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Monolingual and Multilingual HCWs Perceived Discussions and Communication Strategies with Patients

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Abstract

In a study conducted across clinics and hospitals in St. Louis during COVID-19, healthcare workers (HCWs) perceived language/communication barriers with language diverse patients (LDPs) at the onset of the COVID-19 pandemic, and this challenge did not improve over time [1]. In an attempt to continue to address health disparities, the present study uses a subset of data and takes a closer look at demographic factors within the group of HCWs in order to examine whether HCWs' linguistic characteristics (being monolingual or multilingual) matter in perceived communication with all patients and specifically with LDPs, and it specifically examines strategies and techniques used in oral discussions [1]. Overall, findings revealed no reported differences between multilingual and monolingual HCWs in perceived language barriers, with both groups agreeing that these challenges did exist. Specifically, though, multilingual HCWs reported more effective communication and patient understanding in their care discussions with LDPs than the monolingual HCWs. Regarding specific techniques and strategies used for communication with all patients, multilingual HCWs reported higher ratings for LDPs asking questions for clarification as well as their own ability to modify language for better understanding than did their monolingual counterparts. Multilingual HCWs perceived that their patients were better able to repeat back their understanding of both their diagnosis and treatment plan than did the monolingual HCWs. Interestingly, while multilingual HCWs were less likely to report having received training on communication with patients, both groups indicated that they would like further training. Additionally, multilingual HCWs showed more interest than their monolingual counterparts in receiving ongoing

information about how their facility communicates with LDPs. These findings imply the need for increased training and discussion/engagement for HCWs surrounding their communications with all patients, especially LDPs, to maximize/ensure patient understanding in patient/HCW discussions.

Keywords: Communication Strategies; Health Disparities; Language; Language Diverse Patients

Introduction and Literature Review

Nutbeam categorized three dimensions of health literacy (HL) that focus exclusively on the patient: functional health literacy (which describes basic tasks to function, like reading a food label and telling the time for an appointment), interactive health literacy (which includes the skills needed to interact with and understand a healthcare provider, like listening skills and being able to respond to the doctor), and critical health literacy (which covers the skills needed to analyze the health information being presented and use it to maintain control of the situation to get to the outcomes you want, including the idea of being a self-advocate in the health setting) [2]. In all three dimensions of HL, the role of the HCW seems left out of the equation, and clearly there is a dearth in the literature that addresses language differences within groups of HCWs. Since 2000, when the President of the USA signed the Executive Order 13166, healthcare systems in the USA have had a legal responsibility to provide care to all patients in a language that they understand. More specifically, "the Executive Order requires Federal agencies to examine the services they provide, identify any need for services to those with limited English proficiency (LEP), and develop and implement a system to provide those services so LEP persons can have meaningful access to them." One method of attending to the language barriers is to provide language-concordant care, where the patient and physician speak the same language. The lack of multilingual providers, however, who speak the same language as their patients, continues to be an issue, and this may not change any time soon [3]. In the absence of language-concordant care, many hospitals and clinics provide interpretation services, but sadly, it appears that residents are ill-equipped with the necessary skills to utilize language services to communicate with patients. This underutilization of resources can impact patient safety and lead to the formation of career-long habits that normalize linguistically inappropriate care [4].

Challenges with communication due to language and cultural differences between HCWs and patients are well documented, and as recently as 2018, HCWs admit that in the USA the clinical care provided to patients with limited English abilities is different than the care given to English-speaking patients [5]. With the implementation of the curriculum content standards for medical students set forth by the national Liaison Committee on Medical Education (LCME), it is expected that communication skills and cultural competence are part of all medical school training. It is well documented that language-appropriate care improves healthcare communication, utilization, and outcomes [6]. Linguistically and culturally appropriate communication is integral to the effective exchange of information. Given the lack of language-concordant care along with the underutilization of interpreters, the present study attempts to examine whether multilingual healthcare providers, even when they may not speak the same language as the patient, differ in their communication styles and strategies as compared to their monolingual counterparts.

The Present Study

The present study utilizes a subset of data from Brantmeier et al [1]. Brantmeier et al revealed important findings about specific strategies that HCWs utilize in communications with patients about COVID-19 [1]. For example, the 'teach-back' technique had significant higher use with language diverse patients (LDPs) one year into the pandemic than at the onset, but the magnitude of the change was small, with still a minority of healthcare workers giving high ratings for asking patients and clients from language diverse groups to repeat back their treatment plan to confirm understanding. On the other hand, healthcare workers did not give high ratings at either time point for the item "patients from language diverse groups asked questions for clarifica-

tion." Additionally, findings indicated that patients did not repeat back to confirm understanding of both diagnosis and treatment plans at either time. Results also showed that 62% of the HCWs had received training on how to communicate with language minority patients, and 69% said they would like to learn more specific strategies for communication with language minority groups.

Research Questions

The following research questions guide the present study:

- Does the HCW's linguistic characteristic (being monolingual or multilingual) matter with perceived language barriers with their patients? Do HCWs think patients are satisfied with their discussions?
- Are there differences between monolingual and multilingual HCWs' use of techniques and strategies for discussions with LDPs? (i.e.: HCW modifies language, patients ask questions)
- Are there differences between monolingual and multilingual HCWs' use of the teach-back technique for diagnosis and treatment plan with all patients?
- Have both monolingual and multilingual HCWs received training on communication in the past? Are they interested in continued training?

Methodology

The 72-item online survey, entitled Self-Assessment Health Communications (SAHC), was developed and validated by scholars in Applied Linguistics and Psychology as well as HCWs presently active in the profession [1]. The survey took 10-12 minutes to complete, and for the present study, only items that examined oral communication and training of HCWs were included. Demographic information included age, gender, race, ethnicity, profession, division, and use of languages other than English at home. During a time period of 6 weeks, the survey was sent out electronically to respondents by division heads and administrative assistants, approximately one year after the onset of the COVID-19 pandemic. With IRB approval, the letter inviting HCWs to participate explained that the results would be used for research purposes and would inform the development of communication trainings. Participants reported their current experiences and then were asked to recall what it was like at the onset of the pandemic. The survey was initially sent out without offer of compensation, and three weeks after dissemination, a $10 gift card incentive was added to increase participation.

Participants

For the present study, 338 respondents from the St. Louis region completed the entire survey and were included in the analysis (278 women, 59 men, and 1 prefer not to say). Ages for all respondents ranged from 18 to 75 years and older. The largest responding groups consisted of the following: 158 registered nurses, 56 staff nurses, 43 resident/fellow physicians, 31 other, and 27 attending physicians. The largest groups responding came from Pediatrics (127 respondents), Other (114 respondents), Internal Medicine (67 respondents), Intensive Care (42 respondents), Emergency Medicine (23 respondents), and Medical Oncology (21 respondents). Of the total participants in the study, 41 reported speaking languages other than English outside of work. For the purposes of this article, these participants are labeled "multilingual" and their counterparts, who do not speak languages other than English outside of work, are labeled "monolingual."

Results

RQ1: Are there differences between monolingual and multilingual HCWs' perceived language barriers with their LDPs? Do HCWs think patients are satisfied with their discussions?

As depicted in Figure 1 below, monolingual and multilingual HCWs did not report strong agreement or disagreement about experiencing language barriers with LDPs, and this rating did not change over time. Overall, both groups agree that language barriers do exist.

However, as illustrated in Figure 2, for the item that focused on LDP satisfaction with discussions, there is a significant effect of time, of HCW language use outside of English, and a marginally significant interaction. More specifically, all HCWs felt their LDPs were more satisfied with their discussions at the end of the study than at the onset of the pandemic ($p < 05$). In looking at differences by HCW group, multilingual HCWs perceived more satisfaction with their patient care discussions than the monolingual HCWs, and this difference was statistically significant ($p < .05$). For both groups, the difference in perceived satisfaction with LDP/HCW discussions was greater at the end of the study than at the onset of the pandemic. There is a marginally significant interaction between the effect of time and foreign language use ($p=0.058$).

RQ2: Are there differences between monolingual and multilingual HCWs' use of techniques and strategies for discussions with LDPs? (i.e.: patients ask questions, HCW modifies language, HCW uses teach-back, etc.).

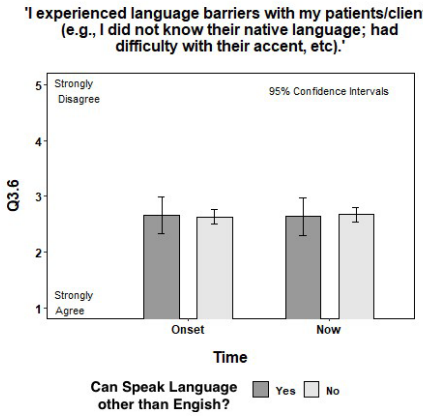

Figure 1

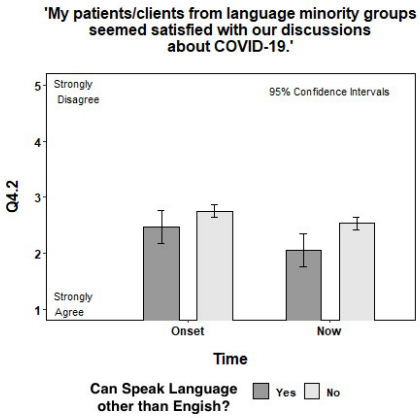

Figure 2

In the present study, as illustrated below in Figure 3, when examining differences between monolingual and multilingual HCWs, there was a significant effect of time and marginally significant effects for language use and interaction with LDPs. Overall, HCWs report being asked more questions about COVID-19 at the end of the study than at the onset of the pandemic ($p < .05$). The marginally significant effects indicate that this was more the case for multilingual HCWs than their monolingual counterparts.

With regard to the communication strategy of modifying language during discussion with LDPs, as illustrated below in Figure 4, there is a significant effect of time and HCW multilingualism/monolingualism. When looking at the groups together, HCWs' ability to modify their language to be understood by patients was better at the end of the study than at the outset of the pandemic; however, multilingual HCWs felt they were better able to modify their language for enhanced understanding compared to the monolingual HCWs. The observed differences between monolingual and multilingual HCWs were statistically significant ($p<0.05$).

RQ3: Are there differences between monolingual and multilingual HCWs' use of the teach-back technique for diagnosis and treatment plan with all patients?

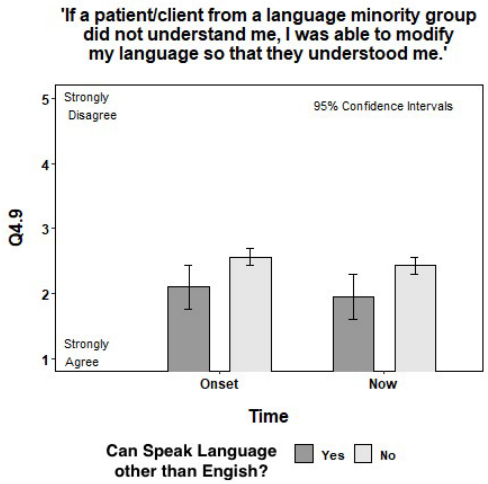

Figure 3

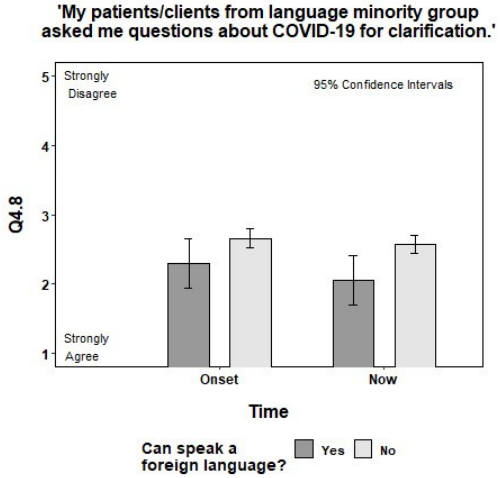

Figure 4

Figure 5, below, shows a significant main effect of time and HCW monolingualism/multilingualism for the teach-back technique, where patients repeat back to HCWs in order to confirm an understanding of the diagnosis. The patient's ability to repeat back the diagnosis was perceived to be better at the end of the study than at the outset of the pandemic, and when looking at differences between the groups, multilingual HCWs indicated that their patients were better able to repeat back their understanding of their diagnosis; this difference was statistically significant ($p<0.05$).

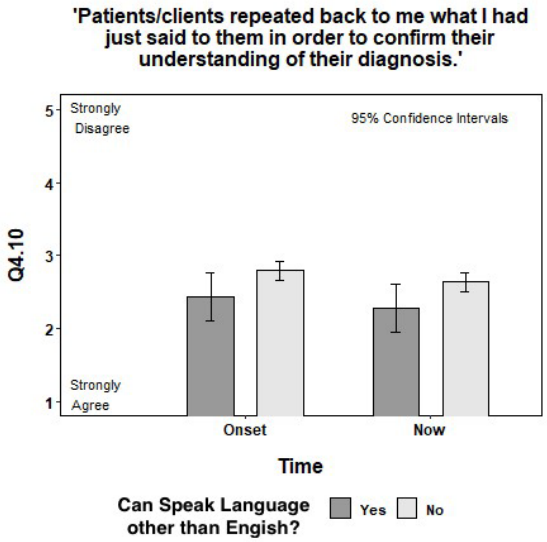

Figure 5

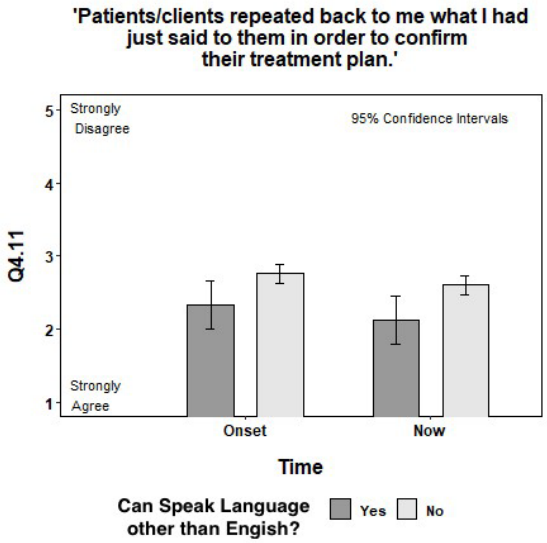

Figure 6

Figure 6 shows a significant main effect of time and of foreign language experience for the survey item about the teach-back strategy for confirming the treatment plan. More specifically, the ability of patients to repeat back their understanding of their treatment plans was perceived to be better at the end of the study than at the onset of the pandemic. Multilingual HCWs perceived their patients were better able to repeat back their understanding of their treatment plan than did the monolingual HCWs. this finding was statistically significant ($p<0.05$).

RQ4: Have HCWs received training on communicating with LDPs in the past? Are they interested in continued training?

As shown in Figure 7 below, HCWs who could speak a foreign language were less likely to report having received professional training on how to communicate with language minority patients. This observed difference between monolingual and multilin gual HCWs is statistically significant ($p<0.05$).

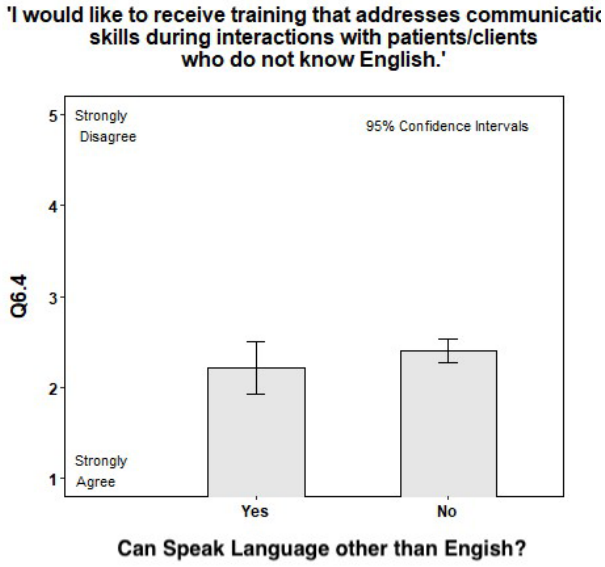

Figure 7

Figure 8 illustrates that foreign language experience did not have a significant impact on HCWs' beliefs regarding the need for formal training to improve communication with LDPs.

Figure 9, below, indicates that foreign language experience did not have a significant effect on HCWs' desires for additional training focused on communication skills when interacting with patients who do not know English.

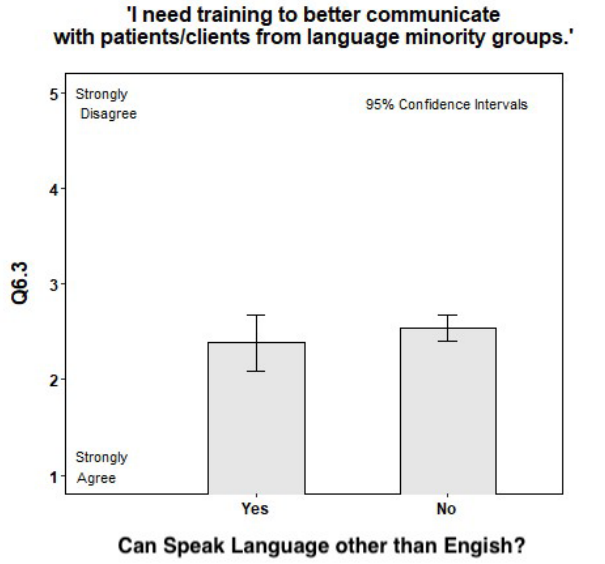

Figure 8

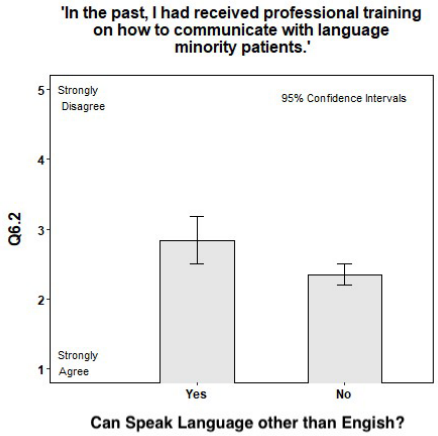

Figure 9

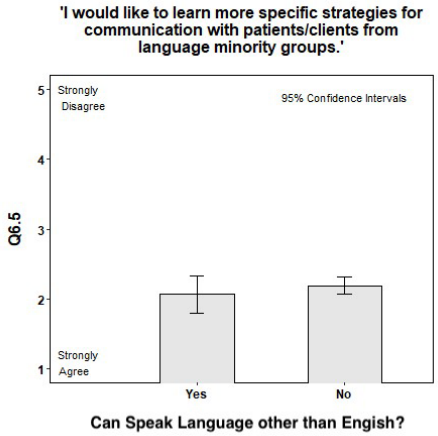

Figure 10

Figure 10 shows that foreign language experience had no significant effect on HCWs' desires to learn more targeted communication strategies for communicating with patients from language minority groups.

The data in Figure 11 below demonstrates that HCWs with foreign language experience were more likely to express a desire for ongoing updates on how their facility is communicating about COVID-19 to minority language groups. This observed difference between monolingual and multilingual HCWs is statistically significant ($p<0.05$).

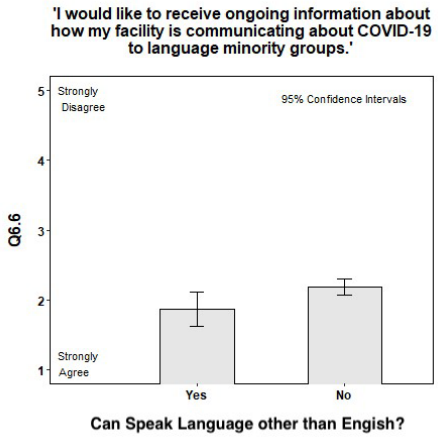

Figure 11

Discussion

Perceived Language Barriers with LDPs

Al Shamsi et al focus on the consequences of poor communication and report that both medical providers and patients claim language barriers are the reason for reduced satisfaction with the quality of healthcare delivery [7]. Clearly, language barriers in healthcare continue to be a challenge throughout the USA. Overall, in the present study both multilingual and monolingual HCWs agree that language barriers with patients did exist. It is important to note that multilingual HCWs reported more effective communication and patient understanding in their care discussions with LDPs than the monolingual HCWs. This contrasts recent work by Nissen et al who reported that both bilingual and monolingual HCWs communicated effectively with their patients [8]. Their study specifically addressed language-concordant versus language-discordant care when expressing uncertainty. The present study did not address the specific situations regarding language-concordant care.

Monolingual and Multilingual HCW Discussions with LDPs

Culturally competent communication is key to ensure that health messages are adequately conveyed to patients [8,9]. Diamond specifically contends that physician demographics should try to reflect the language use of the communities that are being cared for [9]. In a study with Spanish speaking patients, for example, patients with language concordant care providers reported greater patient satisfaction and asked more questions than their non-language concordant counterparts [10]. Furthermore, Narayanan et al report that overall, multilingual care providers felt more comfortable communicating with culturally and linguistically diverse patients than did their monolingual counterparts [11]. The present study did not specifically address comfort levels of HCWs, but with regard to specific techniques and strategies used for communication with all patients, multilingual HCWs reported higher ratings for LDPs asking questions for clarification as well as their own ability to modify language for better understanding than did their monolingual counterparts. The ability to adapt communication to increase understanding, by modifying or simplifying language, in the absence of language concordant care, is integral.

Monolingual and Multilingual HCWs' Use of the Teach-back Technique with all Patients

HCWs should ensure the health information conveyed is clearly understood by all patients, with both the diagnosis and treatment plan. Studies have emphasized the effectiveness of teach-back methods in patient education and the improved outcomes when using this strategy with patient-centered communication [12] With the use of the Teach-Back Technique, HCWs are advised to carefully check their patients' understanding by asking them to repeat back important messages, especially about the diagnosis and treatment plan, and to avoid using epistemic expressions (e.g., "probably") where possible. In the present study, multilingual HCWs perceived that their patients were better able to repeat back their understanding of both their diagnosis and treatment plan than did the monolingual HCWs. This is not surprising given that the multilingual HCWs also reported higher ratings for their ability to modify speech during their interactions with all patients. With modified input, patients may be better able to clarify their understanding when they repeat back the diagnosis and treatment. A future study should directly examine the techniques multilingual HCWs use for simplifying their oral discourse and investigate whether this modified input enhances the patient's ability to teach back both the diagnosis and treatment for all patients with low health literacy.

HCWs' Prior and Continued Communications Training

In the present study, while multilingual HCWs were less likely to report having received training on communication with patients, both groups indicated that they would like further training. Current studies have highlighted the need for more comprehensive training programs to enhance effective communication skills among HCWs. Recently, Ahrens et al emphasize that HCWs need to receive communication training in cultural competency, cultural humility, and how to work with medical interpreters [13]. Similarly, Dube et al suggest practical strategies, such as confirming mutual understanding between clinicians and

patients, to ensure clear communication [14]. Interestingly, the findings from the present study also revealed that multilingual HCWs showed a stronger interest than their monolingual counterparts in receiving ongoing updates about how their facility communicates with LDPs, particularly regarding the COVID-19 pandemic. The overall findings for items about training suggests that multilingual HCWs may better understand the nuances of communication with language minority patients, despite reporting less formal training. Additionally, effective communication with LDPs goes beyond in-person verbal consultations, extending to print materials that patients take home to read and online resources. In addition to effective verbal communication, clear print and digital information play a key role in ensuring minority language populations are adequately informed and engaged in their healthcare.

Limitations and Directions for Future Research and Conclusion

An important limitation of the present study is that respondents were asked to recall perceptions from one year ago, which may lead to memory bias. Additionally, self-report bias may also play a role in the present findings. A future study could explore HCWs' confidence levels when interacting with patients who speak languages other than English, as well as assess their familiarity with specific concepts related to multilingualism, such as code-switching, culture shock, language transfer, false cognates, etc. Culturally and linguistically responsive practices should encourage self-reflection of current communication strategies with all patients. This reflective process could serve as a catalyst, motivating healthcare practitioners to expand their knowledge base about effective communications with all patients.

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