient and delay care. As one PCP from Falls Church commented, “It takes time. I mean it makes the visit very slow.” The reasons they give for not using this service in their private practices mirror those given for professional interpretation services – cost, inconvenience, and delay.

### ❖ **Language Training**

Only two physicians in this study say they have taken language training to improve their ability to communicate with their NEP/LEP patients. These physicians seem exceptional among the focus group participants in the degree of their commitment to serving NEP/LEP patients (i.e., other comments made by these physicians reveal a high interest in serving NEP/LEP patients that goes beyond the norm for the group). In both cases, these physicians were studying Spanish. In one case, the physician was studying medical interpretation while the other was taking a general language course.

Most of the other physicians do not see language training as a realistic option for themselves. Beyond time constraints and already busy lives – as well as a lack of motivation – they raise other obstacles. For example, some feel their practices are so diverse it would be hard just to choose one language to study. “We have so many varied languages, I don’t know what language would help our practice significantly,” said a physician from Columbus. Other physicians point out that learning another language is a multi-year commitment. According to this PCP from Olympia, “It’s not something you can just go through with a year of Spanish at the college and you’re going to be able to translate. So it’s not very practical.”

Finally, it should be noted that throughout this discussion physicians assert they are doing a lot already to serve their NEP/LEP patients. Most say they spend extra time with these patients, use a variety of communication techniques, and welcome family members and friends to act as interpreters. A substantial number also say

they use written materials in various languages and have hired bilingual staff to address to ease language barriers. They have taken these steps on their own, using their own time and money (in some cases), and many seem to want credit for taking these steps.

Most would disagree with the notion that physicians are not meeting the needs of their NEP/LEP patients. They think the steps they are taking are the norm (if not beyond the norm) among their peers and, for the most part, they feel they work fairly well. It should be noted, however, that most of these physicians may not be aware of any norms when it comes to communication with NEP/LEP patients. The majority acknowledges that this topic is not ever discussed among their peers, nor has it been addressed by their various medical and professional associations. “As a priority, it’s pretty low,” acknowledged a PCP from Olympia.

Most say they have not received any information on this topic from any outside organizations, nor are they investigating this topic on their own. Remarkably – and despite increasing ethnic, racial, and linguistic diversity in their own communities and across the country – serving NEP/LEP patients has not been a topic of discussion among the physicians in this study. And, according to many comments in these discussions, most do not think this topic is as pressing as many others facing the medical community. This is in sharp contrast to their near unanimous value of the importance of clear communication as the top priority with their patients.

### III. Family and Friends

The primary method of communicating with NEP/LEP patients, according to focus group participants, is using family and friends as interpreters. Since this approach is so widely used, it deserves a closer look. As mentioned, most physicians seem satisfied with this approach to dealing with communication barriers but some also see flaws and report problems. This section explores physicians' perceptions and experiences using family members and friends as interpreters.

**Most physicians feel there is no alternative other than relying on family and friends. They also feel their peers use this method too.**

Comments made in the focus groups show that using a family member or friend of a NEP/LEP patient to interpret is often the easiest way to deal with a language barrier. In many cases, the patient brings these individuals deliberately with them to the appointment so that they can interpret for them. For their part, many physicians feel they have no alternative but to use these family members and friends. "I think it's okay. I think we don't have any [other] choice," commented a PCP from Falls Church. Furthermore, many physicians in the focus groups believe this is the norm among their peers. As a Falls Church PCP said, "I think...a lot of them are still used to seeing doctors that can't communicate with them, that they are used to having their family members already there."

**Many feel their NEP/LEP patients prefer a family member or friend over a stranger.**

Some physicians believe having a familiar person interpret is preferable than having a stranger – even if this "stranger" is a trained medical interpreter. "[T]o have a stranger [professional interpreter] in there listening in can be difficult," acknowledged a PCP from Olympia. Since the NEP/LEP patient often is the one who brings the family member or friend to act as interpreter, physicians assume this is the choice of patient. Indeed, many physicians feel patients are very comfortable with this arrangement. "I have not seen any privacy issues with ethnic people...This is my friend. This is my aunt. It doesn't seem to be a big issue with ethnic people," explained a Falls Church specialist.

Indeed, some physicians believe a family member or friend can be more effective interpreter than a professional interpreter. Since they know the patient, some physicians believe they can emphasize or underscore points the physician is making. As a PCP from Olympia said, "[I]f it is an adult child who speaks English well, it is really an advantage. They can translate the language, but also culturally translate. Not just strict English, but they can make up something to get their parent to do what they are supposed to do, to scare them a little bit." While

some physicians might be uncomfortable with family members or friends improvising or supplementing the physicians' information, some clearly are not and think it may be an effective way to convey information to the patient.

**Despite the appeal of this approach, many physicians can tell stories in which vital information did not get conveyed to the patient or the doctor.**

*"I don't know if they are necessarily interpreting exactly what I'm saying. Sometimes they laugh and I didn't say anything that was funny at that time."*

*Falls Church  
Specialist*

Many physicians can give examples of family members or friends holding back or adding information to the exchange between doctor and patient that has led to miscommunication. A few physicians told about family members who added their own opinions or even scolded the patient – all the while making it seem like this information was coming straight from the doctor. Other times, the family member or friend will edit what the patient says, only relaying what they feel is important for the physician to know. “[Many] times the father will edit 90% of what the mother said,” explained a PCP from Falls Church. There are also a number of stories in which the physician gave instructions to a family member or friend but this individual did not relay the information to the patient. “And you give the patient advice and they say, ‘Oh, yeah, yeah, yeah’ but they [the family member] doesn’t tell the patient,” said a PCP from Falls Church

Some physicians believe culture plays a role in how the family member or friend interacts with the patient. A specialist from Atlanta made this point when she said,

“Sometimes it is difficult. Especially with the Asian[s]. I find among Asians that many times they try to soften the blow. Of course I am dealing with cancer. Grandpa doesn't need to know that he has terminal lung cancer doctor. So no matter what I say – I will speak for how many minutes and they say, ‘blah, blah, blah’ and it was like ‘Okay, I am sure that is exactly what I said.’ I can’t say they always get what I need to say.”

Gender also plays a role and is, of course, associated with cultural norms. Specifically, in some of the cultures that these physicians encounter, men tend to be the decision-makers for the entire family, particularly their wives. Some physicians tell stories of a husband interpreting for a NEP/LEP wife, and the husband withholding information he does not think the wife needs to know (although the physician wants the wife to know this information). This can be frustrating to physicians who have encountered this but they do not know how get around this challenge.

**Physicians believe a lack of medical interpreting skill among family members and friends is the main reason for miscommunication.**

Much of the miscommunication that occurs when a family member or friend acts as interpreter is not deliberate, according to these physicians. Rather, it is due to

the lack of skill of the family interpreter (who is not professionally trained or certified). They cite medical jargon or complicated medical conditions that family members and friends do not know how to interpret. But even when physicians try to simplify the information they are trying to impart, it is not uncommon that the information still goes astray. One PCP from Olympia explained,

“[W]hen I ask the question in English, the answer I get back through the [family] translator is often very different or not what I asked them. I mean I'll get back an answer that you know is just not what I'm really asking them, and then you try to ask it a different way and then you get a different kind of answer that is not really what you're asking and I don't know what that is. What happens in that translation that you don't end up getting – it's hard for me to get, in a lot of cases, really specific information. I don't know if that is a cultural thing, or if it is a translation thing.”

To avoid miscommunication, one physician told how he has a bi-lingual staff member in the room during the appointment – even if the family member or friend is acting as the interpreter – just to make sure there is an accurate flow of information back and forth. This specialist from Atlanta explained,

“Even if the person that is not English speaking has someone with them to translate I still bring my medical assistant or the person in with me so I am certain that the patient is receiving the information as accurately as my assistant knows that I want to give them and in as much detail...Because of the jargon barriers, she makes sure that in case I slip and say something that is not obvious – that would be more of a subtlety of medical information that – she translates it in sort of common language.”

### **Personal and private information can also emerge during a medical appointment, embarrassing the NEP/LEP patient if a family member or friend is interpreting.**

This is particularly a challenge when a child is acting as the interpreter (which is often the case, according to physicians). “Sometimes they are very uncomfortable,” acknowledged a PCP from Falls Church. Another PCP from that same group made the following point, “Sometimes there is a downside because sometimes patients may prefer that their other family members not know what information they are getting from the doctor, but if they don't speak the language they don't have a choice...[For example,] the mother might not want the son or daughter to know what the gynecological problem is.”

To avoid putting the NEP/LEP patient in an awkward situation, a few physicians say they warn the patient upfront that they may discuss personal or potentially embarrassing issues. In this way, they feel they are giving the patient some choice in terms of who else is in the room during this discussion. “I always make them aware... I make sure it is okay if the person is in there. ‘Are you aware that we're

going to discuss some private issues? Do you have any problems with that?”  
explained a Falls Church specialist.

### **Although they frequently use them as interpreters, many say that children may not be the best choice for this role.**

*"I just this week had an eight year old kid speaking [for] his uncle. It was a horrible choice of translators for him."*

*-Atlanta Specialist*

One reason that children often act as interpreters is that they usually are the only ones in the family with English proficiency, according to physicians in the focus groups. However, this can cause problems. Some physicians point out that children often lack the understanding and the vocabulary to accurately interpret medical conditions. “Younger children may not really understand the concept that you are trying to get across,” explained an Atlanta specialist. A PCP from Olympia made a similar point when he said, “Children just don’t have the language.”

Children may not also be able to cope with the kind of information that physicians sometimes must give to their parents. “What really gets you too is if there is a child interpreting for the parent, I've seen the look of fear on the child's face that their parent is vulnerable,” said a specialist from Falls Church.

Even though these physicians say they prefer not to use younger children (i.e., under age 13) as interpreters – they can give many reasons why this is an inappropriate choice – most appear to use them anyway if this is the only family member accompanying the NEP/LEP patient to the appointment.

### **Some physicians acknowledge that they hold back information from NEP/LEP patients to spare them from embarrassment.**

Physicians say this often happens when taking the medical history of the patient in order to make a diagnosis. This is particularly the case when a young child is acting as the interpreter. A specialist from Falls Church explained, “There are certain things that they don't want the family to know, and so when it comes to that I try to hold back and not say anything. Like, for example, the more personal things between a husband and wife. But that's a down side. You cannot get into things that they should know.” A PCP from Falls Church made a similar comment when he said, “[I]f you have to talk about sex... sometimes we don’t talk about it [in front of the daughter]. [I] just [avoid] those kind of questions... Sometimes it’s just a young kid and we know that it won’t be the proper thing to do [so we don’t ask mom those questions].”

As these and other physicians in this study point out, holding back information from patients is not an ideal situation. Indeed, many feel the patient would want to know this information but feel they cannot engage in particular topics if a child or other family member is acting as the interpreter. The upshot is that many NEP/LEP patients may not be receiving important health information.

## IV. Barriers to Doing More

In the focus groups, physicians identify many barriers to implementing various strategies for improving communication with NEP/LEP patients. There is a strong resistance among many of these physicians – particularly among the specialists – to doing more than they are already doing. Indeed, many already feel that they already go the extra mile for their NEP/LEP patients – e.g., spending more time with them during appointments, explaining information carefully, hiring bi-lingual staff, etc. Some express fear that they will be mandated to take specific steps to accommodate NEP/LEP patients – such as provide professional interpretation services if requested – and many say they would oppose such mandates.

Some of the barriers that keep physicians from taking additional steps have already been briefly mentioned in prior sections of this report – cost, inconvenience, delays during appointments, etc. However, this section explores these barriers in more depth and seeks to shed light on physicians’ perspectives on these issues. Those barriers that are perceived to be most significant are listed first.

### ❖ Lack of Time

*"There is a time issue. If you call the language line, it makes the visit longer."*

*-Falls Church PCP*

Many physicians in this study resist new ideas on this topic because they believe they will take too much time to implement. They say they already face tremendous pressure to see as many patients as possible in a day. In some cases, the health plans they work for require this of them – in other cases, they say they need to see so many patients in order to make a profit. As one PCP from Falls Church said, “I don't know about the rest of the specialties but in our specialty the only way we can survive is by seeing volume and volume and volume.”

Many physicians point out that “time is money” and that the fewer patients they see, the less income they will earn. A physician from Columbus made this point when he said, “In primary care, a lot of people come to you because they want quick service, same day appointments, but they are going to leave you if they've got to wait an hour every time they walk in your office. I used to suture people and I stopped doing that because I realized I am making one person happy and I'm pissing off 30 behind them.”

In this light, spending more time with NEP/LEP patients is something some physicians already find frustrating. As previously mentioned, many say that they have to spend extra time with NEP/LEP patients trying to overcome language barriers. They say they must speak slower, repeat instructions, communicate through family members or friends, write down instructions, and take many other extra steps already just to ensure they are understood. For this reason, many do not seem open to new ideas to

enhance communication because they assume these steps will take more time away from their practice. For example, one of the main reasons physicians give for not using professional interpreters is that it takes too much time both in terms of scheduling and in the overall length of the appointment. However, only a few physicians have actual experience using professional interpreters so may not be able to assess whether using them adds time or not to appointments. As a PCP from Olympia said, “The other thing is the time constraint. You know the translator to the person to the translator and back and the time constraint minimizes the amount of information you can give back and forth.”

### ❖ Cost

Cost emerged as another significant barrier to physicians taking new or additional steps to improve communication with NEP/LEP patients. This is particularly the case with professional interpretation services. As an Atlanta specialist commented, “It was totally, economically not feasible. As a rule, we don’t do that [provide a translator]. We tell them to bring someone.” As already mentioned, physicians believe using a professional interpreter or language line adds to the length of the appointment, which costs them money.

*“I think it’s pretty clear though that any of those alternatives [language lines and professional interpreters] require substantial financial obligation on the part of the physician.”*

*-Falls Church Specialist*

But another issue is that physicians have to pay out of pocket when they use professional interpreters in their private practice because they are not usually covered by insurance. It is no coincidence that those physicians with actual experience using these services tend to use them in a hospital setting, where they are readily available and paid for by the hospital. This study suggests that having to pay out of pocket for these services is a major barrier to more physicians using professional interpreters. “I charged this [NEP/LEP patient] \$100 and I get paid \$50 and I’ve got to pay the interpreter \$100, so you lose \$50 seeing him. So it’s a financial hardship for a lot of offices,” explained a Columbus physician. A PCP from Olympia said, “We can’t afford [to provide an interpreter]. A solo practice can’t afford it.”

Many physicians assert that paying for professional interpretation should be the responsibility of the patient or insurance plan. “Well, I don’t think it’s fair. I don’t think it’s right. I think that [if] they do have insurance; I think the insurance ought to bear that burden,” said a Columbus physician.

## ❖ Lack of Motivation

*"I don't think communication is that much of a problem."*

*-Atlanta Specialist*

Another insight from the focus groups is that many physicians may feel they are already sufficiently addressing the needs of their NEP/LEP patients without needing to do more. On their own, they do not see compelling reasons to take additional or new steps to improve communication. In particular, they seem to feel that relying on NEP/LEP patients to bring family and friends to act as interpreters works fairly well. Despite some bad experiences in the past with miscommunication, most still seem content to using family and friends indefinitely.

This lack of motivation may mean that some physicians are unaware of disparities in care between different ethnic and racial groups and the role that language can play in this issue. They may lack specific information about the problems that can stem from using untrained individuals – particularly family members and friends, but even bi-lingual staff – as interpreters. Even if aware of this data, they may still not believe their own patients are experiencing poorer quality care or facing access problems as a result of communication barriers.

In fact, when asked about specific challenges facing NEP/LEP patients – such as calling the doctor's office to schedule an appointment – most physicians in the groups do not consider these to be significant problems. For example, many believe that NEP/LEP patients usually have English-speaking family members or friends who can call on their behalf to schedule appointments – or that their bi-lingual staff can handle these calls and schedule the appointments. They seem unaware of complaints or problems stemming from something as simple (yet not so simply for NEP/LEP patients) as making an appointment.

## ❖ Not My Responsibility

*"If you want to be really selfish about it, there was a time when people came to this country and learned English."*

*-Atlanta Specialist*

A theme running through the focus groups is the issue of responsibility. Whose responsibility is it to address communication barriers? Some physicians question whether they should bear the whole burden of hiring professional interpreters and paying for other communication services for their NEP/LEP patients. Most physicians in the groups feel they should make efforts to communicate with their NEP/LEP patients and they point out that they already do this – everything from spending extra time with these patients to hiring bi-lingual staff. But it seems that taking other kinds of steps – such as paying for a professional interpreter – may go beyond what many physicians feel is fair. Some believe that insurance companies should reimburse them for these services.

A few also feel that patients should be shouldering more of this communication burden. As a specialist in Atlanta said, “It’s not my job to learn Cambodian, Laotian, Vietnamese, it’s their job to learn rudimentary English.” Another specialist from Atlanta made this comment, “[P]atients have taken a step back in their own responsibility. Patients don’t take enough onus of their medical care on themselves. The medical system is supposed to do all of it for them.”

#### ❖ **Limited Awareness**

As mentioned, many physicians reveal that communicating with NEP/LEP patients is not a topic of discussion among peers or their medical associations. “I don’t know that we talk about it very much among ourselves,” commented a PCP from Olympia. Furthermore, most physicians do not know of any new ideas, models, or strategies for overcoming communication barriers. Most say they do not know where to find professional interpreters, about their credentials and training, or how much they cost. They are unaware of any sources of information on this topic and most physicians are not currently seeking to learn more about it. The result is that there may be gaps in their knowledge of the field beyond their own experiences with NEP/LEP patients.

These barriers, most of which exist simultaneously, may mean that physicians will be hard to reach with messages about improving communication with NEP/LEP patients. The challenge is that they may lack compelling reasons to change the way they currently interact with these patients, and most feel the way they currently do things is just fine.

## V. Motivating Factors

While there are substantial barriers to physicians taking new and additional steps to improve communication with NEP/LEP patients, there may also be opportunities for engaging them on this topic. Many physicians in this study reveal they have gaps in their knowledge about this issue and about ways to improve communication. A number may also have misperceptions about the costs and time involved with implementing various communication strategies – most assume these steps cost too much money and will take too long to implement. And, most physicians strongly assert that clear communication with all of their patients, regardless of culture or language, is a priority.

Given these issues, a number of factors emerge in the focus groups that may or may not be potential hooks for engaging physicians in this topic. Each is explored below.

### ❖ Consequences of Poor Communication

*"You don't diagnose them correctly because they don't understand [what you are asking them]."*

*-Falls Church PCP*

Many of these physicians express concern that their NEP/LEP patients do not always understand them – or that they miss vital information provided by the patient. “You are worried that you are missing something. You are not getting the whole story out,” explained a specialist from Falls Church. In every focus group physicians could tell stories of near misses, patients who did not take the right medication, and patients who delayed medical care when they had an urgent need all due to poor communication. Some of the stories heard in the focus groups can be found on the following page.

In addition to these incidents that physicians know about, they assume there are many more close calls that they never hear about. As an Olympia PCP said, “I’m sure there are things that have happened that we’ve never heard about.” This knowledge worries most of the physicians in this study because they care about their patients and feel a commitment to healing them. Reminding physicians of the kinds of problems that can occur when there is not clear understanding between doctor and patient could compel them to investigate ways to avoid future miscommunications.

## Physician Stories of Miscommunication

“I’m seeing a little baby for a long time, maybe six months and the baby was usually not sick. The baby came in with a runny nose and cough and so I give them medicine. I told the mom to buy the nose drops and put it in the nose and [then to] suction [the nose]. The next time after one [week], the mom came back and said that the runny nose is not getting better, so I found out that she was putting cough drops in the baby’s nose [not nose drops].”

*-Falls Church PCP*

“I got in trouble a couple years ago with an Asian family whose little boy came in for gastroenteritis and I said, ‘Okay, call me tomorrow and let me know how he is doing.’ She called in the morning and just said he is better and [that] he can eat now but he has pain in his leg. Okay. I say, ‘What do you want to do?’ I now tell her we can see her this afternoon. [She says] ‘No, pain in leg is very bad.’ I said, ‘Go to urgent care. I can’t get you in this morning because I was the only doctor in the practice at that time.’ So she said, ‘No, no, I’ll wait. I come in later.’ So she hangs up and the husband calls back two hours later. [He says], ‘Child very, very sick. Pain in leg is much worse, much worse.’ Well, [we] tell him to come in. He came in. He had a ruptured appendix and the mom said, ‘The doctor tell me not to call until tomorrow.’ What! There is no way in blazes we would have said, ‘Don’t call me until tomorrow, period.’ Here is this child with a ruptured appendix. This kid is as stiff as a board coming in and I’m thinking, ‘Oh my golly.’ Now I’m medically, legally [responsible] if they come in but she had no idea what my staff was saying to her. [They were saying], ‘Okay, you can go to the emergency room or you can come in this afternoon.’ So, over the phone it was difficult [for her to understand], and she was one of those moms who I thought understood me and understood English pretty well. We had a pretty good relationship.”

*-Columbus Physician*

“I went in to [the hospital] to see a newborn and this was an Indian family, and the mom was the only one there and they are notorious for being very agreeable about everything and not understanding anything you say. And it was a boy and part of the Indian culture [does not] circumcise and so I said, ‘Are you interested in having your baby circumcised and she said, ‘Oh yes, yes, doctor.’ I said, ‘Do you know what circumcision is?’ She said, ‘Yes, yes doctor, I do.’ I said okay, and so I go about explaining the procedure to her and I have the consent form and I’m talking to her. Fortunately the father comes in the room and I said, ‘Oh, we were just talking about the circumcision,’ and he goes, ‘We don’t circumcise!’ And so she had just been totally agreeable with whatever I said. She had no idea what I was talking about but the whole time she gave like appropriate responses to my inquiry.”

*-Columbus Physician*

“The one incident that we had with medication was where we weren’t sure the patient was taking what they should. It was thyroid and she was pregnant and she was on one dose of medication. We did the blood test. She needed more and so we had her double it up and then she was going to need a refill and so we told them we’ll refill it in the higher dose so she only needs to take one [but instead she took two of the larger dose]. And we thought we had explained it adequately but she came in. Luckily, she came in not very long after that and so we went over it again and made sure what was going on.”

*-Olympia PCP*

## ❖ Medical Errors and Malpractice

Medical errors and malpractice are big concerns and a few physicians are making the link between these concerns and their NEP/LEP patients. “[The] most common cause of a malpractice suit is [a] communication breakdown,” said a physician from Columbus. An Olympia PCP commented, “It’s a serious problem every day in our lives and it could put any of us in big time hot water any time. We live with that potential liability any time.” From this perspective, reducing communication barriers with NEP/LEP patients can reduce the risk of medical errors and malpractice lawsuits.

However, the majority of physicians do not seem to be making this link. “I’m not worried about liability issues. I’m worried that the patient is not getting the care they need. So when it’s shaky on what they’re saying, I’m not thinking liability. That’s not in my mind at that moment,” explained a Falls Church PCP. An Atlanta specialist made a similar point when he said, “I am not worried about medical legality as much as just communication and the patient perceiving the level of instructions and following instructions and getting the best result. Just pure communication.”

A number of physicians also assert that their NEP/LEP patients are least likely than other patients to sue them or cause legal problems. “[NEP/LEP patients] are grateful. They are very easy to take. They never have in mind to threaten you with malpractice or any problem. They are very loyal. It’s a nice population to treat,” said a PCP from Falls Church. An Atlanta specialist echoed this opinion, “I have always gotten the feeling that the people who can’t communicate well with me are actually very appreciative of what we do for them and the extra efforts that they can tell we are making for them.” A physician from Columbus made a specific comment about his NEP/LEP Hispanic patients, “[T]he Hispanics, they are so weary of dealing with the government system. They would be highly unlikely to create a lawsuit.”

The result is that most physicians tend not to worry about the increased risk of medical errors or malpractice lawsuits with their NEP/LEP patients despite the many communication challenges they face. In fact, many perceive these patients to be less likely to cause legal problems than other patients. Given this, it is unclear if making more direct links to medical errors and malpractice in regard to NEP/LEP patients would be effective. Indeed, mentioning malpractice in a message tested in the focus group resulted in a lower score for that message (see later sections of this report). It seems that more physicians find simple arguments about the need for clear communication to be more compelling.

## ❖ Standard of Care

Many physicians in the focus groups initially resist the idea of establishing standards of care around communication with NEP/LEP patients. This idea, raised by the focus group moderator, was proposed to see if physicians support the notion of setting standards in terms of the kind of efforts physicians should take to ensure their patients have access to clear communications with their doctors. The main source of physicians' opposition, based on their comments, is that they dislike mandates and fear they could be held accountable if they fail to meet these standards. "I don't want it to become expected," explained an Atlanta specialist. Another specialist from that same group is concerned that legal action could ensue if physicians were deemed not to be trying hard enough to respond to the communication needs of NEP/LEP patients. "I am not saying I don't mind having it, I just don't want to be all of a sudden to be interpreted by an attorney who says this is a standard of care when it may not necessarily be a standard of care."

Yet many of the physicians appear to find the concept behind this notion to be appealing. In other words, most support the idea that physicians should make as much effort as possible to accommodate the communication needs of their NEP/LEP patients. "I think that we were, without using that terminology, saying that the standard of care is to provide appropriate communication and a level of care of treatment and diagnosis or whatever it is, regardless of language barriers and we as a group are doing whatever needs to be done to get that done," said a physician from Columbus. Another physician from that same focus group made the following comment:

"When you talk about standard of care, it still comes down to if I make a missed diagnosis because I didn't take an adequate history and I do something wrong, I am responsible for the information I took in and the decision I made. That is, if I didn't feel that I had adequate information, it was my job to somehow obtain additional information whether that was to have them bring a family member in or for me to hire an interpreter or whatever, order some test that would give me the answer. It ultimately falls onto my shoulders to get the right answer and do the right treatment."

Others point out that there are already established standards of care that pertain to providing information and taking steps to ensure clear communication with patients. What they are referring to is informed consent. A specialist from Falls Church explained, "If you are going to perform a surgery on a patient, you must explain to them the possible risks and complications. And if there is a language barrier, you may worry that the patient doesn't understand what the possible risks are, and not just in

terms of protecting yourself from a possible medical liability lawsuit, but you want the patient to understand what is going on.” In this regard, many physicians are already required to take measures to communicate clearly with NEP/LEP patients and, in this context, the notion of standards of care is not new.

However, it is the sense of being required or obliged to take additional steps to assist NEP/LEP patients that many physicians resist. As an Atlanta specialist said,

“I feel some obligation almost personally to assist them. If it means making sure that someone in my office can interpret for them and making sure we call back and talk to them, [fine]. Occasionally a patient comes without any family member who does not speak English and I don’t have an interpreter. Having a pamphlet from a drug store is a nice resource to have for them. I agree. [But] I don’t want to be obliged to have to go out and seek those resources.”

Also, some physicians raise the issue of reimbursement. They feel that if standards of care are set regarding communication with NEP/LEP patients, physicians should be reimbursed for these services. As a physician from Columbus said, “I think if it is going to become standard for us to provide interpreting services... we need to get reimbursed for something like that.”

Ultimately, it is physicians’ negative feelings about mandates that prompt most physicians to oppose setting standards of care around communication with NEP/LEP patients. There is a deep resentment among those in the focus groups of the many requirements already imposed on their practices. However, the concept behind this discussion – that physicians should be making as much effort as possible to address communication barriers faced by their NEP/LEP patients – does have broad support.

## VI. More Than Just Language

Throughout this report the focus has been on *communication* barriers with NEP/LEP patients – specifically, language barriers – but the scope of the discussion with physicians encompassed other aspects of communication too, including cultural barriers. Indeed, on their own, physicians seek to expand the conversation beyond language to include all the other kinds of challenges that come with treating patients from different cultures. And, as many physicians point out, communication is affected by the culture of both the doctor and the patients and so is an important factor in their interactions with patients. Following are some of the broader kinds of challenges, including cultural barriers, that physicians raise about treating NEP/LEP patients.

### **Cultural background, traditions, and gender roles affect communication between physicians and NEP/LEP patients.**

Most physicians realize that culture plays an important role in their relationship with NEP/LEP patients, although they believe some of their peers are not sensitive enough to these issues. “I think for me it is not just language issues, but culture issues, and I think that in the office that I’m currently in, I don’t think there is sensitivity to cultural issues in terms of what people are comfortable with and not comfortable with,” said a PCP from Falls Church.

*“I just feel like I fight a battle all of the time about the myths. Communication is very important.”*

*-Atlanta Specialist*

Physicians in this study share many stories of cultural challenges they have faced when treating NEP/LEP patients. For example, a Columbus physician told the following story about his Somalian patients:

“It’s not only language but the culture of the Somalian. The women will not speak to me. Say their husband is ill and the husband has made all the decisions for them. The father did and their husband now makes all the decisions, and their only family is that husband. I come into the room to see the patient. He really can’t speak for himself. The wife literally goes and stands behind the pillar of monitors as I enter the room, and it took me a little while to figure out. I said, ‘What’s going [on]?’ the first few times it happened but this is a consistent occurrence until we tracked down another family member. So I had no one to communicate with about this patient when the patient couldn’t speak for themselves. Even the wife was there and her English probably wasn’t good anyway and whether I had an interpreter or not, she would not participate in any decisionmaking. It wasn’t just language but it was cultural as well.”

The kind of challenges the Columbus physician above described seem common among physicians of NEP/LEP patients. They tell stories of women from other cultures deferring to them when in fact they – as the physician later learned from a male family member – did want a particular procedure done. Others say they must push beyond the usual affirmative responses of some cultures – their desire to be agreeable to the physician and others in authority – to find out their real

opinions behind the “yes, yes” responses. Some tell of the challenges of uncovering the face of Muslim women so they can treat them. Others say their Hispanic patients are not assertive enough and tend not to ask questions or raise concerns during appointments.

In most cases, these physicians say that in situations where there is a cultural gap they must think and act creatively to obtain the information they need to successfully treat the patient.

### **Some say that discussions about medications can be particularly challenging with patients from other cultures.**

Some physicians say that culture plays a large role in their discussions with NEP/LEP patients regarding medications. A number of physicians say they must sort out the various herbs and home remedies that some of their NEP/LEP patients are taking. “The other difficulty in my field is what people are intaking, in terms of medicines, herbs, supplements. In different cultures people take different things. It's hard to understand what it is that they are really taking. It is hard, also, to get them to understand that I want to know everything they are taking, not just the prescription drugs,” explained a specialist from Atlanta. Another specialist from that same group added, “In their own cultures they can get medicines that are called different things, that's hard, too. I can't figure out what it is.”

In some cases, they say their patients are reluctant to reveal the herbs and home remedies they are taking for fear the physicians will forbid them. The challenge is, according to physicians, that they need to know how the patient is already treating themselves before they can prescribe a particular medication or treatment option.

### **Many physicians feel literacy and education levels are also important factors to consider when treating NEP/LEP patients.**

Some physicians believe that not enough attention is paid to the education level of NEP/LEP patients. They believe this makes a difference in how they interact with these patients. For example, some physicians discussed the ease in treating well-educated, professional Japanese patients who work at a local company. They assert that limited or no English-proficiency does not really get in the way since there are other ways to communicate. For example, written materials can be used when there is a language barrier. Also, their company often provides a professional interpreter or pays for language lines to overcome language barriers. The physicians who treat these patients say there is no real barrier, and that they encounter no problems treating these patients since they have many ways to communicate with them.

*“It is not only the language, it is speaking at a level that person understands.”*

*-Atlanta Specialist*

In contrast, most of the other physicians in this study say they treat patients with lower educational attainment and from lower-socioeconomic backgrounds. They say literacy is a problem for many of these patients. They explain that they must

simplify the terms they use and how they explain complicated medical conditions. As a Falls Church PCP said, “[It’s] not a language issue. It’s what is their level of education? Can they write? Can they read? Are they understanding the terms you are using, or it may be a language barrier but I would say that definitely takes more time if you have to either explain it in different terms or explain it several times in different ways because there is a problem in terms of literacy, or because you are using an interpreter or a translator. I think it makes the visit longer.” A specialist from Falls Church commented, “The level of education of the patients differ. Patients who have not gone to school at all...they will not understand.” And an Atlanta specialist said, “You are talking to a fourth or sixth grade level to most people. Therefore when it is then communicated into a second language it makes it more difficult.”

**Others point out that the health communication is a challenge regardless of language. Medical terminology is confusing, and it takes effort to identify what is going on with each and every patient.**

Many physicians in this study say that communication is always a challenge in their profession regardless of language. They give many examples of communication barriers with English speaking patients. They say it is the nature of their profession that it can be a struggle getting to the bottom of what is going on with their patients. An Atlanta specialist explained:

“If I say, ‘Do you drink alcohol?’ Immediately, ‘Oh no.’ But the patient smells like beer, but to them beer is not alcohol, beer is beer. Then there is alcohol. It depends on what word you use. If you ask about chest pain, they may not have chest pain, but it may be pressure. So it depends on what word you use that you may get a yes or no answer to. So a lot of times [I have them] describe what [they] are feeling instead of asking questions about pain or whatever. That is true when communicating with English speaking patients, now if you do that in a situation that’s unexpected and very tense or whatever, usually you are going to end up getting some misperceptions of what the care is or what the expectations from the prognosis is. I can figure it out pretty easily. I say, ‘Do you understand what I am telling you?’ ‘No.’ And we have just spent 15 minutes going step by step.”

An Olympia PCP concurs and made this comment, “I believe a lot is missed because even with our English speaking patients who only speak English, grew up speaking English, they are often misunderstanding just from the use of medical terminology, thinking they understand and they don’t ask questions because they’re afraid to ask. So there is a significant amount of miscommunication or misunderstanding just when there is no language barrier at all other than the professional language versus the lay language.”

To many physicians in this study, the challenges of treating NEP/LEP patients do not seem so unique after all. Clear communication with all patients is always the

goal, say the physicians, but usually it is a struggle regardless of the specific language they face. In this context, some physicians resist making NEP/LEP patients a special case, or considering taking particular steps to address their individual needs. Most feel that the efforts they make with all their patients usually work with NEP/LEP patients as well, and many are not convinced that bringing in a professional medical interpreter, for example, will significantly improve the flow of communication between physicians and patient.

## VII. Messages

As part of this study, we tested messages developed to engage physicians in a conversation about improving communication with NEP/LEP patients. The barriers that physicians face to this topic – already detailed in this report – and their gaps in information had a direct effect on how they reacted to these messages. The results of the message testing can be found in the tables on the following pages.

As these tables show, most physicians rated the messages highly on a 1 to 10 scale (with ten being the most positive rating). They found elements of virtually all of the messages to be appealing. Recall that throughout the focus groups, the physicians stressed the importance of clear communication with their patients as a driving principle of their practices. Because of this, they respond positively to the focus on communication in each of the messages. However, there are other elements in messages they find problematic.

Specifically, direct references to “medical errors” and “lawsuits” in connection to NEP/LEP patients are not effective with many of these physicians. They explain that these terms are red flags and that physicians have a knee-jerk negative reaction to messages about these issues. Many physicians also find this language to be threatening – even though some admit that it is true – and feel that messages are more compelling without mentioning these potential outcomes of poor communication.

In addition, economic messages that emphasize the potential benefits of marketing to NEP/LEP communities are not compelling to some physicians. This reflects what physicians said earlier in the focus groups – only a handful seem to be purposely marketing their services to minority or immigrant communities.

Of note, there is a difference between which messages physicians find most “convincing” and most “motivating.” Message A, which they find most convincing, directly links clear communication with quality care – something physicians in this study strongly agree with. They give it such a high rating because they find it to be a believable statement and one that they personal support. However, this message may not motivate them to action. Rather, it is Message E that physicians find most motivating among the messages we tested. This may be due to the message’s emphasis on *tested methods* that are effective in addressing communication barriers. This is new information for most physicians and gives them the impression that there are communication ideas and services that they can use in their own practices that are cost-effective and efficient.

## Results of Message Testing

Message	"Convincing" Average Rating (1-10)	"Motivating" Average Rating (1-10)
<p><b>Message A:</b> Clear communications between a doctor and patient is essential to providing quality health care. This is especially true of patients who speak little English. When they understand what the doctor is telling them they can take better care of themselves, follow their doctor's advice and take their medications properly. With non-English speaking populations on the rise, striving for better communications with these patients protects their quality of care. To learn more about this and steps you can take today call (800) XXX-XXXX or visit us online at <a href="http://www.XYZ.org">www.XYZ.org</a>.</p>	<b>7.9</b>	<b>6.0</b>
<p><b>Message B:</b> Language barriers can lead to miscommunications with non-English speaking patients and have the potential to drive up health care costs from repeat visits, misdiagnosis, and unnecessary tests and procedures. For health care facilities looking to provide top-notch care, with an eye on the bottom line, effective language services can reduce costs. To learn more about this and steps you can take today call (800) XXX-XXXX or visit us online at <a href="http://www.XYZ.org">www.XYZ.org</a>.</p>	<b>7.5</b>	<b>6.2</b>
<p><b>Message E:</b> Overcoming language barriers to better serve patients can be a daunting prospect for health professionals and a burden to hard-working staff. Ever-changing federal regulations only add to the challenge. Tested methods exist that may prove effective at breaking down these communication barriers in a way that values staff time, and gets measurable results from a quality and cost-efficient perspective. Health care facilities can adopt these rather than start from scratch to create their own systems. To learn more about this and steps you can take today call (800) XXX-XXXX or visit us online at <a href="http://www.XYZ.org">www.XYZ.org</a>.</p>	<b>7.4</b>	<b>6.5</b>
<p><b>Message D:</b> Dramatic increases in this country's non-English speaking patient base create great opportunities for doctors to expand their practices. To fully realize the benefits of this changing marketplace, health professionals must first overcome new challenges -- such as increased language barriers -- that can compromise care, prevent access, and undermine patient confidence in their health care provider, if they are not properly addressed. To learn more about this and steps you can take today call (800) XXX-XXXX or visit us online at <a href="http://www.XYZ.org">www.XYZ.org</a></p>	<b>7.1</b>	<b>5.9</b>
<p><b>Message C:</b> Miscommunications with patients who speak little English can lead to increased medical errors including misdiagnosis and unnecessary tests and procedures. This raises serious liability issues. Providing effective language services decreases the chance for errors and the opportunities for lawsuits. To learn more about this and steps you can take today call (800) XXX-XXXX or visit us online at <a href="http://www.XYZ.org">www.XYZ.org</a>.</p>	<b>6.9</b>	<b>5.6</b>

### Summary Table of Message Testing

Most Convincing Message	Average (across groups)	Most Motivating	Average (across groups)
<b>Message A</b>	<b>7.9</b>	<b>Message E</b>	<b>6.5</b>
<b>Message B</b>	<b>7.5</b>	<b>Message B</b>	<b>6.2</b>
<b>Message E</b>	<b>7.4</b>	<b>Message A</b>	<b>6.0</b>
<b>Message D</b>	<b>7.1</b>	<b>Message D</b>	<b>5.9</b>
<b>Message C</b>	<b>6.9</b>	<b>Message C</b>	<b>5.6</b>

This finding is important to those seeking to motivate physicians to take steps to improve communication with NEP/LEP patients. Learning that there are tried and true methods to enhance communication with NEP/LEP patients that respect physicians' concerns about costs and time is potentially powerful to these focus group participants.

#### IMPLICATIONS

- MD's struggle with quality communication with all patients primarily due to differences in medical profession language and lay language, education level differences, culturally or educationally influenced word meaning and variable patient communication styles. LEP patients present just one more set of variables that mimic challenges faced as a daily occurrence with English speaking patients. Advances in patient-provider communication around literacy and cultural competency will help physician improve communications with limited English speaking populations. Research in literacy and cultural competency should play special attention to populations with limited English skills.
- MD's take care of patients one at a time and continuously balance financial self interest and medical ethics. Interactions with patients are individualized and resources within their reach are applied based on the perceived needs of each patient. In this regard LEP patients are no different than other patients. MD's will develop experience and strategies to deal with limited English speaking patients over time and with frequency of encounters. Sharing knowledge about new populations and how others are dealing with language barriers will help physicians adapt their practices more quickly and more effectively.
- In most areas the LEP population is small. Except for a select few, loss of this market has minimal financial implications for MDs practices. This may change as the Spanish-speaking population increases or as cultural factors such as brand loyalty become more evident to practitioners. The

economic advancement of subsequent generations will also contribute to increased desirability of this population and increase priority of adapting practices to language and cultural requirements.

- Creating a “special class” or mandating interpreters for LEP that result in increased costs for MDs may result in a negative reaction to accepting this population into private practices - a contrary incentive to improving communication and becoming better able to care for this population as patients.
- Solutions that are low cost and convenient are more likely to be used; for example the use of hospital trained interpreters available to private practices.
- Standards of care linked to feasibility and availability of tools to deal with language barriers are likely to be more effective – in other words as more tools and methods become available and physicians successfully incorporate these into their practices, standards of care will become the norm.