Reviewer’s report

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

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Reviewer: Renata Meuter

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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.

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.

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

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.

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.

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.

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

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.

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.

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.

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.

P15/293. Useful additional material to consider and include:


Are the methods appropriate and well described?
If not, please specify what is required in your comments to the authors.

No

Does the work include the necessary controls?
If not, please specify which controls are required in your comments to the authors.

No

Are the conclusions drawn adequately supported by the data shown?
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No

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Not relevant to this manuscript

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