Working with Interpreters: A Medical Education Tool in Cross-Cultural Communication

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Medical Education Tool

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Abstract

As Canada becomes more linguistically diverse, the skills required to work with limited English proficiency (LEP) patients and interpreters become increasingly valuable to family medicine. This project proposes a medical education tool for third-year medical students to start developing these skills early. It incorporates evidence from current literature about existing medical education tools, the impact of simulation experiences on learner empathy, and best practice guidelines for working with interpreters. “Working with Interpreters: A Medical Education Tool for Cross-Cultural Communication” is an Objective Structure Clinical Education (OSCE)-style simulation with a preceding introductory module and post-simulation debrief. The introductory module follows the flipped classroom model to review recommendations for working with interpreters and to prime students to reflect on the impact that language barriers can have on LEP patients. The simulation session places medical students in the LEP patient role by using the Pocket Talker device to simulate a communication barrier, and asks students to rotate through the roles of patient, interpreter, and interviewer. Suggested methods for evaluation of this tool include the Jefferson Scale of Physician Empathy (JSE) and a skills checklist to evaluate students’ competency working with interpreters.

Introduction

Patients with limited English proficiency (LEP) represent a sizeable portion of the Canadian population with their own unique needs and challenges when it comes to accessing the health care system and receiving medical care. According to the 2021 Canadian census, 12.7% of Canadians primarily spoke a language other than English or French at home[1]. LEP is a barrier to navigating the health care system in Canada, and

has implications in clinical outcomes, patient satisfaction, and quality of care provided. Several studies have shown that patients who encounter language barriers are less likely to engage in surveillance screening (e.g. pap smears, mammography), higher rates of non-compliance with management plans due to communication challenges, and lower rates of patient satisfaction[2,3]. Some challenges for physicians who take care of LEP patients include more time-consuming encounters, decreased confidence about quality of care, and stress about meeting ethical standards[2,4]. The use of interpreters in the medical setting has been one way to address language barriers encountered by LEP patients, and has been shown to improve communication, use of health services, clinical outcomes, and patient satisfaction[4-7]. However, access to interpreters is not always readily available, and working with interpreters is a skill that needs to be developed and practiced by physicians[4,8,9]. Curriculum about working with LEP patients and interpreters is present in many medical schools, but the nature of the curriculum varies. A survey of medical schools in the U.S. reported that 76% of the schools responding have some type of training on how to work with interpreters. Of these schools, 34% included didactic sessions in the curriculum, and 34% included standardized patient encounters[10]. Working with LEP patients and interpreters is a skill intrinsic to family medicine, as it supports family physicians' ability to provide patient-centered care, develop a strong patient-physician relationship, and meet the needs of an increasingly linguistically diverse community. This project aims to develop an evidence-based medical education tool for medical students that establishes competency in working with LEP patients and interpreters, and to propose strategies for practical implementation of the tool.

Background

As part of the development of this medical education tool, a literature review was conducted to analyze existing medical education tools about working with interpreters, studies on the effectiveness of medical learners in a simulated patient role, and best practice guidelines for working with interpreters.

One such existing medical education tool for working with interpreters was developed at the Albert Einstein College of Medicine in the Bronx, New York City, U.S.A[11]. Researchers implemented a curriculum session called "Cross Cultural Communication-Using an Interpreter" for third-year medical students. The session was initially held six weeks prior to medical students beginning their clerkship rotation, but was subsequently moved to the first week of clerkship based on student and faculty feedback. This change was made to allow students to apply the skills they learned from the session sooner as they began their clerkship rotations. The session itself was divided into two parts: the first hour consisted of a video about Mohammad Kochi's story, a patient with cancer, to prompt discussion about varying beliefs about health and the impact of language on health care delivery, and videos illustrating "do's and don'ts" of working with interpreters and LEP patients. The second hour consisted of a practice session for students to work with Spanish-speaking standardized patients and Spanish teachers acting as untrained interpreters. A faculty facilitator worked with a group of eight students and a standardized patient-interpreter pair, with students taking turns interviewing the patient using the interpreter (picking up from where the last student left off in the interview) and opportunities for "time-outs" to provide feedback from the group and the facilitator. In the third year of the session's implementation, researchers included a video to illustrate the "do's and don'ts" of using a

telephone interpreter given the common use of telephone interpreters in the medical college's affiliate hospitals. Researchers conducted a survey among the medical students to measure their confidence in communicating with a LEP patient, working with an untrained interpreter, and using a hospital language line. 77.3% of students agreed or strongly agreed that they "felt more prepared now than before the session to communicate with a patient who has LEP" and 76.4% of students agreed or strongly agreed that they "felt more prepared to access a hospital language line". The results are promising in regards to the value of this session for medical students, although the survey only measured the students' perceived level of confidence and did not include an objective measure based on the evaluation of their performance by the facilitator, standardized patient, or interpreter. The session in the study also exclusively used untrained interpreters, which is valuable exposure given the reality that many LEP patients only have their family members to interpret for them, but it can be argued that it is also valuable for medical learners to practice working with interpreters trained in medical interpretation.

This literature review also aims to explore the value of medical learners taking on a patient role via simulation. A scoping review by Karvelyte et al. analyzed existing literature about the impact of simulating the patient experience on empathy in healthcare professionals[12]. In the 77 articles reviewed, methods for simulation included glasses to simulate impaired vision, gloves to simulate motor and sensory deficits, ear plugs and headphones to simulate hearing loss and auditory hallucinations, weights to simulate muscle weakness, and restrictors on elbows and knees to simulate reduced joint mobility. The review found that 27% of studies measured impact on learners quantitatively (i.e. standardized

questionnaires, Jefferson Scale of Physician Empathy), 49% measured impact qualitatively (i.e. thematic analyses of interviews), and 30% used a mixture of quantitative and qualitative methods. 87% of the articles found the simulation experience had a positive impact on learners, 7% had no impact, and 6% had a negative impact. However, this scoping review does not describe how a "positive" vs "negative" impact is defined in their analysis. Nonetheless, it is valuable in summarizing the variety of simulation methods that exist in current medical education tools, and suggests there are multiple studies that support the value of a simulated patient experience for medical learners.

Finally, this literature review looks at best practice guidelines for working with interpreters to incorporate in this project's medical education tool. The Canadian organization, Cultural Interpretation Services for Our Communities (CISOC), published their "Guide to Working with Interpreters" in 2023[13]. CISOC makes several recommendations for healthcare providers about appropriate language to use and speaking tips, including using proper nouns, making one point at a time, avoiding compound questions, and avoiding jargon. A discursive paper by Hadziabdic and Hjelm published in the International Journal of Evidence-Based Healthcare also provides suggestions overlapping with those in CISOC's guide, and additional recommendations about seating relative to the patient and interpreter and commentary about the importance of recognizing the cultural and social context of medical interpretation for patients and their families[14]. The limitation of these guidelines is that it is intrinsically difficult to objectively measure the effectiveness of the recommendations made. Although there are several studies that have examined the use of interpreters as an intervention itself, no studies were found that studied the impact of individual recommendations made by best practice

guidelines for working with interpreters (e.g. speaking in shorter sentences, sitting in a triangle with the patient and interpreter) on outcomes such as patient satisfaction, patient understanding, or clinical outcomes.

Study Design/Method

The following project goals were used to guide development of this medical education tool:

1. Analyze existing research on simulation curriculum about working with medical interpreters and simulation curriculum that places learner in the patient role.
2. Develop an evidence-based medical education tool for medical students about working with simulators.
3. Propose strategies for practical implementation of the tool.

A literature review was conducted to analyze existing medical education tools about working with interpreters, studies on the effectiveness of medical learners in a simulated patient role, and best practice guidelines for working with interpreters—the findings of which are discussed in greater detail in the Background section of this project. Incorporating the findings from available literature, the format of this educational tool is an Objective Structure Clinical Education (OSCE)-style simulation with a preceding introductory module. The intended audience of this education tool are third-year medical students because of their established history-taking and physical examination skills, and their stage of training transitioning from mostly lecture-based learning in the classroom to clinical encounters[11]. The preceding introductory module was developed to complement the OSCE-style simulation in accordance with the flipped classroom model, which has been shown to have good outcomes on learning achievement and motivation[15]. It includes

information about tips for working with interpreters and videos intended to provoke students to consider the effect that language has on access to healthcare and differing perspectives on health. These videos were obtained from open access, reputable sources and were created for educational purposes[16-18]. The cases created for the OSCE-style simulation are intended to be straightforward and at the third-year medical student level, with the focus on history-taking with a LEP patient and interpreter rather than diagnosing and treating the clinical scenario. The Pocket Talker devices and masks in the simulation are used to balance low cost and ease of access with the project's goal of creating a rudimentary language barrier experience. Facilitators guiding the discussion and simulation are volunteer staff physicians or residents, given their experience with medical history-taking and working with LEP patients and interpreters.

Results

"Working with Interpreters: A Medical Education Tool for Cross-Cultural Communication" consists of a preceding introductory module, an OSCE-style simulation, and a post-stimulation debrief. The objectives of the medical education tool are as follows:

1. Establish competency in working with LEP patients and interpreters among third-year medical students.
2. Provide the opportunity for third-year medical students to practice working with interpreters.
3. Develop an understanding of the challenges and barriers to health care faced by LEP patients.
4. Foster a deeper level of empathy and compassion through the simulation experience.

The introductory module is a PowerPoint presentation that is intended for medical students to review at their own pace prior to the simulation session (Appendix 1). This method of delivery was chosen given the evidence for the flipped classroom model[15]. It begins with an introductory video from Stanford Continuing Medical Education titled "Health Disparities for Patient with Limited-English Proficiency"[16]. The video is a concise summary of the challenges encountered by LEP patients when navigating the healthcare system and challenges of the healthcare providers taking care of them, and includes a real-life case to illustrate the importance of using professional interpreters rather than relying on family members. The module then goes through introductory information about the language demographics of Canada and a summary of the impact that language barriers have on healthcare access, outcomes, and patient satisfaction to convey the relevance and importance of communicating with LEP patients. The next few slides of the PowerPoint go over the types of interpreting, the benefits of interpreters, and "do's and don'ts" of working with interpreters. The last few slides were created with the goal of priming students to think about the cultural impact that language has on patient understanding and access to health care. It includes a short video from the Centers for Disease Control and Prevention (CDC) titled "Culture and Language Affect Health Literacy"[17]. The video shows Dr. Kathy Wilson, a public health educator, discussing the effort to understand an Inupiat community's attitudes towards cancer screening in Alaska given their disproportionate risk of developing colorectal cancer. The final activity in the introductory module is to review the case of Mohammed Kochi, an immigrant from Afghanistan and the challenges he and his family faced navigating his cancer diagnosis[18,19]. Mr. Kochi's story is one of four stories in the documentary "Worlds Apart"

created by Maren Grainger-Monsen and Julia Haslett, and was also used in the curriculum developed in the study by McEvoy et al[11]. The introductory module asks students to review a short video clip from the documentary and the Worlds Apart facilitator's guide that gives greater detail about Mr. Kochi's story, background context about Afghani attitudes towards healthcare, and Afghani immigration to the U.S., in addition to several case discussion questions for students to reflect on.

The simulation session has an accompanying facilitator's guide and sample cases (Appendix 2). The format of the session starts with a brief discussion led by the facilitator, which serves as a preamble to the simulation session and a follow-up reflection of the introductory module. Medical students are divided into groups of three, with student A taking on the role of the standardized patient, student B as the interpreter, and student C as the interviewer. It is possible that groups can be more than three students, as long each student has a chance to rotate through each of the roles. Student A is equipped with the headphones of the Pocket Talker, while student B uses the microphone of the Pocket Talker to communicate with student A. Student C should wear a mask so that student A is unable to lip read. The use of the Pocket Talker with headphones is intended to be a rudimentary and limited method to simulate a language barrier, but even simple methods of simulation such as headphones to simulate hearing loss have been shown to positively impact learners' empathy towards patients[12]. The cases given ask student C to take a history from student A, with student B "interpreting". Student C will be given a short prompt while student A will be given the case with the necessary background information. The goal of the history-taking in this activity is to practically apply the skills needed to work with interpreters, rather than diagnosing and clinically managing the patient. Students will

not be expected to come up with a management plan for the cases. The facilitator's guide includes instructions about fostering a supportive learning environment and allowing opportunities for "time-outs" to be initiated by student C or the facilitator if student C becomes stuck during the interview. There will be built-in time after each interview for the facilitator and students to provide feedback, in addition to a longer debrief period at the end of the session with some accompanying discussion questions. These discussion questions are intended to solidify the students' reflections about their experiences in each of the roles and asks them to consider their experiences in their future clinical encounters.

Discussion

Most Canadian medical schools have a clinical practice skills course as part of the curriculum, and this session was modeled after existing clinical skills sessions with the intention of easy integration into current curriculum. Steps for implementation of this session would include finding space and time for the session (approximately two to three hours) during the academic calendar, recruiting facilitators to guide the session, and distributing the introductory modules and facilitator's guides to the students and facilitators, respectively, prior to the session. As outlined by the education tool objectives, the goals of this session are to provide medical students an early opportunity to practice their skills working with interpreters before they enter clinical practice, and to provoke reflection about the challenges faced both by LEP patients and the healthcare providers taking care of them. The hope is that this medical education tool will have positive implications on learners' confidence levels and competency working with interpreters to provide care to LEP patients.

There are several ways that “Working with Interpreters: A Medical Education Tool for Cross-Cultural Communication” can be evaluated. One evaluation tool that has been used in previous studies about simulation sessions is the Jefferson Scale of Physician Empathy (JSE), a questionnaire for healthcare providers that was designed to provide an objective measure of empathy in the patient care setting[12,20]. The JSE can be administered prior and after the session to measure the impact that the session had on empathy level among students. Learners’ competencies in working with interpreters can also be evaluated following implementation of this medical education tool. A sample skills checklist is included in Appendix 3. It would also be possible to evaluate this medical education tool through a randomized controlled trial (RCT). Suggested structure of this RCT would involve dividing medical students into two groups, one group that goes through the simulation session as described and the second group that only reviews the introductory module. The JSE can then be administered to compare differences in responses between the two groups. Alternatively, an additional OSCE-style session with standardized patients and interpreters instead of medical students in those roles can be organized so that medical students can be assessed on their competency in working with interpreters using a rubric.

Limitations

Although there are studies that have shown improved outcomes for medical learners who have curriculum about working with interpreters and studies that have shown that there is positive impact on empathy for medical learners who take on a patient role in simulation, no studies could be found that involves a simulation experience where medical learners are in a simulated LEP patient role. As a result, the evidence that this project’s medical

education tool is limited in that it is based on studies that have evidence supporting separate components of the tool rather than the tool as a whole. Another limitation is the inherent challenge of simulating an experience as complex and varied as the language barriers that LEP patients encounter. Use of the Pocket Talker headphones as a communication barrier is a tiny representation of the systematic and generational barriers that LEP patients face when navigating the healthcare system. Given this complexity and the chosen audience of third-year medical students, this tool also does not address how patient expectations of medical management can differ based on their cultural and social backgrounds. Collaborating with LEP patients to develop a management plan that respects their cultural beliefs towards health and is realistic in the setting of a resource-scarce healthcare system is a significant skill that is needed to work with LEP patients.

Conclusions

"Working with Interpreters: A Medical Education Tool for Cross-Cultural Communication" is a medical education tool consisting of a preceding introductory module and simulation-based cases. The goals of this tool are to develop competency in third-year medical students to work with interpreters and to foster an understanding and empathy for LEP patients navigating language barriers in the healthcare system. The tool is based on research about studies on the effectiveness of simulation learning, studies on the effectiveness of medical learners in a simulated patient role, and best practice guidelines for working with interpreters. This tool is limited by the lack of studies about medical learners in the simulated LEP patient role and the inherent difficulty of simulating the complex experiences of LEP patients. More research is needed in the medical education field about language barriers and cross-cultural communication. This project aims to

address this gap by reviewing existing literature, proposing a sample medical education tool, and ultimately bringing attention to the importance of adequate communication with LEP patients in healthcare.

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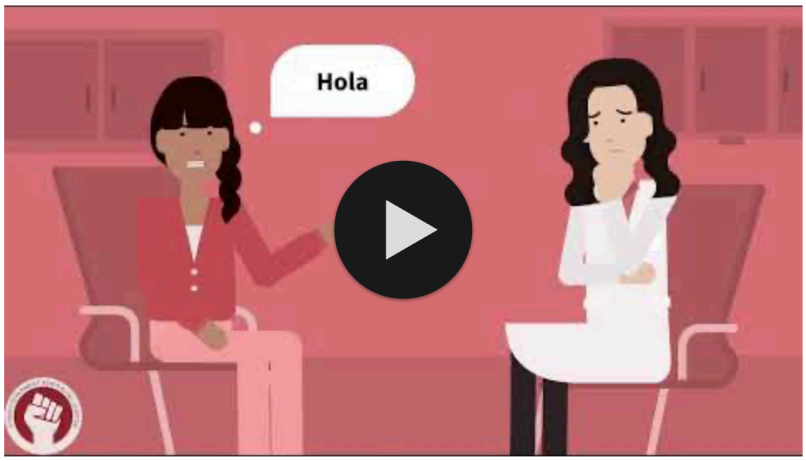
Appendix
Appendix 1

Working with Interpreters: A Medical Education Tool for Cross-Cultural Communication

Introductory Module

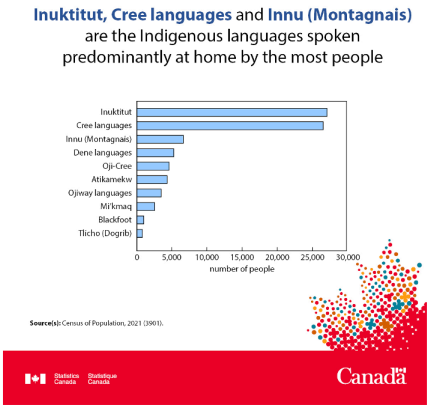
Introductory Video

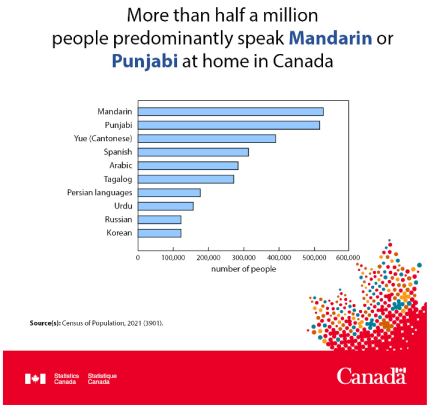
Stanford CME: Health Disparities for Patients with Limited-English Proficiency



Introduction

- In the 2021 Canadian census, 12.7% of Canadians (4.6 million people) primarily spoke a language other than English or French at home





Introduction

- Limited English Proficiency (LEP) is a barrier to navigating the health care system in Canada

- Why do language barriers matter?
  - Less likely to engage in surveillance screening
  - Higher rates of non-compliance
  - Lower rates of patient satisfaction

- Healthcare provider challenges
  - More time-consuming encounters
  - Decreased confidence about quality of care
  - Stress about meeting ethical standards

Working with Interpreters

- Using interpreters has been shown to improve communication, use of health services, clinical outcomes, and patient satisfaction

- Various forms of interpreting: in-person, telephone, video

- Family and friends should not replace professional interpreters
  - Lack fluency, particularly in medical terminology
  - May add or leave out important info
  - Emotional burden, conflict of interest

Working with Interpreters: Do's

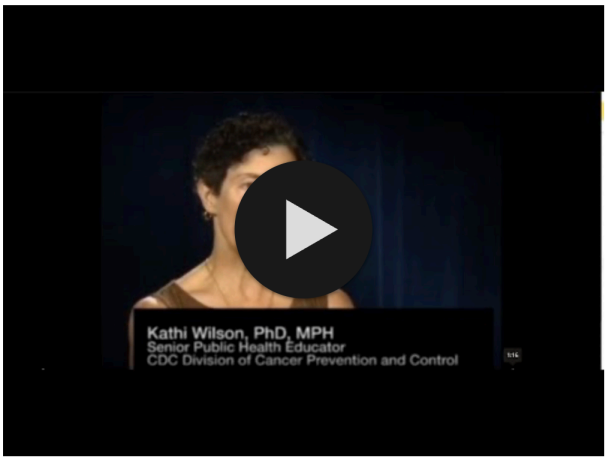
- Use clear, simple sentences
- Talk at your natural volume and pace
- Use proper nouns (e.g. "John said" rather than "he said")
- Make one point at a time and frequent pauses to allow time for interpreter to translate
- Always focus on the patient rather than the interpreter
- Position yourself so that you are visible to both the patient and the interpreter
- Use open-ended questions and the teach-back method
- Be patient

Working with Interpreters: Don’ts

- Avoid using jargon, slang, metaphors, etc.
- Avoid compound questions
- Avoid interrupting
- Avoid speaking privately with the interpreter

Cultural Humility Primer: Video

CDC: Culture and Language Affect Health Literacy



Cultural Humility Primer

- It is important to recognize that a patient's primary language, cultural background, and social context will affect their attitudes towards healthcare and the healthcare decisions they make for themselves

Mohammad Kochi's Story

Take the time to read through Mr. Kochi's story (pg. 6-12 in Worlds Apart) and watch the accompanying video

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Appendix 2

Session Objectives

1. Establish competency in working with LEP patients and interpreters among third-year medical students.
2. Provide the opportunity for third-year medical students to practice working with interpreters.
3. Develop an understanding of the challenges and barriers to health care faced by LEP patients.
4. Foster a deeper level of empathy and compassion through the simulation experience.

Facilitator Guide

- Begin the session by asking if anyone has a personal or clinical experience with an interpreter. Feel free to share your own experiences. Some discussion questions can include:
    - How do you think language barriers affect patients' access to healthcare? Health outcomes?
    - What are some challenges that you can think of that healthcare providers encounter when working with LEP patients?

- Review format of practical skills session:
    - Medical students will be divided into groups of 3, with student A as the standardized patient, student B as the interpreter, and student C as the interviewer
    - Each student will take turns rotating through the roles of patient, interpreter, and interviewer
    - Student A should be equipped with a Pocket Talker that Student B uses to communicate with them. Student C should wear a mask to avoid student A lip reading
    - Each student will have 20 min to take a history based on a short prompt, including time for time-outs that can be initiated by student C or facilitator if student C gets stuck
- Review session objectives. The focus of this session is to develop skills working with interpreters rather than learning the medical content in the cases. (See attached supplementary info for do's & don'ts of working with interpreters)
- Establish low stakes nature of the session. It can be helpful for learners to acknowledge the challenge and vulnerability of taking a history in front of others, but that mistakes are a natural part of learning
- Take 10 min after each interview to ask for feedback from the students acting as the interpreter and the patient and provide feedback for the student acting as the interviewer
- Take 20 min at the end of the session to ask the students to share their thoughts and feelings as the interviewer, interpreter, and patient during the case. Some debrief questions that can be used include:
    - What were some challenges as the interviewer?
    - How did it feel to be the patient in this scenario?
    - Is there anything you would do differently interacting with LEP patients after this session?

Supplementary Information

Working with Interpreters

Do's	Don'ts
• Use clear, simple sentences • Talk at your natural volume and pace • Use proper nouns (e.g. "John said" rather than "he said") • Make one point at a time and frequent pauses to allow time for interpreter to translate • Always focus on the patient rather than the interpreter • Position yourself so that you are visible to both the patient and the interpreter • Use open-ended questions and the teach-back method • Be patient	• Avoid using jargon, slang, metaphors, etc. • Avoid compound questions • Avoid interrupting • Avoid speaking privately with the interpreter

References:

Cultural Interpretation Services for Our Communities. Guide to Working with Interpreters. CISOC. Published December 2023. Accessed February 10, 2024. https://www.cisoc.net/_files/Guide_to_Working_with_Interpreters.pdf

Hadziabdic E, Hjelm K. Working with interpreters: Practical advice for use of an interpreter in Healthcare. *International Journal of Evidence-Based Healthcare*. 2013;11(1):69-76. doi:10.1111/1744-1609.12005

Case A: Eileen
Prompt: Eileen is a 40-year-old female who is coming in to see her family doctor about abdominal pain.

HPI:

- The abdominal pain has been going on for the past 6 months
- It is intermittent and lasts a few hours and will go away on its own
- It is located centrally in the upper abdomen. The pain feels like "burning"
- The pain is worse at night and after big meals. The pain is relieved with water.
- No diarrhea, constipation. She has occasional associated nausea but no episodes of vomiting. She has 1 BM per day and has not noticed any change in appearance, nor blood in her stool. She is passing flatus. No dysuria or increased urinary frequency.
- She has no bloating with the abdominal pain. No early satiety. No unintended weight loss, fever, fatigue, or night sweats.
- No recent changes to diet or medications.
- No chest pain, shortness of breath.
- Her menstrual cycles are regular. Her LMP was 2 weeks ago. She is currently taking OCP.

PMHx:

- Tonsillectomy in childhood

Meds:

- Lolo (OCP)

Allergies: None

Social:

- She lives with her husband (Tom) and 6-year-old daughter (Ella)
- She works as an accountant
- She does not smoke. She has 1 glass of wine per week. She drinks 2 cups of coffee per day. No recreational drug use.
- No known sick contacts or recent travel

FHx:

- No history of cancer in the family
- Both her parents have high blood pressure

Case B: John
Prompt: John is a 60-year-old male who is coming in to see his family doctor about his cough.

HPI:

- The cough has been going on for as long as he can remember
- He coughs up clear or yellow phlegm
- The cough is worse when he's sick with a cold.
- He has been feeling progressively more short of breath over the past year, especially with exercise.
- No chest pain. No dizziness/lightheadedness, loss of consciousness, leg swelling, or palpitations.

PMHx:

- Hypertension
- Dyslipidemia

Meds:

- He is on amlodipine 2.5 mg once daily and rosuvastatin 10 mg once daily

Allergies: None

Social:

- He lives with his wife (Jackie). He has 2 adult children.
- He retired 5 years ago as a cook.
- He has been smoking 1 pack of cigarettes per day since he was 20 years old. He drinks 4-5 beers once a week. No other recreational drug use.
- No known sick contacts or recent travel. He got 3 COVID vaccines but did not get his flu shot this year.

FHx:

- There is no significant family history

Case C: Lisa
Prompt: Lisa is a 30-year-old female coming into see her family doctor about her lower back pain.

HPI:

- She has been having this pain for the past year or so
- The pain is in her lower back and aching in nature. There is no radiation into her buttocks or legs.
- The pain is worse with movement and relieved with rest
- There is no numbness or paresthesias. No peripheral limb weakness. No saddle anesthesia, fecal incontinence, or urinary retention. No history of trauma. No fever, weight loss, or night sweats.

PMHx:

- Healthy

Meds:

- Occasional Tylenol and Advil for her back pain

Allergies: None

Social:

- She lives with her partner (Jordan)
- She works in childcare at a daycare
- She drinks 1-2 beers/ciders per week. She smokes a joint of marijuana once a month or so. She does not smoke cigarettes. No other recreational drug use.

FHx:

- There is no significant family history

Appendix 3

Working with Interpreters Rubric

Complete = 2 points Partially complete = 1 point Incomplete = 0 points

Positioned themselves visible to both patient and interpreter	/2
Introduced themselves	/2
Used clear, simple sentences	/2
Avoided compound questions	/2
Focused on patient rather than interpreter	/2
Avoided use of overly technical medical terms, slang, or jargon	/2
Did not interrupt the patient	/2
Demonstrated appropriate body language (i.e. nodding, eye contact with patient)	/2
Showed patience during the interview	/2