Author’s response to reviews

Title: The Power of Language-Concordant Care: A Call to Action for Medical Schools

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Responses to Reviewer Comments

Editor Comments

Both reviewers were positive about this paper and I agree that it has the potential to be an important contribution to the area of language concordance in health. However, as it currently stands, it does not meet this potential and I ask you to carefully address all points raised by both Reviewers.

Response: Thank you for the opportunity to revise this manuscript. Please find our responses to the reviewers’ comments below.

Indeed, I think they both are making a similar comment in that there is a narrowness in the current manuscript that needs to be addressed. Both Reviewers make this explicit. With this in mind I think the authors should broaden the paper’s perspective and discuss challenges faced by medical schools with respect to language concordance. Similarly I ask the authors to take particular note of the way they define concordance and also to refer to the Segalowitz and Kehayia (2011) paper.

Response: Thank you for this feedback. We have incorporated edits to better frame this paper as relevant globally with examples from non-U.S. countries. We have also included the definition of language concordance from Segalowitz and Kehayia (2011) in the second paragraph. We added challenges specifically about addressing the complexity of language concordance, including linguistic proficiency, health literacy and other aspects of communication on page 11.

I also feel that Reviewer 1’s comments around what language the physicians actually used in the interactions needs to be clearer than it currently is (P8/139). Please clarify whether the physicians spoke in “shared L1 and if they physicians were trained in English or in their L1.
I also think that Reviewer 1 raises an important issue about how competent a speaker actually has to be in L2. Please take particular note of this point and explain.

Response: The definitions of language-concordant and language-discordant physicians in the cited study have been added.

Reviewer 1

Review: The Power of Language-Concordant Care: A Call to Action for Medical Schools
Molina, R.L., & Kasper, J. I enjoyed reading this manuscript and agree that a call to action is needed. However, given the title I was surprised by the manuscript's somewhat narrow focus on the US and its medical schools, including in much of the literature that was reviewed. I believe this topic requires a more comprehensive survey of the literature.

Response: Thank you for this comment. We have added several references, as suggested by the reviewers, to reflect the global literature. Because this was submitted as a Debate article, it is not intended to be a systematic review of the literature on this topic. We chose to focus on the U.S. literature because of its linguistic diversity and to spark debate and conversations rather than describe all efforts around language-concordant care globally. Our hope is that faculty from other medical schools around the world would share their expertise and experience on this topic. We mention this framing on page 6: “While this debate focuses on literature in the U.S., the challenge of language concordance in clinical care is relevant around the world.”

Language concordant care is challenging: how do we best provide language concordant care to the many more patients worldwide? The call to action is for medical schools to increase their training in a second (other) language (L2) but there is little acknowledgement of the difficulties inherent in such an approach. That is not to say it should not be done, however this article would be stronger if it also outlined what the challenges are and set out a possible (and feasible) approach for medical schools. I have suggested a few references that may help with this. Also, there was no mention of foreign trained medical doctors. The experience those doctors have in practice, and their interactions and outcomes with patients, are relevant to this call to action. There is a literature on their experience, their challenges, patient perspectives and those of their peers, and these may be relevant when it comes to arguing for language concordant care.

Response: We have incorporated challenges with this approach on page 11. We chose not to include additional data about international medical graduates given the complexity of the literature on the topic. For example, one systematic review (Michalski et al, PLoS One, 2017) found additional challenges for IMGs with regard to language proficiency, communication, and hierarchy in medical fields that precluded optimal patient-centered care.

A further issue that is not explicitly addressed in the manuscript is that medical practitioners who are taught an L2 will not be providing language concordant care. I have made some comments
about the definition of language concordance that is used in the manuscript. Some main comments follow below: P5/88. I would use 'importance' rather than valence

Response: Thank you. We have replaced this term.

P5/90. I'm a little confused by the definition of language concordance that is used here. Firstly, it is unclear if this is simply the definition used in this manuscript. Secondly, it is very specific and defines concordance as occurring when both parties speak 'the same non-English language'. There are issues with the definition, and it also narrows the applicability of the manuscript, as if assuming that only encounters that occur in American English are 'normal'. I do not imagine that this is what the authors intend.

Response: Thank you for this feedback. We have incorporated the definition of language concordance from Segalowitz and Kehayia (2011) in the second paragraph.

For the purposes of being able to generalise to the world more broadly, I recommend that concordance is defined in relation to interlocutors' first languages (L1s; see for example Segalowitz & Kehayia, 2011). In the case of patients in English-speaking areas of the US, where American English is the native and dominant language (L1) spoken, then language concordance would exist where both parties speak English as their native and dominant language (L1). However, it should be recognised that any context in which both interlocutors speak the same native and first acquired language (which, in the US and elsewhere, could be Spanish, Mandarin etc.), there is language concordance. Language discordance exists if one or both interlocutors have to speak their non-native language. Language discordance therefore exists, in the US context, when an English L1 health practitioner (unable to speak any other languages) has a medical consultation with a patient who speaks English as a second language (L2) or possibly even as a third or fourth language. It exists when a medical practitioner trained to also speak L2 (at some level of proficiency) provides care in that language to a patient for whom it is the L1. It exists when a health practitioner whose first language is not English treats a monolingual English speaking patient. It also exists when that same practitioner treats a patient whose first and dominant language also is not English. Thus true concordance exists when both interlocutors speak the same first language; when one or both interlocutors communicate in their 'other' language we have a language discordant situation. This is important because where there is language discordance (i.e., when not all parties communicate in their first and preferred language), there are likely to be differences in proficiency and experience, in the ability to understand the nuances of the language that is being used and, consequently, in the resulting care and patient outcomes.

Response: We have incorporated the Segalowitz & Kehayia reference and have included a discussion about challenges in operationalizing this definition on pages 11-12.

When the definition is reworked, it will become clear that other aspects of the manuscript will need some rewriting and will need to be more critical to support the arguments that are made.
Response: Thank you for this observation. We have amended our definition and added text to support our arguments throughout the manuscript.

P5/90. While it may be true that sharing a language is helpful, this may not in and of itself engender trust.

Response: Yes, we agree that sharing a language is an important foundation to build trust, but may be insufficient alone. We have revised the sentence to clarify this point.

P8/139. Is there other data to which the authors can refer? I'm concerned that, in the study referenced here, language concordance was derived entirely from the patients' responses and therefore not independently captured. I am also concerned that this point confuses the issue of language concordance with that of the language actually used in the consultation. It seems that the assumption is that the other language was spoken. This matters for the overall call to action, which is to teach language as part of the medical training curriculum. From the reference used (and others) we cannot tell if the physicians who were language concordant (1) spoke to their patients in their shared L1 and (2) if these physicians were trained in English or in their L1. The latter is quite important when it comes to physicians being able to transmit, accurately, the correct medical information to their patients.

Response: We have clarified the definitions used in the cited study.

When we are calling for medical training to include another language, we need to recognise that (1) the new doctors may not feel at all comfortable, and perhaps may be quite anxious, communicating in a second language (there is reported data on this) and (2) they may also be concerned that their ability to discuss medical details is not going to be as good as it is in their L1. I appreciate that the authors allude to some of the problems further on in the manuscript. For another perspective, see for example O'Brien and Shea (2009, Journal of Immigrant and Minority Health, 13(2)): they did not find language preference always to be the key to patient satisfaction. It would be helpful to unpack this in order to argue why language concordance is the way to go (and bearing in mind the implications of how concordance is defined). Such an argument should be more balanced and recognise the difficulties, including that fact that it is not always that clear what is valued most by patients.

Response: We added a sentence to recognize the other components to foster a therapeutic alliance aside from language and referenced the O'Brien and Shea article mentioned above on page 11.

P10/206. Do they really need to be 'as competent in their L2 as in their L1'? Also, is that golden standard really achievable? For this call to action to be persuasive, it would be good to have a more critical evaluation of what is needed to overcome a language barrier.
Response: Thank you for this feedback. We have added a paragraph about feasibility challenges on pages 11-12.

P11/227. It would be worth referring to Segalowitz and Kehayia (2011): In that paper suggestions are provided as to what could be included to ensure that health practitioners who are taught another language. These include the need to determine how fluent a practitioner needs to be to be efficient and communicate clearly, and suggestions of how to retain L2 skills.

Response: We have included some of the suggestions in the Segalowitz and Kehayia paper on page 11.


Response: Thank you for these references. We have added the Ali and Johnson reference.

Reviewer 2

Thank you for the opportunity to review this interesting paper. I found the arguments in the paper to be well developed and I feel that this paper will make an important contribution to the literature by (hopefully) stimulating discussion, ideas and changes to medical training in this area. The authors provided a solid overview of why the system needs to change and what the issues are. I felt that the manuscript was well written, that the arguments were well presented and backed with appropriate literature and the conclusion provided a particularly good summary of what could be done to improve current training.

Response: Thank you for these comments. We agree that the goal of this paper is to stimulate discussion about fostering language-concordant care in medical school training.

I feel like all the comments I want to make are more about engaging with the content of the paper rather than suggesting how it can be improved. For example, I did find myself wondering about how this could work in Australia (where I am) and in other non-US countries, where we don't have a dominant non-English language (like there is with Spanish in the US for example) so I wondered about the practicalities of implementing language classes into our training. I also wondered about how the recommendations could apply to student's who already have proficiency in a language other than English (so Bi or Multi-lingual medical students) and whether recommendations could be made more explicit about supporting them to develop medical linguistic competence in their own language/s. The paper currently appears to be arguing for English-speaking students to learn a second language but I think there is scope for being
more explicit about how bi/multi lingual students should also be assessed for their competence in communicating medical information competently. And I was wholeheartedly agreeing about the training in the use of interpreters. So to me, the stimulation of these ideas is further reason why I think this paper should be published. My only comment would be that I think you have made a good attempt to take a global focus in the paper, but it also feel it is very US centric in the literature, arguments and recommendations. Perhaps that is intentional, but I feel there is scope for broader Global appeal with this paper.

Response: We have changed some of the language to be inclusive of other countries outside of the U.S. We decided to use the U.S. as a platform to spark discussion given the linguistic diversity in the U.S., but certainly recognize the discussion applies broadly around the world.

I wish the authors all the best in having this work published and I look forward to seeing the ideas progressed/translated in practice.

Response: Thank you for this comment.