

Strategies for Designing an Effective Medical Language Program

Tiffany M. Shin^a; Carmen Pérez-Muñoz^b; Marco A. Alemán^c; Pilar Ortega^d

^aWake Forest School of Medicine, Department of Pediatrics, Winston-Salem, NC, USA;
<https://orcid.org/0000-0002-0577-5871>

^bWake Forest University, Department of Spanish, Winston-Salem, NC, USA;
<https://orcid.org/0000-0002-5823-1368>

^cUniversity of North Carolina at Chapel Hill School of Medicine, Department of Medicine, Chapel Hill, NC, USA

^dUniversity of Illinois College of Medicine, Departments of Medical Education and Emergency Medicine, Chicago, IL, USA; <https://orcid.org/0000-0002-5136-1805>

Summary

Medical language education seeks to address healthcare inequities by equipping clinicians to care equitably for populations who prefer non-dominant languages. In the United States, Spanish is the most common non-English language spoken with four out of ten Hispanic individuals reporting limited English proficiency. Although a majority of U.S. medical schools provide some form of medical Spanish education, current medical Spanish training and assessment vary widely across schools, and faculty report multiple barriers to successful implementation. In this Editorial, we provide recommendations for developing and improving a medical language program using an evidence-based, scholarly approach. Using medical Spanish education as a frame of reference, we present a stepwise approach to medical language education. With these strategies, educators can improve medical language program sustainability and its impact on clinicians' competencies in communication skills in the languages relevant for the populations they serve.

Introduction

Medical language education seeks to address healthcare inequities by equipping clinicians to care equitably for linguistic minority populations. Patient-clinician language discordance—or in other words, when patient and clinician do not speak the same language—contributes to health disparities and results in worse health outcomes [1]. Thus, strategies to increase patient-clinician language concordance may improve key measures of health for linguistic minorities.

Medical Spanish education equips clinicians to care effectively for Spanish-speaking populations in areas where Spanish is a non-dominant language. In the United States (U.S.), four out of 10 Hispanic individuals report limited English proficiency (LEP), and the Hispanic population of 57.7 million is predicted to increase to constitute almost 30% of the U.S. population by 2060 [2]. Medical Spanish training is becoming more widespread in the U.S. and worldwide due to learner interest and demand, but training and assessment methodologies vary [3]. According to a recent national survey, 46% of medical schools that report medical Spanish education lack structured curricula altogether and rely instead on student-run clubs or activities to provide language exposures for students interested in caring for linguistic minorities [3].

Using medical Spanish education as a frame of reference given available literature and our real-world experiences as educators, we present a stepwise approach to medical language education that can be applied to other languages. With these strategies, educators can improve medical language program sustainability and its impact on clinicians' communication skills in the languages relevant for the populations they serve.

Step #1: Secure an institutional investment

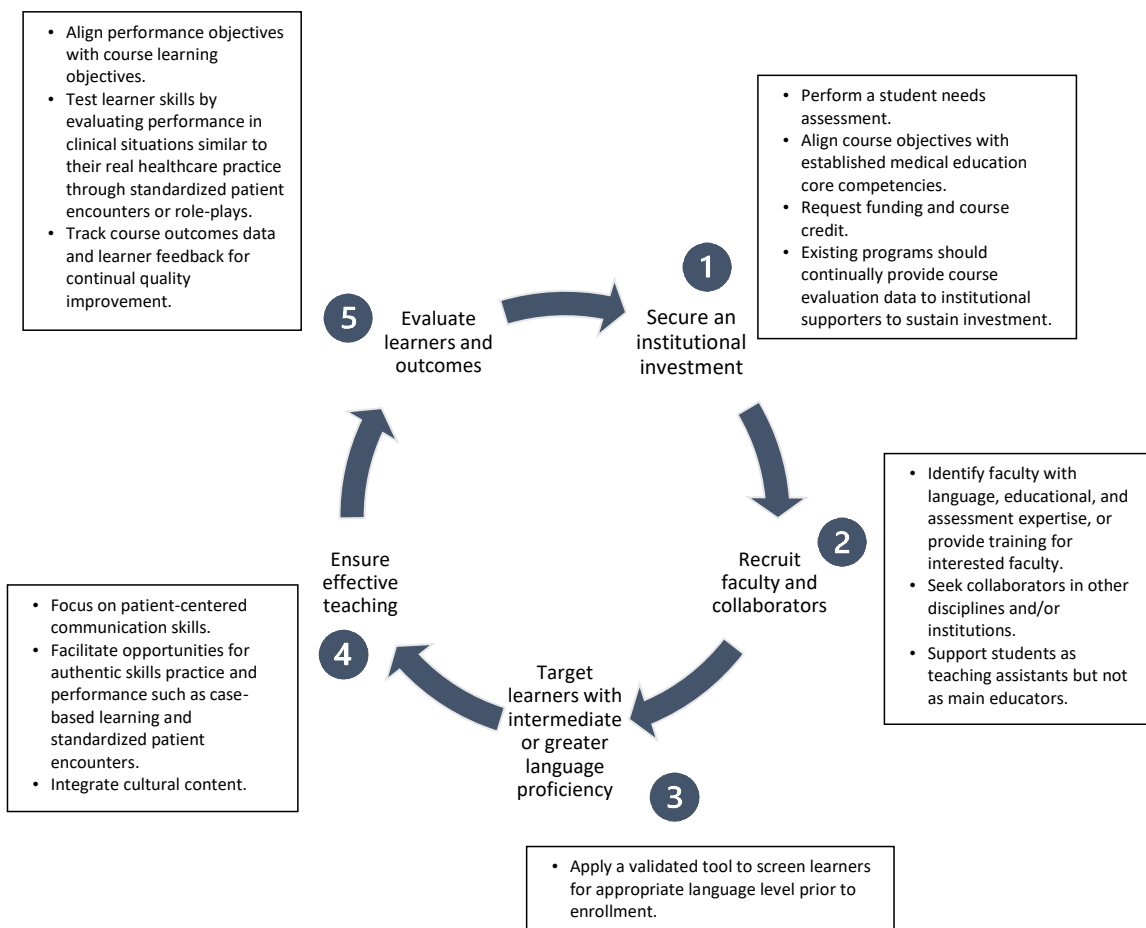
Demonstrating institutional relevance is the first step necessary to designing an effective medical language program (Figure 1). To establish the groundwork for program sustainability, leaders should conduct a student needs assessment and poll students to obtain information such as interest in or experience working with patients with LEP, interest in taking a medical language course, and attitudes regarding the perceived value of medical language training. Medical language programs can positively influence recruitment and admissions, and faculty can highlight how prospective students often mention medical Spanish opportunities as a factor in choosing a medical school.

Additionally, leaders should identify medical language course learning objectives that align with pre-established medical education core competencies. Faculty can structure medical language education to address foundational requirements for medical trainees, such as the following: 1) the seventh standard of the Liaison Committee for Medical Education, which requires that medical school curricula address communication skills, cultural competence, and education regarding healthcare disparities and 2) the core competencies of the Accreditation Council for Graduate Medical Education for patient care, interpersonal skills, and communication.

Institutional support needed for sustainable medical language programs includes financial support and course credit. Funding is a common barrier to implementing medical language programs, but demonstrating value helps faculty advocate for funding and secure an institutional commitment. Internal funding often will be a more sustainable resource compared to medical education grants, which may be only temporarily helpful in launching a nascent program. The

primary expense of a medical language program is compensation for faculty and/or instructors. Medical language education is time-intensive and requires a high number of hours for faculty-student contact, direct observations, standardized patient (SP) assessments, and detailed feedback. Supporting educational faculty by securing protected time and compensation is essential to program sustainability. Other expenses include funding for SPs and administrative support. In addition, medical language programs should be officially incorporated into institutional curricula with the opportunity to receive formal credit, which adds value to the program and can enhance student retention.

Figure 1. Summary of Five Steps for an Effective Medical Language Program



Step #2: Recruit faculty and collaborators

As a mixed discipline, medical language education incorporates the fields of medicine, language pedagogy, and social sciences. In U.S. medical schools, faculty physicians typically are the primary instructors for medical Spanish programs, but other potential educators include language department faculty, community language instructors, interpreters, and students. Students’ efforts to develop medical language initiatives should be structured and supervised by knowledgeable faculty. Collaboration between medical and language experts is an ideal form of instruction, as faculty with medical training understand the necessary skillset for applying languages to the

healthcare setting while language professors are skilled in the pedagogical aspects of language acquisition. Faculty must speak the target language fluently and be skilled in language teaching methodologies and assessment. Identifying faculty with this complex skillset can be challenging, and an alternative option is to identify and support a faculty member who is interested in acquiring these skills.

Medical language programs benefit greatly from strong collaborations, especially those that help contextualize education within population health. Collaborations between medical educators involved in clinical skills curricula helps to ensure coursework integration and improve educational methodology. Partnerships with undergraduate campuses can facilitate engagement between medical and language experts. Connecting with other medical language educators to share knowledge and resources also contributes to the improvement of medical language education, such as through the National Association of Medical Spanish. Partnerships with community clinicians and organizations can facilitate student engagement in contextual clinical learning, service learning, and advocacy. Guest lectures by community members who work with the target linguistic minority population allow students to gain a deeper understanding of the health, cultural, and socioeconomic strengths and needs.

Furthermore, leadership can engage learners in program development and quality improvement in order to ensure that learners' needs and expectations are met. Student partnership in early curricular development can enhance teaching methods and ensure a learner-centered approach. Faculty can work with student collaborators on shared tasks for program development. Students can provide useful input for logistics such as timing and location of sessions. They can be strong advocates for a program by writing a letter to institutional leadership, assisting faculty with administrative tasks, volunteering for role-play sessions, and establishing community partnerships. Students likewise gain meaningful experiences in medical education and professional growth.

Step #3: Target learners with intermediate or greater language proficiency

Medical language leaders should structure programs for learners with intermediate proficiency and above to allow students to realistically achieve patient-centered clinical communication competencies. Faculty can screen students prior to entering a program using the Interagency Language Roundtable (ILR) modified scale for physicians, which provides a description of the five proficiency levels for individual self-assessment and has demonstrated accuracy that is comparable to a validated oral proficiency interview [4]. Intermediate language proficiency would be consistent with an ILR level of "fair" or above. Faculty may use standardized language evaluation tools available in their respective countries or regions, such as the European Language Portfolio and the Common European Framework for References of Languages. Similarly, the American Council for the Teaching of Foreign Languages provides language proficiency guidelines that can be applied to language evaluation in medical educational contexts.

Step #4: Ensure effective teaching

Curricula should go beyond teaching vocabulary and prioritize teaching skills useful for patient-clinician conversations. Students should acquire person-centered language skills for direct patient care, not overly technical or jargonized language. Instructors thus should present vocabulary in the context of patient-clinician discourse. A useful strategy is to provide

vocabulary for students to learn independently prior to class, then dedicate class sessions to authentic communication practice with clinical role-plays or small group discussions. Case-based learning enables students to actively engage in realistic medical scenarios. Case content should closely follow prior knowledge acquired in general coursework. This helps students reinforce medical knowledge, learn new material in the target language, and establish contextual learning and application. Clinical cases should be used for class practice, simulations, and student assessments. To enhance experiential learning, students can practice in patient rooms or simulation centers. Educators should intentionally include scenarios of miscommunication that could lead to serious medical errors, regardless of the target language, to help learners work through failures in communication in a low-stakes environment.

Cultural content should be integrated throughout the curriculum, including health-relevant cultural information and appreciation of regional or pronunciation varieties of the target language. Programs should provide students with an understanding of the heterogeneity of the communities that speak a particular language and avoid presenting stereotypes. Cases should not be direct translations of dominant language (e.g., English) cases. For example, medical Spanish cases should be contextualized within the sociocultural realities of Spanish-speaking patients and reflect a wide range of Spanish-speaking nationalities, linguistic variations, economic and societal backgrounds, and real-life situations.

Additionally, faculty should equip students with self-awareness of their language strengths and limitations, providing detailed feedback and teaching learners to self-assess their skills. This helps students avoid “false fluency”—believing they are competent enough to use a target language with patients when they are not. Even for students who successfully complete a medical language program, language skills will vary depending on use during and after training. Faculty should help learners understand the importance of continually self-assessing their language abilities and limitations throughout their training and career.

Medical language programs also should teach students how to properly assess patient language preference, which may vary with the context or content of the medical encounter, and how to work with medical interpreters. Working with interpreters should not be viewed as a failure by students who have participated in medical language programs; instead, interpreter use should be normalized and encouraged whenever it is needed. Clinicians should have a lower threshold for using an interpreter in medical encounters involving procedural consent, psychiatric interviews, end-of-life care decisions, traumatic, or emergency situations. Trained medical interpreters add value, both linguistically and culturally. If students are unsure of their skills, it is best to err on the side of safety by requesting a medical interpreter.

Step #5: Evaluate learners and outcomes

Medical language programs must evaluate learners’ skills prior to use in patient care. For instance, per expert consensus, medical Spanish students should meet the following recommended target competencies: 1) demonstrate medical Spanish knowledge regarding organ systems, 2) demonstrate medical Spanish knowledge regarding common disease entities, 3) provide patient-centered explanations of diagnoses and assessment, 4) provide patient-centered explanation of treatment and evaluation plan, and 5) demonstrate determination of self-assessed confidence and limitations [5].

At minimum, performance assessments should occur at the mid-point and end of a course. Ideally, students should be assessed using simulated clinical encounters with SPs who are native speakers in the target language, allowing for comprehensive evaluation of communication competencies: oral language proficiency, listening comprehension, oral medical language knowledge, communication and interpersonal skills, and understanding of sociocultural contexts affecting population health [5]. If SP encounters are not possible, an alternative approach is assessment through role-play with faculty or fellow students. Faculty should ensure that patient cases and grading rubrics they develop target the above competencies. Commercial language examinations may be suitable for some programs, but their costs and lack of specificity to the specific clinical roles and duties of trainees or physicians pose challenges for implementation as a general standard.

Collecting meaningful learner outcome data enables faculty to demonstrate progress and make ongoing improvements. With clear medical language objectives aligning with assessment tools, faculty should evaluate educational interventions and seek to demonstrate measurable student progress in knowledge, skills, and attitudes. Conducting pre- and post-assessments of learners helps demonstrate change and determine fulfillment of desired program outcomes. Additionally, learners should complete program evaluations and suggest areas for improvement. Sharing these metrics with institutional leadership helps encourage program growth and continued support. With thoughtful and robust data collection, medical educators can contribute to scholarly work on medical language education.

Conclusion

The strategies provided in this article can serve as a framework for medical language programs to advance equitable healthcare access and quality. Leading an effective medical language program is achievable and realistic within the context of medical education and requires continual re-evaluation. Medical language education is uniquely gratifying as educators' investments can resonate in the future careers of multilingual physicians and improve the care delivered to linguistic minority patients.

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