A Call for the Professionalization of Medical Language Education to Prevent Misuse of Limited Language Skills and Ad hoc Interpretation

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ABSTRACT

In an increasingly global society, medical language courses present an opportunity to teach physicians the clinical communication skills needed to provide high quality care for patients who speak non-English languages. Yet, despite a growing number of medical language programs, most courses are missing the professional framework that typically characterizes medical education.

Specifically, a lack of standardized proficiency assessment and feedback, paired with unclear institutional guidelines around interpretation and bilingual care, paves the way for communication errors and disparities in healthcare for linguistic minorities. Within the context of the hierarchy in medicine, medical trainees are potentially vulnerable to overstepping the limits of their language ability in an effort to impress their supervising physicians or to save time by attempting to communicate with patients on their own using partial language skills instead of seeking a medical interpreter. In this commentary, the authors use the case of medical Spanish in the United States to provide a framework for the professionalization of non-English language education in medical education settings, identifying three key opportunities: (1) equip learners to accurately self-assess language skills, (2) provide individualized performance feedback to learners, and (3) develop clear institutional policies regarding safe use of bilingual skills and partnership with medical interpreters.

1. Introduction

In today's society, the language in which clinicians train may not reflect the range of languages spoken by a country's population. For example, in Lebanon, although the most widely spoken language is Arabic, all seven of the medical schools in the country teach in either French or English.[1] In Canada, 22.8% of the population speaks French, 75.4% speak English, and 17.9% are bilingual (English- and French-speaking).[2] As of 2021, out of seventeen total Canadian medical schools, three provide instruction solely in French, three in English and French, and the remaining eleven in English only.[3] In the United States (US), Spanish is by far the most common language spoken among the 61 million residents who speak a language other than English at home, of whom 25 million report having limited English proficiency (LEP).[4] After Spanish, the most common languages spoken in the US are Chinese (Mandarin and Cantonese), Vietnamese, and Korean.[5] Yet, all accredited medical schools in the US teach and assess learner skills in English only. The mismatch between language of professional instruction and population language needs presents a challenge to effective communication and patient care.

The lack of specialized training, standardized examination and licensing, and a profession-wide code of ethics regarding use of non-English languages for communication with patients (without a medical interpreter) leaves physicians and trainees to determine for themselves whether and how to use such language skills in their work. As a result, even medical professionals with some bilingual skills may not be consistently equipped to provide safe, effective care for patients speaking non-English languages.

Self-motivated students and clinicians may seek opportunities to learn or improve medical language skills. For example, many medical schools in the US offer medical Spanish opportunities, largely due to student demand. In a survey of 125 US medical schools published in 2021, 78% reported offering a medical Spanish course, though only 21% met basic curricular standards such as faculty educators, curricular structure, and learner assessment.[6] Although such courses have arisen to meet the growing need for competent Spanish-language communication in healthcare, their content and design vary widely and may lack features essential to achieving this goal.

In this commentary, we provide a framework for the professionalization of medical language education in non-English languages, using published literature and our own experience regarding medical Spanish in the US. We call on medical school administration and students themselves to professionalize medical language education. We present three key recommendations: (1) equipping learners to self-assess language skills, (2) providing individualized performance feedback to learners, and (3) developing clear institutional policies regarding safe use of bilingual skills and partnership with medical interpreters. These strategies highlight the role of medical education in preparing clinicians for providing equitable care to linguistically diverse patient populations.4

2. Proficiency Assessment of Language Skills

Medical students in the US with second language skills are often asked to serve as ad hoc medical interpreters, stepping in to "help" their English-speaking supervisors or colleagues communicate with Spanish-speaking patients in clinical settings.[6] "Ad hoc interpreter" refers to a person who is called on to interpret but has not received specialized training or certification to do so. Even after completing a medical Spanish course, medical students who step into this role are serving as ad hoc interpreters because medical Spanish courses do not (and should not) teach the specific skill of interpretation. Medical students and physicians who take medical language courses are not preparing to serve as interpreters but rather to provide language-concordant care. Importantly, to teach language-concordant care, courses must teach not only the language itself, but also *when* and *how* to use it responsibly. In other words, it is essential for students and physicians with non-English language skills to understand their limitations in a language and how to effectively work with a professional medical interpreter.

Based on the 2021 national survey of medical Spanish curricula at US medical schools by Ortega et al, 79% of medical schools that allowed students to use Spanish in the clinical setting permitted their students to do so without an assessment of language competency.[6] In the absence of policies regulating language use in the clinical setting, medical students and institutions may perceive completion of medical Spanish coursework as the equivalent of approval to serve as a bilingual medical student or as an interpreter. Paired with the lack of institutional restriction on student use of unassessed language ability, this paves the way for ad hoc interpretation or use of inadequate language skills. This is problematic because medical Spanish courses often include students with multiple levels of Spanish proficiency, so it follows that students who complete the course will have variable levels of communication skills in the target language. Medical Spanish, and communication skills in any language, should be treated as a graduated competency for which progressive skill mastery will be achieved by individual learners at different points.[6] Furthermore, despite the prevalence of medical Spanish education, courses vary in rigor and pedagogy. A standardized, evidence-based curriculum including standardized patient (SP) encounters for learner assessment and routine program evaluation has been proposed.[8]

In addition to formative and summative language proficiency assessments incorporated in medical Spanish curricula, we propose that medical students interested in using non-English language skills in patient care should be taught to periodically self-assess their medical language skills. These self-reported skills should be verified through objective, standardized, and validated assessments prior to use in patient care, given that self-assessment alone has been shown to have variable accuracy, particularly in the intermediate proficiency ranges.[9-12] Table 1 provides both formative and summative evaluation suggestions for proficiency assessment implementation. These recommendations may be applied to the multilingual training of medical professionals across the world in languages other than the primary language of instruction at their medical institutions.

Moreover, it is important to recognize that communication skills extend beyond language alone, and encompass aspects of non-verbal communication, culturally acceptable behaviors, interpersonal trust, and variations in health/lifestyle preferences and practices. Hence, evaluating the progress of clinicians who wish to use a non-English language in patient care should involve a multifaceted approach. The National Council on Interpreting in Health Care provides a recommended process for the evaluation of professional medical interpreters and includes accuracy, respect, and cultural awareness.[15] Such a multifaceted approach could be modified and evaluated as a comprehensive guide to assessing students and physicians' readiness for language-concordant care.

3. Individualized Feedback

Prior study has found that US physicians with lower levels of Spanish proficiency report more frequent use of ad hoc interpreters as compared to those with intermediate and advanced proficiency.[16] Further, students and physicians may be unaware that professional interpreters are available, may find them difficult to access, or may not be trained in effectively

partnering with them.[18] All medical students and physicians should be taught to properly identify their language skills and limitations as well as to work with professional medical interpreters. Through individualized feedback, medical Spanish learners may improve self-awareness of language strengths and limitations. For example, students who achieve advanced proficiency may be encouraged to pursue formal credentialing as a bilingual physician in order to provide direct patient care in a non-English language (without a medical interpreter).

In addition to standardizing curricula and student self-assessment processes, educators should also provide language learners with intentional and explicit feedback regarding the limits of their language abilities, including advice on how to use their medical second language in clinical settings, if at all.

Consider the case of a hypothetical medical student, Alex, who last studied Spanish for four years in high school in the US. She enrolls in medical Spanish in her first year because she is greatly motivated to help underserved patients. By the end of the course, she can understand the main idea of most clinical conversations in Spanish and is pleased to be paired with a bilingual Spanish-speaking physician for her clinical preceptorship. Alex regularly observes her mentor conducting visits in Spanish and understands the main points of each encounter. At the end of one such visit, the physician asks Alex to go back into the room and remind the patient to pick up her prescription. Alex says to the patient, "*Recojo la receta de la farmacia*," to which the patient replies "*Muy bien, gracias.*" While Alex meant to say, "*Recoja la receta*," meaning the patient should pick up the prescription, she mistakenly conjugated in the first-person present tense, saying to the patient, "I will pick up the prescription from the pharmacy." This simple conjugation error could lead to severe consequences for the patient, especially as many immigrants are not familiar with the pharmacy or prescription system in the US to obtain medication. In this scenario, Alex has taken a role in patient care beyond her medical Spanish abilities and risked the possibility of patient harm, despite her good intentions and efforts to serve Spanish-speaking patients.

This scenario is not far-fetched. In our personal experiences, we have been placed in the position of serving as bilingual providers or as ad hoc interpreters in clinical settings. This has occurred not only in medical school, but also while volunteering in hospitals as high school and undergraduate students. Like Alex in the hypothetical scenario, most medical students have not been given formal education on the potential for patient harm in language discordant situations. In the absence of regulation and education, students are left to rely on the judgment of attending physicians and other staff who may request that they speak in Spanish. Sometimes, even when students do not feel comfortable in a given patient scenario, they may feel obligated to accept in order to avoid disappointing supervisors and also to save time or "try their best" for the patient, who is typically grateful for even the smallest efforts to communicate in their language.

In general, students of intermediate and lower competency levels should work with a professional medical interpreter during patient interactions.[18] For those with intermediate proficiency, progressive language development could be encouraged through shadowing bilingual care team members, such as physicians and interpreters, and through additional opportunities for medical language study[19]. Students of beginner proficiency levels could be directed to opportunities for improving their fundamental skills in the target language, such as basic language courses, informal practice in non-clinical settings, and immersion experiences.[20] Additionally, medical students should be empowered to recognize when they are not ready to provide medical care in a particular language as well as to turn down inappropriate requests for ad hoc interpretation (Table 2).

Returning to the hypothetical case, individualized feedback for Alex would be best provided immediately after the encounter to maximize learning. The bilingual supervising physician could directly observe Alex when she interacts with the patient in Spanish. When noticing the conjugation error, the physician can gently interrupt, address the patient and clarify the intended message that in fact the patient should pick up the prescription from the pharmacy. The supervisor then asks the patient to repeat back what they understood to be the next steps in getting their medications after the visit. Following the encounter, the physician and Alex should debrief about the visit. The supervisor and trainee can each share what went well and what could have been improved about the communication. In doing so, the supervisor can point out the miscommunication and they can jointly discuss how the error was repaired and how a similar mistake could be avoided or repaired in the future.

4. Institutional Policies around Interpretation and Bilingual Care

Medical language courses do not occur in isolation. US medical students and physicians who enroll in medical language education practice in a clinical environment that exposes them to a linguistically diverse patient population. For this reason,

it is necessary to pay attention to institutional policies and practices, such as the availability and accessibility of professional medical interpreters, which can either help or hinder students/physicians from providing language-appropriate care.

Although participation in medical Spanish educational opportunities is optional at most medical schools, formal training in the ability to provide appropriate care to culturally and linguistically diverse populations should be required for all future physicians to ensure equitable care regardless of the patient's preferred language.[18] Currently, these skills are not prioritized in student skill assessment in US undergraduate medical education. Most, if not all, Objective Structured Clinical Examinations involve only English-speaking SPs, never evaluating a medical student's ability to assess the need for an interpreter, navigate effective clinician-patient communication in language-discordant situations, or work with a professional interpreter. Global linguistic competency skills benefit all students, regardless of their language abilities.[18]

These skills include how to understand one's own language skills, how to communicate properly with patients during interpreter-mediated encounters, how to recognize signs that an interpreter may be editing or omitting messages and how to act with cultural competency and humility.[22] Intercultural communication skills, the role of cultural health practices and beliefs, and a comprehensive approach to communication are imperative to culturally and linguistically effective care. We call on medical schools to implement and emphasize global linguistic competency instruction throughout clinical skills and communication courses for all medical students, outside of optional non-English language courses that may be offered at school.

In the US, the infrastructure to implement these changes exists, both in the medical education curriculum and at an institutional level. Medical schools already implement patient safety training, including an introduction to privacy laws, technology security, and basic life support when first-year students begin orientation. Global linguistic competence could be introduced at these pre-clinical sessions, with practical components added later as students prepare for clinical clerkships. Table 1 presents examples for implementing institutional policies aligned with the professionalization of non-English language use in patient care.

5. Conclusions

To promote the professionalization of medical language education, we propose the following framework. First, students should be guided in developing awareness of their own level of proficiency at the beginning and end of a medical language course using standardized self-assessment tools. Second, this self-assessment should be complemented by reliable, standardized assessments such as SP encounters and used to provide individualized guidelines for language use, allowing students to improve or use their language ability without compromising patient safety. Individualized feedback for students should focus on enhancing their ability to self-assess strengths and limitations and promote the professional use of language by holding clinicians to an appropriately high standard of service for all patients. Finally, institutional policies addressing interpretation and bilingual medical care are necessary to set professional expectations for all healthcare providers, including students. These recommendations for medical schools and medical trainees serve as a general framework for the professionalization of medical education in languages different from the language of primary instruction across the world.

While institutional change to incorporate these recommendations will require time and partnership with medical education faculty and administration, we call on our fellow students and educators to start with their own multilingual education efforts, such as existing electives, workshops, and clubs. Both student and faculty leaders can and should incorporate education about the consequences of ad hoc interpretation to ensure students recognize the limits of their language proficiency and the progressive nature of second language mastery. Most importantly, giving all medical students and physicians, regardless of language ability, guidance to appropriately channel their enthusiasm for high-quality patient care will empower them to best advocate for, listen to, and serve all patients and communities. Our patients deserve nothing less.

Table 1. Opportunities for Professionalization of Medical Language Skills and Example Strategies for Implementation

Opportunity for Professionalization	Example Strategies for Implementation
Proficiency Assessment	• Schedule periodic self-assessments using the Interagency Language Roundtable scale modified for physicians[13] (e.g., every 6-12 months throughout medical training) • Conduct assessments by faculty and SPs[14] after observed patient/SP encounters for medical language students and any other students who wish to provide medical care in a non-English language • Consider third-party assessment options, such as the phone-based Clinician Cultural and Linguistic Assessment or the Physician Oral Language Observation Matrix[23]
Individualized Feedback	• Faculty provides learners with text/verbal feedback from faculty and SPs regarding performance in SP encounters • Learners complete guided self-reflections regarding strengths and limitations following SP encounters • Learners complete guided self-reflection following any clinical experience with non-English language-speaking patients (e.g., clerkships, shadowing, study abroad)
Institutional Policies around Interpretation and Bilingual Care	• Review/create institutional policies regarding use of medical students as ad hoc interpreters • Review/create institutional policies regarding qualification of medical students/physicians to provide direct care in a language other than English • Educate all students and faculty about institutional policies and procedures for requesting a medical interpreter and for using non-English language skills • Teach students to appropriately address/decline requests to serve as ad hoc interpreters • Diversify the institution's pool of SPs to include racial, ethnic, cultural, and linguistic diversity to assess all students' abilities to communicate with patients who speak non-English languages

Abbreviations: SP, Standardized Patient

Table 2. Common Challenges Encountered by Medical Students with Skills in Non-English Languages and Recommended Strategies to Address Them

Challenge	Recommended Strategies
How to prepare to participate in clinical experiences with potential exposure to patients who speak non-English languages	• Inform yourself of the linguistic and cultural characteristics of the patient population and ask about what educational components will be offered by your medical school to prepare you to care for this population. • Understand your institution's methods and policies for requesting medical interpreters (e.g., onsite interpreter, video, or phone system options; how to request an interpreter including urgent/emergent requests; who can call an interpreter). • Inquire about the clinic's practices regarding medical interpreters when starting a clinical clerkship and offer to provide this information yourself if needed. • Investigate educational options offered by your medical school to increase your language and cultural skills in the target non-English language.
How to respond to a request to serve as a medical interpreter	• Use your knowledge of institutional methods and policies for requesting a medical interpreter, request the interpreter yourself. • Offer to explain what you have learned regarding the interpreter request process while mentioning the benefits of using a professional interpreter. • If the requester declines your offer to contact interpreter services and insists on you interpreting, make an effort to understand why the requester is reluctant to involve professional interpreter services. • Politely explain that you are unable to provide high-quality interpretation. For example, "I know the interview process takes longer with an interpreter in the mix. Unfortunately, my Spanish skills in a clinical setting are limited and would not help speed up the process, and I am worried that it could harm the patient." • Politely explain, if applicable, that you are qualified as a bilingual medical student and could directly interview the patient in Spanish but that you are not qualified as an interpreter and could therefore not provide that service.

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