A significant proportion of U.S. Hispanic patients being treated for diabetes speak little or no English. In contrast, the majority of clinicians in the United States speak only English. This language gap creates barriers to the delivery of quality health care for Hispanics with limited English proficiency and diabetes. This article discusses a range of practical solutions to bridge the language and cultural barriers and improve outcomes for these patients. While the focus is on Hispanic patients who are being treated for diabetes, the recommendations in this article can apply to other patients with limited English proficiency.
Effective communication throughout a patient encounter is an essential element of providing high-quality health care. Physicians must be able to obtain accurate medical histories and patients need to be able to understand the instructions and treatment options given by their physicians.

Language barriers can contribute to misunderstandings between the involved parties and lead to substandard care. Even when physicians and patients are fluent in the same language, communication can be difficult when discussing sensitive health-related issues. In the case of patients with limited English proficiency (LEP), the critical elements of effective communication become even more difficult to achieve and the consequences of miscommunication are likely to be more severe. In addition, research has shown that effective physician-patient communication improves health care outcomes for LEP patients.

As the prevalence of the foreign-born population in the United States increases, it is becoming more commonplace for physicians to encounter a greater number of LEP patients, particularly those speaking Spanish. Currently, Hispanics constitute the largest minority population in the United States. The U.S. Census Bureau estimates that by the year 2050, the Hispanic population will be 25% of the U.S. population. Type 2 diabetes disproportionately affects Hispanics in the United States. It is estimated that 10.4% of Hispanics 20 years or older have diabetes; in contrast, 6.6% of non-Hispanic whites have diabetes. Hispanics have the highest lifetime risk of developing diabetes—45.4%, compared with non-Hispanic whites—26.7%.

According to the 2000 U.S. Census, 18% of persons age 5 years or older spoke a language other than English at home, with Spanish being the predominant non-English language for 28.1 million members of the U.S. population. Of those persons reporting Spanish as the language spoken at home, 28.1% reported speaking English less than very well.

**Legal rights to language access**
The legal basis for patients’ rights to language access lies within Title VI of the 1964 Civil Rights Act, which protects against discrimination on the basis of race, color or national origin. The U.S. Supreme Court in its rulings has considered discrimination based on language the same as discrimination against national origin.

Title VI of the Civil Rights Act requires health care professionals and organizations to provide interpretation or translation services to enable LEP patients to have access to health care services that is equal to the access of English-speaking patients. The legal responsibilities apply to any recipient of federal funding (ie, grants, Medicaid, Medicare, other) regardless of whether the funds were received directly or indirectly (eg, subcontract).

Title VI protections extend to all of the operations of an individual or organization, not just the portion that received the federal funds—and it applies without regard to the amount of funds received. Moreover, language access services must be provided to all of the patients of an individual health care professional or an organization once they accept federal funds.

Additionally, the language interpreters must be competent, though not necessarily certified, and the interpretation services must be provided at no cost to LEP patients.

Notwithstanding the federal legal requirements, the reality is that many health care professionals are not making language access services available for their LEP patients. The reasons for the noncompliance with language access services range from lack of knowledge of their legal responsibilities and inconsistent enforcement of these laws, to the cost of providing language interpretation services. Regrettably, thousands of LEP patients continue to encounter language barriers when attempting to access health care services, despite the provisions in Title VI.

**Language barriers**
It has been reported that linguistic barriers are a cause of decreased access to healthcare services, decreased preventive care screening, decreased medical comprehension, increased risk of adverse medication reactions, decreased patient recall, decreased patient satisfaction and decreased question-asking behavior for Hispanic LEP patients. In fact, a study of Hispanic subjects found that the primary language (Spanish) was more strongly correlated with decreased health care usage than was the income level. A study by Flores and colleagues showed that language barriers can play a significant role in medical mistakes.

Similarly, language barriers can introduce difficulties in the management of chronic diseases such as diabetes. Studies have shown that Spanish-speaking patients have limited understanding of diabetes as a disease entity and of its long-term effects.
These patients are less likely to be taking insulin, less likely to practice self-monitoring of blood glucose levels, less likely to identify normal glucose levels, less likely to be familiar with the term A1C, less likely than English-speaking patients to receive written materials and more likely to be non-adherent. Furthermore, in a survey of diabetic patients, 33% of Spanish-speaking respondents described having problems with understanding and communicating with their physicians and difficulty understanding their prescriptions, compared to 16% of English-speaking respondents.

Another study revealed that Hispanic patients with diabetes who spoke English faster had lower fasting blood glucose than were those who spoke Spanish at home. Another study revealed that Hispanic patients with cardiovascular risk factors. They reported that Hispanic patients with diabetes who spoke Spanish at home were more likely to have elevated fasting blood glucose than were Hispanic patients who spoke English at home. Another study revealed that diabetic patients with LEP were significantly more likely to report suboptimal clinician-patient interactions—physicians not understanding their problems, physicians not explaining, lack of confidence or trust in their physicians, physicians not showing respect, patients treated poorly because of language barriers—than English-proficient patients. Moreover, the suboptimal reports were more common with language-discordant physicians (ie, physician and patient speak different languages) than with language-concordant physicians.

The study results described above clearly demonstrate the need to bridge the language gap with LEP patients. In addition to language, consideration must be given to cultural values. In the same way that language barriers reduce the likelihood that a LEP patient will seek health care services, cultural differences often translate into cultural barriers that diminish effective communication, resulting in the same reduced access to health care.

Cultural barriers
The Hispanic community is rich in cultural traditions, beliefs and values. These cultural values can act as barriers to the health care of Hispanic patients. Moreover, fluency in Spanish and cultural competence by health care professionals are independently associated with greater ability to elicit and respond to patients’ concerns. It is important to recognize these cultural values to ensure a positive physician-patient relationship and to avoid unnecessary conflicts.

Ultimately, the outcomes for Hispanic patients can be enhanced with culturally competent care. However, while these cultural values may play a significant role, they should not be expected to apply to the same degree nor have the same effect on all of the individuals within the Hispanic community. The most representative of these values are familismo, fatalismo, personalismo, respeto and simpatia. See Table 1.

Overcoming both language and cultural barriers has had a positive effect in the primary care of Spanish-speaking patients. Clinicians can avoid the pitfalls of these barriers and be effective in their communications with Hispanic patients by providing appropriate responses to these cultural values and providing interpretation services when needed.

Bilingual-bicultural professionals are considered the ideal interpreters since they are fluent in both the patient’s language and the patient’s culture. Logically, being able to speak to LEP patients in their language is a critical step toward establishing communication, but this does not take into account the cultural aspects of communication that may require interpretation. Hispanic health care professionals who have cultural backgrounds that are similar to those of their patients are more likely to recognize and readily address any cultural value that may interfere with communication. The second best interpreters are the bilingual professionals, as they are able to communicate directly with patients. It is recommended that both bilingual-bicultural and bilingual professionals complete an interpreter-training program to optimize their effectiveness and to nullify any overestimation of their abilities as an interpreter.

The study by Perez-Stable and colleagues shows the positive effect on health care outcomes when LEP patients with diabetes or hypertension have language concordant physicians. Unfortunately, there are relatively few bilingual-bicultural and bilingual professionals to meet the needs of the growing number of LEP patients in the United States.

LEP patients are most commonly cared for by physicians or other health care professionals who speak only English. Typically, language-discordant professionals will use some form of interpreter services. There are advantages and disadvantages of utilizing the different types of interpreters.
The cost of providing these interpretation services differs depending upon the types of services provided. \(^{23,24}\)

Adhoc interpreters are usually the patient’s family members or friends. In many cases the patient’s children serve as interpreters. These interpreters are readily available, as they frequently accompany the patient to their medical encounter. However, while family members and friends can help support patients during appointments, they are rarely trained in medical interpretation. In such cases, confidentiality may be difficult to maintain and the discussion may be embarrassing for both the patient and interpreter. The quality of the interpretation is often inadequate, the meaning is edited inappropriately by the interpreter and commonly information is omitted.\(^{23}\)

This interpretation inadequacy can lead to misunderstandings and misdiagnoses, even more so in the case of children as interpreters due to their limited vocabulary.\(^{11,23,25}\) Indeed, Flores and colleagues reported most errors in medical interpretation are committed by

<table>
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<th>Term (Definition)</th>
<th>Potential as barrier when respect for the cultural value is perceived as lacking</th>
<th>Recommendations</th>
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| **Familismo** (social structure in which the needs of the family as a group supersedes the needs of the individual) | - Delays in important decisions or treatment initiation  
- Poor continuity of care and adherence to treatment  
- Dissatisfaction with care  
- Creates unnecessary conflicts between patient and physician | - Encourage patients to bring family members with them to their visits  
- Allow sufficient time for the family members to discuss medical decisions  
- Educate the family members regarding diabetes  
- Encourage the family members to be involved in the patient’s diabetic treatment |
| **Fatalismo** (belief that individuals cannot change his/her fate) | - Avoidance of preventive healthcare services  
- Avoidance of effective treatment options | - Emphasize efficacy of the treatments available, including insulin  
- Make reference to patients values to encourage acceptance of treatment |
| **Personalismo** (formal friendliness) | - Patients may feel physician does not care about them  
- Reluctant to share history or concerns about diabetes  
- Poor continuity of care and adherence to treatment  
- Dissatisfaction with care  
- Reluctant to start insulin regimen | - Decrease physical distance during patient interactions  
- Increase socially appropriate physical contact  
- At each visit display an interest in the patient’s life  
- Provide a business card |
| **Respeto** (Respect) | - Patient reluctant to ask questions to the physician as it may be viewed as disrespectful  
- Patient may nod in agreement as a sign of respect, but not understand  
- Patient may become resentful if they perceive that they are not being treated with respect | - Use appropriate greetings and titles  
- Special emphasis on eliciting patient’s concerns  
- Involve patient in treatment decision making  
- Utilize the formal Spanish form of you (ie, usted) |
| **Simpatia** (kindness, politeness and pleasantness in the face of a stressful situation) | - Dissatisfaction with care  
- Reluctant to share history or concerns about diabetes | - Special emphasis on displaying courtesy, a positive attitude and social amenities |

(Table 2).\(^{23}\) The cost of providing these interpretation services differs depending upon the types of services provided.\(^{23,24}\)
<table>
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<th>Type of service</th>
<th>Advantages</th>
<th>Disadvantages</th>
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| **Ad-hoc interpreters** (patient’s family member, child or friend) | ■ Readily available  
■ Free  
■ Patient may trust the person | ■ Interpretation may be inadequate  
■ Confidentiality is difficult to maintain  
■ Patients may withhold sensitive information  
■ Conflicts of interest may arise  
■ May omit important information  
■ May edit patient’s or physician’s statements  
■ Usually not trained in medical terminology  
■ A patient’s child may be embarrassed or too young to understand |
| **Community volunteer interpreters**               | ■ Usually understands culture  
■ Free | ■ Confidentiality may be a problem  
■ Interpretation may be inadequate  
■ Usually not trained in medical terminology  
■ May not be truly fluent in the patient’s language (false fluency) |
| **Bilingual Staff**                                | ■ Knows healthcare team well  
■ Likely familiar with terminology in the practitioner’s field  
■ Viewed as trustworthy by the patients | ■ Interruption of regular duties  
■ Availability inconsistent  
■ Usually little or no training in medical interpretation  
■ May not be truly fluent in the patient’s language (false fluency) |
| **Telephone Interpreters**                         | ■ Readily available  
■ Provides services for multiple languages | ■ Costly  
■ Misses visual cues (facial expressions, gestures)  
■ No national standards for interpreter competency  
■ Encounter may take longer time |
| **Remote-simultaneous interpretation**             | ■ Fewer errors  
■ Provides services for multiple languages | ■ Costly  
■ Misses visual cues  
■ No national standards for interpreter competency |
| **Contracted Interpreters**                        | ■ Provides services for multiple languages  
■ May be familiar with patient’s cultural values | ■ Costly  
■ No national standards for interpreter competency  
■ Not readily available  
■ Service may be delayed if traveling involved  
■ Encounter likely to take longer |
| **Bilingual/bicultural or Bilingual health care professionals** | ■ Ideal interpreter  
■ Knowledgeable of both language and culture of the patient’s  
■ Readily available | ■ Available number of these health care professionals are not sufficient to meet the needs of LEP patients  
■ May overestimate fluency |
ad-hoc interpreters and are more likely to have impending clinical consequences compared with errors committed by trained hospital interpreters. Nevertheless, Kuo and Fagan found that Hispanic patients had high levels of patient satisfaction and comfort when their family members or friends were used as interpreters. Conversely, experts in medical communication recommend using ad-hoc interpreters only as a last resort and discontinuing the use of children as interpreters altogether.

Community volunteer interpreters usually have an adequate understanding of the patient’s cultural values because they may come from the same background. Like ad hoc interpreters, these volunteer interpreters are unlikely to have been trained in medical terminology, and for that reason the quality of interpretation can be less than ideal. In addition, depending on the size of the community, confidentiality can also be difficult to achieve and maintain. Nevertheless, if they are properly trained in medical interpretation, community volunteer interpreters can be useful, particularly for languages that are less commonly encountered.

Bilingual staff members are often knowledgeable when it comes to medical terminology, but generally are similar to ad hoc interpreters because both lack training in language interpretation. They are inconsistently available, since they often juggle serving as interpreters along with their usual work duties. Yet, if they are trained as medical interpreters and their language abilities are tested, they can certainly be a valuable resource for the LEP patients and their health care professionals.

Telephone interpreters can generally be reached any time of day or night. Typically, they provide interpretive services in multiple languages, which is useful for practices with a multilingual practice base. However, since there are no established national standards, the competency of these interpreters may vary widely. In addition, since the interpreters are in remote locations, they are unable to take into account visual cues such as facial expressions or gestures. Nonetheless, a study by Lee and colleagues showed that Spanish-speaking patients were satisfied with their care to the same degree when telephone interpretation was used as when seeing language-concordant physicians. In contrast, they were less satisfied with their care when using family members or ad hoc interpreters.

Remote-simultaneous medical interpretation organizations are similar to telephone language lines in that they are able to provide services in multiple languages with interpreters in remote locations. In simultaneous interpreting, interpretation takes place at the same time as the interpreter is hearing the original speech. Conversely, interpreting services by a language line occurs only after the speaker has completed speaking and entails the need for a pause for the interpreter. In their study, Gany and colleagues found that remote-simultaneous medical interpretation improved patient satisfaction and privacy among LEP patients as compared to usual and customary interpreting. It should be noted that the inability to take into account visual cues during interpretation applies to this type of service as it does with telephone interpretation.

Contracted interpreters are professional interpreters who have received training in medical concepts and terminology, confidentiality, cultural issues, and communication and interpretive skills. They usually provide services through an agency, community colleges or social service programs or on a freelance basis. The competency of these interpreters varies widely, as it does for telephone and remote-simultaneous medical interpreters. The interpreters deliver their services while present in the room with the physician and the patient. Delays in service may occur if the interpreter needs to travel. Karliner and colleagues studied the impact of using professional interpreters for LEP patients upon clinical care. They found that professional interpreters are associated with improved clinical outcomes, improved communication and patient satisfaction with their care as compared to ad-hoc interpreters. Additionally,
they showed that the quality of care for LEP patients approaches that of patients without language barriers when professional medical interpreters are used.28

Providing appropriate interpreter services for LEP Hispanic patients with diabetes improves not only communication during physician-patient interactions, but also their clinical outcomes.2,22,26,28,29

**Bridging cultural barriers**

Proficiency in a language does not equate to cultural familiarity and competence. Further, fluency in Spanish and cultural competency have been shown to be independently associated with the following:

- A greater ability to elicit and respond to patients’ concerns and problems.
- Discussion of diagnosis, prognosis and treatment options.
- Significant improvement in dietary and diabetes self-care-related knowledge.
- Improved patients’ assessments of interpersonal care processes for Hispanic patients with diabetes.19,30

Use of a culturally appropriate diabetes self-care education program for Spanish-speaking patients demonstrated improved knowledge scores, improved lipid profiles and reductions in A1C levels.30-32

Family involvement (familismo) in decision making is particularly important to the Hispanic population. Physicians and other health care professionals can improve care for diabetic Hispanic patients by encouraging them to invite their family members to their visits. Physicians should prompt family members to ask questions and participate in discussions about treatment options.12,20,21

Clinicians may counter the adverse consequences of fatalismo—avoiding preventive healthcare services and effective treatment options—by emphasizing the importance of preventive care. In addition, the efficacy of medication, including insulin in the treatment of chronic diseases such as diabetes, should be discussed. Physicians practicing culturally competent care may use their cultural beliefs to promote healthy lifestyles and acceptance of treatment (eg, “take care of yourself so you can be there for your family”).12,20,21

An easy and effective way for physicians to personalize their approach (personalismo) is by decreasing the physical distance between themselves and their patients during office encounters. Increasing socially appropriate physical contact, providing a business card and routinely demonstrating interest in the patient’s personal life—work, school and family—are all positive approaches physicians can take to enhance patient visits.12,20,21

Demonstrating respeto for Hispanic patients entails being formal during any verbal exchange, particularly in a first encounter. Physicians can relay respect to Hispanic patients by addressing them as “M. r.” or “M. r.s.” or “M. s.” instead of using their first names. When speaking in Spanish it is recommended that usted be used, which is the formal term for you in Spanish, instead of using tu the informal term.12,20,21

Addressing the cultural value of simpatia requires health care professionals to have a positive attitude and place special emphasis on being courteous and pleasant.12,20,21 Lastly, communicating effectively with Hispanic patients being treated for diabetes involves providing culturally appropriate care and responding appropriately to their cultural values.19,30-32

**Recommendations for using medical interpreters**

There are multiple suggestions that may help clinicians facilitate the process of using trained medical interpreters in their practices while improving access to these services for their LEP patients. Following are some helpful suggestions:33

1. **Instructions for identifying patients in need of interpretation services**
   - Ask patients which language they prefer to be used during their visits.
   - Flag the patient’s chart regarding language preferences.
   - Post signs and provide forms and educational materials in the most common non–English languages encountered in your practice.
   - Provide lists of medications and instructions in the patient’s language of preference.

2. **Instructions for clinicians**
   - Save time by preparing in advance questions to be addressed during the encounter.
   - Develop interpreter-physician action plans for each patient encounter.
   - Maintain eye contact and speak directly with the patient.
   - Speak in standard language using straightforward sentences.
   - Ask one question at a time.
   - Avoid interrupting the interpretation.
   - Improve bilingual staff interpretation skills by providing access to ongoing interpreter training.

3. **Instructions to be given to the interpreters**
   - Use the universal form of the language, and avoid use of regional words.
   - Discuss your confidentiality policies with the interpreter.
   - Provide any necessary patient background to the interpreter, particularly if using telephone or remote-simultaneous medical interpretation.
   - Introduce the interpreter to the patient.
Remind the interpreter that everything interpreted during the patient encounter and all information discussed must be kept confidential.

Ask the interpreter to speak in first person when speaking to either the patient or the clinician.

Instruct the interpreter to translate everything stated in the presence of the patient.

Financing interpreter services
A variety of affordable resources are offered to provide language interpretation services. The availability of these resources varies depending on community and state reimbursement policies; that are in place.34

Multiple states avail themselves of federal matching funds through Medicaid and State Children’s Health Insurance Program, or SCHIP, to reimburse interpretation services. Other states contract directly with interpreter organizations.

Several managed care organizations reimburse physicians for using interpretation services. In addition, local hospitals that provide interpretation services have offered discounted services to physicians in their area.

To help address interpreter services, physicians should:

- Develop collaborative contracts with other physicians to obtain discounted services for using telephone or remote-simultaneous medical interpretation.

- Investigate if there are any not-for-profit or charitable organizations in your region that provide medical interpretation services.

- Contact local colleges or other community organizations for possible volunteer interpreters who can work under direct supervision of the clinician. In exchange for service commitment, offer medical interpretation training.

Table 3
Internet Resources—Information on interpretation services and cultural diversity

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<tr>
<th>Interpretation services</th>
<th>Cultural Diversity</th>
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Final notes
Currently, Hispanics are the fastest growing minority population in the United States. Diabetes affects this group in a disproportionate manner. Language and cultural barriers often lead to poor health care outcomes for U.S. Hispanics.

Professionally trained medical interpreters have been shown to improve effective communication between clinicians and LEP patients and improve the clinical outcomes.

In addition, U.S. laws have established the legal and ethical obligations of health care professionals and organizations to offer language-interpretation services to LEP patients. Health care professionals can ensure that this population obtains high-quality health care by addressing the barriers to health promotion and disease prevention with the assistance of trained interpretation services and culturally competent care.
References


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