

Further Readings

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Interpreters and Language

Language is the means by which a physician and a patient exchange illness-related information, share beliefs about health and illness, and engage in shared decision making. When language barriers exist in provider-patient interactions, patients are likely to incur more cost. For example, patients with limited-English-proficiency (LEP) have higher use, longer stay, and more resource utilization (e.g., diagnostic testing) of emergency visits, and reduced use of preventive care and primary care services. Patients with LEP are significantly disadvantaged when interacting with providers, experiencing problematic care. They are less likely to receive follow-up appointments after an emergency visit, less likely to understand a health care provider's instructions, less likely to receive emotional support from their provider, and less satisfied with the quality of care (even in areas

unrelated to language). Compared to English-speaking counterparts, patients with LEP make fewer comments during a medical encounter, and the ones they do make are more likely to be ignored by their providers. The literature is replete with studies showing how language barriers can negatively affect access to and quality of care and can lead to undesirable health consequences.

Parents' LEP status is also a major predictor of their children's health disparities. Children of parents with LEP (compared to those with English-proficient parents) have delayed illness care, reduced routine care, higher resource utilization for diagnostic testing, and longer visits in the emergency department. Parents with LEP have a higher risk of problematic medication dosing. They also have odds that are three times as high of a child having fair/poor health status, double the odds of a child spending at least one day in bed for illness in the past year, and significantly greater odds of a child not being brought in for needed medical care for six of nine access barriers to care. When aiming to improve health disparities for minority and immigrant children, it is important to recognize their parents' LEP status as a critical factor in their illness experiences and management.

The Solution?

Interpreters often are viewed as the standard solution to language barriers between providers and patients by health care communities and policy makers. In the United States, since the late 1970s, there have been federal and state legislative efforts to require physicians to provide interpreters for patients with LEP. The most recent action at the federal level is an Executive Order, Improving Access to Services for Persons with Limited English Proficiency, issued by former president Bill Clinton on August 11, 2000, which resulted in U.S. Department of Health and Human Services' guidelines in 2003 to require health care providers to offer language assistance for persons with LEP. As of 2012, many national and regional interpreter associations in the United States have advocated for a national certification for medical interpreters, although a standardized process is still a work in progress.

The assumption that interpreters are the solution to language barriers is largely based on the

conceptualization that interpreters can act as cultural brokers and patient advocates in cross-cultural encounters, improving patients' access to and quality of care. However, providers often are concerned about interpreters' involvement and power, fearing their influence over the provider-patient relationship as well as the content and process of provider-patient communication. As a result, the codes of ethics for medical interpreters traditionally view interpreters as a conduit, requiring them to adopt a passive, noninterfering role that provides neutral and faithful relay of information. Many researchers, however, have demonstrated that such an expectation is unrealistic and impractical due to the complexity and dynamics of cross-cultural medical encounters. Rather than prescribing a limited role to interpreters to ensure high quality care, researchers have recommended that providers receive training on working with (different types of) interpreters, be adaptive to the communicative needs and contexts in interpreter-mediated interactions, and nurture institutional cultures and practices that promote interpreters' (appropriate) involvement in the delivery of care.

Several reviews have found that on-site professional interpreters can raise LEP patients' satisfaction and quality of care to a level approaching that of patients without language barriers. However, it is not uncommon for health care providers to utilize a wide variety of interpreters, including bilingual staff (e.g., nurses), ad hoc interpreters (e.g., patients' family members), and trained interpreters (e.g., telephone interpreters and on-site professional interpreters). In fact, various studies have found that trained interpreters generally are used less than 20 percent of the time, even in states that institute legislation mandating interpreters and/or cultural competency in health care settings.

Although time constraints and lack of availability are often cited as barriers to the use of professional interpreters, recent studies argue that institutional norms, organizational structures, alliances of care, therapeutic objectives, and specialty-specific needs can influence providers' choice of interpreters. Providers make calculated decisions on their priorities and weigh their options. For example, waiting for a professional interpreter for hours before checking to see if

a patient is still in pain adds to the health disparities experienced by patients with LEP. Taking five minutes to locate a telephone interpreter to ask the patient to roll on her back may appear to be a big waste of time. From this perspective, researchers have argued that the exclusive use of professional interpreters in bilingual health care can be costly and impractical. Rather, health care institutions should develop guidelines on the adaptable, appropriate, and effective use of different types of interpreters based on specific factors and criteria (e.g., institutional ethics, treatment complexity, clinical urgency, and communicative goals).

Finally, researchers have repeatedly and reliably established that linguistic problems are not the only ones faced by patients with LEP. The health care community cannot expect that, by removing language barriers, patients with LEP are going to share similar illness experiences, health-related beliefs, or behavioral patterns with English-speaking patients. Language barriers are simply the most observable difference in cross-cultural health care. A meaningful and effective solution to health disparities experienced by patients with LEP needs to recognize their sociocultural differences in illness ideology, communicative preferences, and illness-related needs.

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See Also: Cultural Differences; Cultural Sensitivity; Culture-Centered Approaches; Intercultural Health Communication; Public Health Intervention: Multicultural Communities.

Further Readings

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Intervention Evaluation Methodology Technologies, New

The Internet, mobile phones, and social media can facilitate evaluation at all phases of a health communication project, including formative, process, and outcome evaluation. The main advantages technology affords for evaluation of communication programs include reach to large numbers of people, automation and better control of data collection, and more rapid implementation of evaluation. At the same time, technology-based evaluation can suffer from lack of detail and inadequate representation from diverse audiences, as well as problems in achieving data from probability samples.

Technology in Formative Evaluation

The use of the focus group to help define campaign parameters is a staple of health communication campaign development. Internet technology and social media tools such as chat rooms facilitate the capacity to collect formative program development data through online chat rooms and discussion boards. These are situated within Internet provider or social media sites, where people interact with one another synchronously (as in chat rooms) and asynchronously (in threaded discussion).

The use of chat rooms for formative data collection and focus groups demonstrates that the approach can hasten the process of data collection and allow for a rapid compilation of ideas

relevant for health communication; in addition, online events eliminate the need for travel or meeting space. Researchers have also utilized online threaded discussion to obtain perspectives from a more geographically dispersed audience than would otherwise be possible in focus group/audience research. When collecting data online in chat rooms or threaded discussions, there is no need for transcription.

The synchronicity required in chat rooms necessitates substantial work in recruiting enough participants to make the chat dynamic and engaging and encounters the risk that chatters may be distracted and engaged in multiple activities at once. Asynchronous threaded discussion overcomes these issues, allowing people to post responses to questions on their own time. However, the amount of detail and depth to qualitative answers obtained online does not always match that achievable through face-to-face encounters.

Technology in Process Evaluation

Understanding who is exposed to a health communication campaign, and which elements are engaging, is central to the process evaluation endeavor. Technology-based process evaluation tools can allow for documentation of Web-based campaign metrics: for example, daily and/or unique visits, how viewers got to the site, and what they did there (e.g., which pages were viewed, the order in which they were viewed). This can be particularly useful in helping to understand whether the message the campaign intends to send is being seen and by whom (demographics of viewers are obtainable), and receivers are "going deeper" by clicking on links (i.e., the "click-trail") or taking desired actions (known as "conversion"). These tools can also generate data in real time, making it easier to alter campaign strategies or change directions in order to maximize campaign effect.

Online analytic tools can blend with real-world campaigns; if the campaign has a Web site named for the campaign materials, evaluators can track people who link to it. A simpler way to achieve the same outcome has emerged, called the quick-response or QR code. Using a mobile phone, one can take a picture of the QR code that then takes the participant directly to a Web site where he or she can get more information about a campaign.