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Language and Health Equity during COVID-19: Lessons and Opportunities

Pilar Ortega[1,2], **Glenn Martínez**[3], **Lisa Diamond**[4]

[1.]Department of Emergency Medicine, University of Illinois College of Medicine, Chicago, IL

[2.]Department of Medical Education, University of Illinois College of Medicine, Chicago, IL

[3.]Department of Spanish and Portuguese, Ohio State University, Columbus, OH

[4.]Immigrant Health and Cancer Disparities, Department of Psychology and Behavioral Sciences, Memorial Sloan Kettering Cancer Center, New York, NY

Abstract

Racial and ethnic health inequities have been magnified during the coronavirus disease 2019 (COVID-19) pandemic. Linguistic barriers are a recognized source of health inequities for ethnic minority communities whose health communication needs cannot be adequately met in the majority language. Emergency circumstances, such as respiratory distress and end-of-life care, carry elevated risk of medical error due to miscommunication and are increasingly common during the current pandemic. We have identified three key opportunities to improve health equity for linguistic minority populations as a result of the COVID-19 public health crisis: patient and clinician language data collection in health systems, linguistically and culturally appropriate public health messaging, and health care workforce communication skills education.

Keywords

Language concordance; limited English proficiency; LEP; patient-physician communication; COVID-19; health disparities

Significant racial and ethnic disparities in coronavirus disease 2019 (COVID-19) infection rates and clinical outcomes have recently emerged in the United States.[1–2] Linguistic barriers are a significant contributor to COVID-19-related health disparities in racial/ethnic minority communities whose health communication needs cannot be adequately met in English.[3–4] Eighty percent of the 25.1 million people with limited English proficiency (LEP) in the U.S. comprises speakers of five languages: Spanish (64%) followed by Chinese, Vietnamese, Korean, and Tagalog.[5] The Hispanic/Latinx community—a group in which 44% of Spanish speakers also have LEP[5]—accounts for a disproportionately large percentage of COVID-19 deaths in New York and hospitalization rates in Boston.[3,6] In Illinois, Latinos represent the largest number of confirmed positive COVID-19 cases in the state despite being undertested compared with other groups.[7]

Corresponding Author: Pilar Ortega, MD, University of Illinois at Chicago, College of Medicine, 808 S. Wood St., Suite 990, Chicago, IL 60612, portega1@uic.edu, Phone: 312-996-4463.

Emergency health communication, such as during respiratory distress or at the end of life, is associated with elevated risk of medical error due to miscommunication.[8] Since the COVID-19 pandemic has rapidly increased the frequency and number of these circumstances, it has magnified the lack of health system preparedness for meeting the needs of linguistic minority populations. Weaknesses in health system preparedness, however, provide an unparalleled opportunity for learning. We have identified three key opportunities to improve health equity for LEP populations as a result of the COVID-19 public health crisis: patient and clinician language data collection in health systems, linguistically and culturally appropriate public health messaging, and health care workforce communication skills education.

Language Data Collection in Health Services

Health care organizations in the U.S. are federally mandated to provide language-appropriate health services to patients of any language preference.[9] Strategies to provide such services include hiring qualified bilingual staff and using medical interpreters.[10] Language-concordant care delivered by a competent bilingual provider is superior to interpreter-mediated care,[11] but language competencies for clinicians are not systematically assessed or reported.[12] Moreover, despite federal mandates for the collection of race, ethnicity, ancestry, and language (R/E/A/L) data, patient language preference is not consistently or accurately recorded.[12–13] Further, race alone does not sufficiently characterize individuals of Hispanic/Latinx ethnicity—who may be of any race, or persons who self-identify as Asian—a term that encompasses many distinct nationalities and languages. Without reliable R/E/A/L data or information about clinicians' language proficiencies, it is difficult to study the impact of these variables on patient outcomes. More accurate reporting has the potential to improve language-concordant pairing of patients and clinicians in telehealth visits, which could serve to bridge prior geographic inaccessibility in communities of need.

When language abilities of patients and clinicians are not consistently collected, it is difficult for health professionals or health systems to adequately prepare to care for individual patients with LEP. Although professional medical interpreters are recommended when a language-concordant provider is unavailable, data show that clinicians often resort to less accurate alternatives, (e.g., Google Translate, untrained family members or staff, or their own limited language skills) due to convenience, urgency, or lack of knowledge.[14–15] The COVID-19 pandemic has led to increased patient volume, decreased clinician and onsite interpreter staffing, and abridged duration of medical encounters.[16] Patients with LEP and the clinicians caring for them face unique challenges in these circumstances, since communication in language-discordant scenarios requires more time and relies heavily on nonverbal cues that may now be hidden behind screens or personal protective equipment.[3]

While remote-access professional interpreting systems, including telephone and video, currently exist, technological challenges, delays, and inaccessibility remain significant barriers to their regular use by hospital staff who, especially under urgent high-volume circumstances, may feel forced to "get by" with their own limited skills or with untrained individuals who are immediately available.[17] Some hospitals seeing large numbers of COVID-19 patients have requested community members to volunteer as interpreters,

sometimes announcing that no prior experience or training is necessary for these roles—an approach that further threatens patient/interpreter safety and communication accuracy in an already medically and psychologically challenging environment. We propose that accurate and consistent collection of language data about clinicians and patients be enforced in order to facilitate health system preparedness and accountability to meet the communication needs of patients with LEP who are particularly vulnerable to poor health outcomes during limited-resource crisis situations.

Linguistically and Culturally Appropriate Public Health Messaging

Public health messaging about pandemic-related recommendations or requirements such as sheltering in place, quarantine, and wearing facemasks must be culturally and linguistically adapted. Delayed, inaccurate, poorly translated, or limited messaging to these groups may result in magnified health disparities due to unmitigated risk of viral transmission in subsets of the community that already suffer from reduced access to care. For example, a disproportionate burden of disease in the Hispanic/Latinx community during the initial years of the AIDS epidemic has been attributed to knowledge gaps regarding disease transmission and the spread of misconceptions about the disease.[18] In the COVID-19 pandemic, this community already has increased risk of viral exposure due to their over-representation as essential workers in agricultural and food supply sectors and housing circumstances, which may not permit compliance with quarantine recommendations.[3,6]

Individuals with decreased access to language-concordant care typically also have poor access to public health information from the internet, newspapers, magazines, or community organizations,[19] making culturally and linguistically-appropriate public health messaging particularly critical. Older Hispanic/Latinx adults, who are more likely to have LEP and are at greater risk of poor outcomes from COVID-19, are also less likely and less willing to use technology (e.g., phone calls, text messages, social media, and patient portals) for health information or management purposes compared with other groups.[20] The effectiveness of urgent public health messaging strategies in linguistic minority communities should be further studied in order to plan future efforts to reduce the spread and burden of disease, to increase appropriate access to care (including telehealth and language services, when indicated), and to address specific community needs (e.g., living conditions, job loss, and immigration concerns). Public health messaging to these groups cannot simply be literal translations of dominant-language messages but must address the social determinants of health that affect access to care and health outcomes, the force of which increases under pandemic conditions. We propose that public health departments, health systems, and health policy leaders collaborate with community organizations, patients, and clinicians, to ensure that public health communications are inclusive of the social, cultural, and linguistic realities of minority populations.

Health Care Workforce Communication Skills Education

Incorporating language skills in clinical education programs for the U.S. health care workforce—including medical schools and other health professions programs—has been proposed as an important strategy for improving language-concordant care and health

equity for linguistic minorities.[12,15] Language skills education includes dedicated medical language courses, such as medical Spanish, to teach clinicians independent and competent provision of direct patient care in the target language and to impart understanding of their limitations.[21] Moreover, global linguistic competencies and cultural humility are critical communication skills recommended for all clinicians, regardless of non-English language abilities, in order to teach health professionals best practices in caring for linguistic minority patients, such as working with medical interpreters, respecting cultural approaches to health and illness, and addressing sociocultural barriers to medical care.[22]

The COVID-19 pandemic has significantly disrupted medical and health professions education in general.[23] While medical educators are forced to transform pedagogy to virtual platforms and consider new ways of teaching and assessment of clinical skills, this challenge also presents the opportunity to rethink courses that can make an impact in improving health equity for diverse populations. For example, medical Spanish courses have been increasingly incorporated into medical school curricula due to student demand, trends in patient demographic characteristics, and as strategies to address equitably the Liaison Committee on Medical Education's communication skills and cultural competence standards.[12,22] Practicing medical language and cultural skills in an interactive, live virtual classroom that includes role play activities may present a unique opportunity to prepare future health professionals to communicate competently in a telehealth environment with patients with LEP. We propose that medical schools and other health professions programs implement and evaluate educational approaches—including virtual strategies—to teach and assess the linguistic and cultural communication skills of medical students and other clinicians as a strategy to improve language-concordant and culturally appropriate care for minorities both during and after the pandemic.

Conclusions

The COVID-19 pandemic has exposed significant, urgent, and life-threatening unmet health communication needs in linguistic minority communities. Working collaboratively on the collection of patient and clinician language data, the improvement of linguistically and culturally appropriate public health messaging, and the increase of effective health care workforce communication skills education will help us to heed the lessons of the current crisis. Most importantly, these opportunities have the potential to create a long-lasting impact in health care and medical education systems and to improve health equity for vulnerable linguistic minority communities well beyond the current pandemic.

List of Abbreviations

AIDS	Acquired immunodeficiency syndrome
COVID-19	Coronavirus disease 2019
LEP	Limited English proficiency
R/E/A/L	Race, ethnicity, ancestry, and language
U.S.	United States

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