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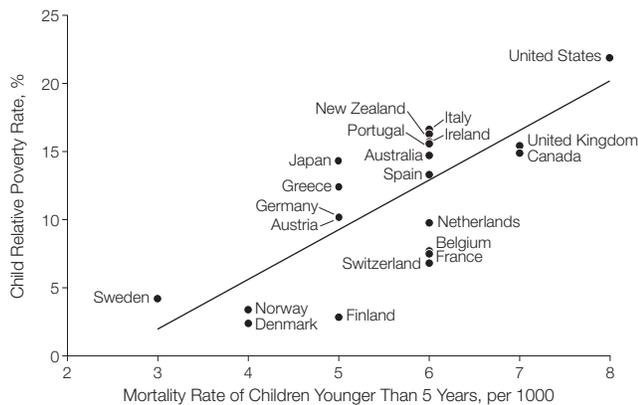
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Figure. Relationship Between Relative Child Poverty and Under Age 5 Mortality in High-Income OECD Countries



Child relative poverty rates were extracted from data reported in the 2005 United Nations Children’s Fund (UNICEF) report on child poverty in the world’s rich countries.¹² Child relative poverty was defined as having equalized household income (equalized by dividing total household income by the square root of the number of individuals living in the household) of less than 50% of the national median. Mortality rates of children younger than 5 years for the same period covered by the poverty estimates were extracted from data reported in the 2003 UNICEF report on the *State of the World’s Children*.¹³ Data are presented for all high-income Organisation for Economic and Co-operative Development (OECD) countries for which data were available in the 2 reports. Linear regression was used to estimate and plot the linear trend between relative child poverty and mortality rates of children younger than 5 years ($r^2=0.56$; relative child poverty = $-0.09 + 0.04 \times$ mortality in children younger than 5 years).

terminants of child relative poverty and many examples of successful approaches to reducing child relative poverty.^{4,12,14} Addressing these issues is not merely a matter for health professionals and health policy but centrally con-

cerns the willingness of the electorate in democracies to tolerate the existence of inequality and its effects.

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Describing Physician Language Fluency Deconstructing Medical Spanish

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LANGUAGE BARRIERS ARE INCREASINGLY IMPORTANT IN US health care. Limited English proficiency is associated with poorer health care processes and outcomes.¹ Disparities in care for patients with limited English proficiency persist even when socioeconomic and insurance status are considered, suggesting that language and culture also play an important role.² Accumulating research shows that having a language-concordant physician is associated with improved quality and outcomes.³⁻⁵ Using professional interpreters can also lead to better care for patients with limited English proficiency,⁶ but physicians and medical trainees underuse professional interpreters, fre-

quently substituting their own limited spoken Spanish during clinical encounters.⁷

Because many physicians who provide language-concordant care are not native speakers of Spanish, studies are needed to help understand the degree of fluency a clinician needs to provide high-quality, language-concordant communication. In addition, a more basic problem is the lack of consistency in describing and assessing physicians’ linguistic

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skills. Terms like “medical Spanish,” “conversational fluency,” and “semi-fluent” appear regularly in health professionals’ curricula vitae and residency training, credentialing, and job applications. The inconsistency in describing and assessing language skills represents an important but surmountable barrier to progress in improving clinical communication for patients with limited English proficiency.

Spanish is the most common non-English language spoken in the United States by patients as well as physicians.⁸ Although data are limited, it appears that most physicians who provide language-concordant care for Spanish-speaking patients are nonnative speakers.⁹ For such clinicians, weighing the pros and cons of providing language-concordant care against those of using a professional interpreter can be challenging. Schenker et al¹⁰ have described 4 main factors to consider when deciding how and when to use an interpreter in clinical settings: the accessibility of interpreter services, patient preferences, the clinical scenario, and the degree of “language gap” between patient and physician.

While some progress has been made in developing solutions to enhance the availability of professional interpreter services,¹¹ more research is needed to assess the degree of language gap between patient and physician. For example, questions remain regarding how aware clinicians are of their own language proficiency and how fluency should be assessed. Preliminary research suggesting that physicians and trainees are aware of their own linguistic skills^{3,12} needs to be confirmed in larger studies that define the types of scenarios involved, use standardized fluency assessments, and measure a variety of outcomes important to patients.

The fundamental problems of how to reliably describe and report physician fluency remain. Nonmedical fields appear to be more advanced in developing standardized descriptions of professional linguistic proficiency. For example, in the 1950s, after determining that most Foreign Service officers had inadequate fluency in their work-related languages, the Foreign Service Institute led the development and validation of a standard scale for language skills in speaking, listening, writing, and translating. The scale has been revised and validated by the Interagency Language Roundtable (ILR), an organization now comprising representatives from academia and from government and nongovernment organizations.

For speaking proficiency, the ILR scale includes 6 main levels with associated skill-level descriptions. Briefly, level 0 speakers have no communicative ability other than isolated words in the target language. Level 1 speakers can ask and answer uncomplicated questions about familiar topics but may need some repetition to understand. Level 2 speakers can give straightforward instructions but may use awkward or inaccurate phrasing. Level 3 speakers can communicate effectively in most social and professional situations but may have difficulty communicating some abstract topics. Level 4 speakers are near-fluent and are sensitive to cultural references but may have trouble with unusual dialects or slang. Level 5 speakers can communicate like native

speakers. Other organizations, such as the American Council on the Teaching of Foreign Languages, also have adapted the ILR scale for their own proficiency guidelines.¹³

The standardized ILR scale for describing second-language proficiency has not been widely adopted within health care, particularly for physicians. The lack of a consistent way to report fluency currently impedes the development of strategies to eliminate health care disparities, which could include matching patients with limited English proficiency to truly bilingual physicians. The term “medical Spanish,” an expression that commonly appears in the titles of phrase books and hospital-sponsored courses, is particularly problematic, since it combines the distinct constructs of general fluency in Spanish with knowledge of more specialized clinical phrases and vocabulary. General fluency can be thought of as encompassing several linguistic skills such as grammar, syntax, vocabulary, sentence structure complexity, ability to readily speak and understand the language, and ability to express ideas and correct miscommunications. In contrast, the “medical” portion of the term refers to specific knowledge of health-related vocabulary and phrases.

Enhancing general fluency in Spanish (eg, ability to understand complex statements or ask nuanced follow-up questions) is more complicated than acquiring knowledge of basic medical terms (eg, words for diseases and body parts or phrases allowing a physician to ask about symptoms). However, gaining facility with basic medically related vocabulary may be mistaken for enhanced general fluency. Evidence supporting this comes from studies demonstrating that brief, intense language training in groups of medical trainees with limited Spanish proficiency may lead to diminished use of interpreters as well as to significant communication errors.^{14,15} Physicians with low levels of general Spanish proficiency who develop “medical Spanish” skills are unlikely to be able to engage in health communication that requires linguistic nuance, such as clarifying understanding or engaging in shared decision-making. Failure to distinguish between the constructs implicit in the phrase “medical Spanish” leads to confusion and ultimately to poorer care for patients with limited English proficiency.

Health care organizations, educational institutions, researchers, and clinicians should adopt a standard like the ILR scale for reporting and measuring fluency levels for non-English languages. The ILR scale is already widely used and could become the basis for establishing a standard of fluency reporting for physicians to provide language-concordant care.¹³ These assessments, whether self-reported or ascertained through formal testing, should refer to general speaking fluency. Experience or skill using second languages in medical settings should be described separately from assessment of general fluency. Even without developing policies for fluency testing, health care organizations could take the initial step of requiring physicians to use the ILR scale rather than their own words to describe their language proficiency.

As reporting of fluency becomes more consistent, the next steps in policy and research would become more apparent.

Policies guiding care provided by physicians at the extremes of language proficiency should be relatively straightforward. Since physicians with low-level general fluency (ILR 0-1) are unlikely to provide effective clinical communication without a professional interpreter, standards set by regulatory organizations could require that these physicians document interpreter use at least for key clinical encounters, such as admission to the hospital, initial emergency department encounters, obtaining informed consent for procedures, and providing discharge instructions. Similarly, since physicians with fluency in the ILR 4 to 5 range can provide language-concordant care that makes interpreter use unnecessary, such policies would not be relevant for them.

Decisions and policies about providing language-concordant care are more challenging for clinicians in the middle of the proficiency spectrum (eg, ILR 2-3). In this area, research studies should characterize the relationship between fluency level (self-assessed and measured) and ability to communicate clinically in different scenarios and communication domains. Such research also would need to consider the potential incentives for overstating or understating Spanish-language skills. Until this research is conducted, physicians in the middle range of proficiency, who might be able to provide competent language-concordant care in some settings but not others, should use judgment and consider factors such as specific resources, scenario, and patient preferences.¹⁰

Adopting a consistent way of describing fluency should also lead to progress in the area of fluency testing. Currently, more than 30 different commercial tests are available for measuring language fluency; most can be mapped to the ILR scale.¹¹ Formal testing of physicians who report having high-level (ILR 4-5) Spanish fluency is probably unnecessary or could be obviated by having a professional interpreter converse with the clinician. If resources are available for fluency testing, they should be directed primarily toward clinicians who rate their proficiency in the middle of the range (ie, those reporting ILR 2-3-level fluency) who intend to provide language-concordant care. From a health care organization's perspective, a major benefit of testing would be to ensure that a clinician's fluency is not significantly lower than the self-reported level, thus necessitating implementation of policies on interpreter use and documentation. Also, institutions could benefit from identifying physicians who test at a higher level of fluency (ILR 4-5) than their self-assessment and who therefore can provide language-concordant care. Institutions should also encourage physicians who want an accurate appraisal of their own fluency to take a voluntary formal test of oral proficiency.

Although a uniform scale for describing fluency should be adopted, initial policies probably should stop short of setting highly explicit competence standards for providing language-concordant care (except at the extremes of the fluency spectrum) until more studies can provide insight into the language-skill levels required to provide safe, quality health care in various clinical scenarios. As understanding

of these proficiency levels evolves, more precise guidelines can be developed to help physicians, clinical leaders, and policy makers formulate evidence-based decisions about language-concordant care.

In summary, educational institutions, researchers, and health care organizations should avoid using fluency descriptions that have not been standardized. Use of ambiguous terms, such as "medical Spanish," offer little information about linguistic skills and impede progress in research and policy development for the provision of health care to a US population with increasing linguistic diversity. Moving to a consistent way of describing linguistic proficiency could ensure higher-quality health communication for patients with limited English proficiency.

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