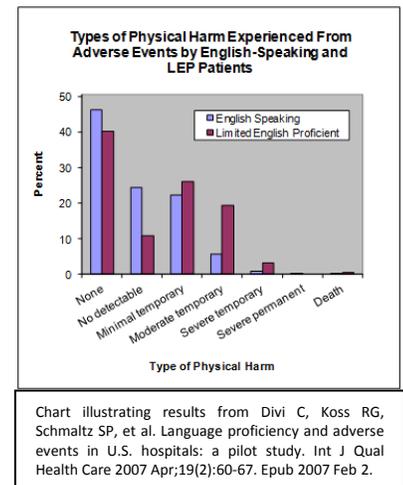


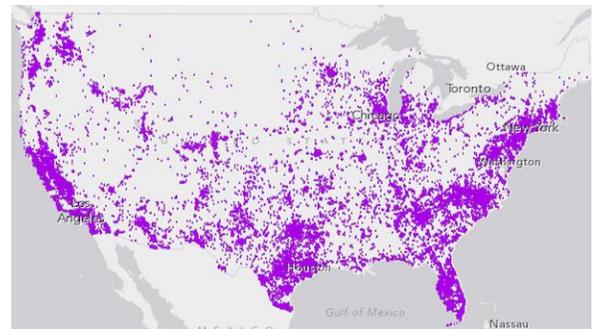
## Addressing Language and Culture Differences in Health Care Settings

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Health care encounters can be stressful, compromising a patient’s ability to fully engage and understand. This is particularly challenging for patients who are limited-English proficient (LEP) and not able to speak, read, write or understand English at levels appropriate for successful encounters in healthcare settings. This places them at greater risk for [communication challenges](#) than their [English-speaking counterparts](#). According to a [report](#) from the Agency for Healthcare Quality and Research (AHQR), “research suggests that adverse events affect patients with limited English proficiency (LEP) more frequently, are often caused by communication problems, and are more likely to result in serious harm compared to those that affect English-speaking patients.” The [table at right](#) shows disparate results in types of physical harm from adverse events among English-speaking and LEP patients.



It is imperative for health care practices to take steps to address linguistic and cultural barriers faced by the increasing numbers of LEP patients. Data from the 2011 American Community Survey show that 20% of U.S. residents—or 60 million people—do not speak English at home. Two-thirds of this multilingual and multicultural group consists of Spanish speakers. Hispanics also represent the group with the [lowest health literacy levels](#). For example, the map on the right illustrates the prevalence of Spanish speakers who speak Spanish at home and also say that they don’t speak English “very well.” Each dot represents about 10 people. Similar [linguistic maps](#) are available for other language groups—French Creole, Chinese, Japanese, Persian, Polish, and Arabic. Language barriers are accompanied by invisible cultural barriers that can further impede effective communication.



According to [Betancourt](#), the goal of cultural competence is “to improve the ability of health care providers and the health care system to effectively communicate and care for patients with diverse social and cultural backgrounds.” Most professionals working to address linguistic and cultural differences in health practices work under the umbrella of “cultural competence” as opposed to “health literacy.” Many, in fact, view cultural competence and health literacy as separate fields. However, some practitioners, such as [Shaw, et al.](#), approach the challenge with a more holistic view.

Cultural beliefs around health and illness, including but not limited to those shared by ethnic minorities or immigrants, contribute to an individual’s ability to understand and act on a doctor’s instructions in ways that are intimately connected with literacy levels. An understanding of health literacy that neglects the role of cultural beliefs about health and illness is limited in the range of populations it can describe. A patient’s ability to comprehend her physician’s instructions is shaped by cultural factors that extend beyond literacy and education. Important work remains to link research on culture, low health literacy and language barriers, especially as they affect low-income minorities and immigrants to the U.S.

They conclude that “well-rounded programs are needed that address language barriers, cultural barriers and low health literacy simultaneously in primary care and prevention settings.” The [Health Literacy Universal Precautions Toolkit](#) answers this call for a “well-rounded” program. It includes two tools to address linguistic and cultural differences in health care practices. Tool #9 addresses language differences while Tool #10 explores the issue of cultural differences.

In **Tool #9, How to Address Language Differences**, there is an acknowledgement that “addressing language differences is an important part of addressing health literacy universal precautions and is also a requirement by law.” These laws include the Civil Rights Act of 1964, the [CLAS Standards](#), and others. Health care practices caring for Medicaid and Medicare beneficiaries must provide language services to their LEP patients. Some recommended actions for health care practices include:

- Assessing and documenting patients’ language preferences and language assistance needs. The Census Bureau, for example, offers [“I Speak” Cards](#) written in 38 languages. Health care practices can download this list and display the cards in an accessible area so that patients can identify the language they speak. Another way to identify patients’ language assistance needs is to ask all new patients, (through the person making the appointment), “What language do you feel most comfortable speaking with your doctor?” “Would you like an interpreter?” “In which language would you feel most comfortable reading medical or health care instructions?”

Once you identify the patient's language assistance needs, it should be recorded in the patient's medical record. In addition, at the reception area, a clear sign should inform patients' about their [rights to language assistance services](#).

- Language Assistance Services are also referred to as “language access” services or “linguistic competence.” These services include [interpretation](#) and [translation](#). Interpretation requires that a bilingual individual know the subject matter and be able to render the oral message accurately from one language to another. Translation requires that a bilingual individual convey the meaning of a written message from one language to another in written form. They require different skills. When there is bilingual staff sufficiently proficient (and that proficiency should be tested) in the language spoken by patients, health care practices also provide “language concordant” care—care in the language spoken by the patient.

For [interpretation](#), health care organizations use contract and onsite certified interpreters, as well as trained bilingual health care professionals who assist LEP patients and their health care providers with oral communication. In many instances, they also act as cultural brokers who clarify potential areas of cross-cultural conflict. Interpreter training should include attention to health literacy as well as culture. In instances where a patient speaks a lesser known language, telephone medical interpreters are often used. There are also guidelines about who should not interpret. For example, using untrained bilingual staff or family and friends for interpretation have been shown to lead to significant medical errors. Additionally, minor children should never be used as interpreters.

For [translation](#), health care organizations need to translate signs, forms, and educational materials. Some large organizations have dedicated translators on staff. Other organizations contract out translations. It is important to remember that principles of plain language used to write documents in English should be followed as well in translated materials. Tool #9 also offers websites with a large selection of health education materials translated into various languages. Check out NIH's [MedlinePlus!](#)

Although not included in Tool #9, three excellent resources are the Agency for Healthcare Research and Quality's [Improving Access to Language Services in Health Care: A Look at National and State Efforts](#), the Disparities National Coordinating Center's [March 2014 Community of Practice \(CoP\) Call](#) on Language Services in Health Care, and Kaiser Foundation's [Qualified Bilingual Staff \(QBS\) Model and Program](#).

## **Tool #10: Culture and Other Considerations**

This tool helps providers and organizations “avoid miscommunication in cross-cultural situations and foster more patient-centered relationships.” This is achieved with changes at various levels of health care. (For an in-depth discussion of the organizational, structural, and clinical levels of cultural barriers, see [Betancourt et. al.](#)). Tool #10 acknowledges that understanding issues related to patients’ culture, religion, or social situation can shed light on why they make certain choices. Some recommended actions include:

- Avoiding stereotypes and learning about the health beliefs and cultural practices of specific patients by asking questions. Tips on how to ask these questions are offered. As one example, “I am not familiar with your culture and beliefs. Can you teach me what I might need to know so that I can better treat you?”
- Improving cross-cultural communication skills through various continuing education courses.
- Developing expertise in the particular customs and beliefs of a group when the health practice cares for many patients who share the same cultural background. Areas of learning include: health beliefs and customs, ethnic customs, religious beliefs, dietary customs, interpersonal customs, and expectations. Some suggested web sites offering information on specific cultures include [EthnoMed](#) and [Culture Clues](#).

Effective communication with all patients is at the core of quality health care. To provide quality care to the increasing number of LEP patients from different cultural backgrounds, health care practices have to bridge that communication gap with linguistically and culturally appropriate services.