Whereas, The U.S. population’s linguistic demographics continue to diversify with over 350 languages spoken in the U.S.;¹ and

Whereas, Population estimates regarding individuals with limited English proficiency (LEP) suggest there are over 25 million people with LEP in the U.S., the majority (64%) of whom are Spanish speakers,²⁻³ and with substantial additional population who may not have general LEP but may have difficulty communicating in English during medical encounters due to the complexity of health-related cultural-linguistic elements, illness-related stressors, and other concomitant access-to-care challenges in minority populations;⁴⁻⁶ and

Whereas, The federal government mandates that health care be provided equitably to patients in their preferred language regardless of national origin or language preference;⁷⁻⁸ and

Whereas, Data demonstrates that language concordance, defined as direct patient-physician communication in the same language, improves patient outcomes and satisfaction;⁹⁻¹¹ and

Whereas, Data demonstrates that language concordant care is superior to professional interpreter-mediated medical care;¹²⁻¹³ and

Whereas, A majority of medical schools report offering opportunities for linguistic education for medical students in languages other than English (e.g. medical Spanish) due to patient population demographic needs and increasing student demand;¹⁷ and

Whereas The long-term outcomes of medical school education in non-English medical communication skills, such as appropriate interpreter use,¹⁸⁻¹⁹ cultural competency, and linguistic training (e.g., medical Spanish)²⁰ are currently unknown and would require collection and evaluation of physician language proficiency data; and

Whereas, Existing language concordance preliminary data of primary care providers’ languages conducted in California demonstrates a gross language concordance mismatch compared to the regional population linguistic profile,²¹ and conducting similar studies locally, regionally, and nationally would enable a needs assessment of available physician resources with regards to underserved populations; and
Whereas, the Six-point Physician Linguistic Proficiency Self-assessment Scale, from the Adapted International Language Roundtable (ILR) Scale for Physicians\textsuperscript{23} can measure language fluency as follows:

- **Excellent** – Speaks proficiently, equivalent to that of an educated speaker, and is skilled at incorporating appropriate medical terminology and concepts into communication. Has complete fluency in the language such that speech in all levels is fully accepted by educated native speakers in all its features, including breadth of vocabulary and idioms, colloquialisms, and pertinent cultural references.
- **Very Good** – Able to use the language fluently and accurately on all levels related to work needs in a healthcare setting. Can understand and participate in any conversation within the range of his/her experience with a high degree of fluency and precision of vocabulary. Unaffected by rate of speech. Language ability only rarely hinders him/her in performing at task requiring language; yet, the individual would seldom be perceived as a native.
- **Good** – Able to speak the language with sufficient accuracy and vocabulary to have effective formal and informal conversations on most familiar topics. Although cultural references, proverbs and the implications of nuances and idiom may not be fully understood, the individual can easily repair the conversation. May have some difficulty communicating necessary health concepts.
- **Fair** – Meets basic conversational needs. Able to understand and respond to simple questions. Can handle casual conversation about work, school, and family. Has difficulty with vocabulary and grammar. The individual can get the gist of most everyday conversations but has difficulty communicating about healthcare concepts.
- **Poor** – Satisfies elementary needs and minimum courtesy requirements. Able to understand and respond to 2-3 word entry level questions. May require slow speech and repetition to understand. Unable to understand or communicate most healthcare concepts.
- **None** – Unable to function in the spoken language. Oral production is limited to occasional isolated words. Has essentially no communicative ability; therefore be it

RESOLVED, That our American Medical Association initiate collection of self-reported physician language proficiency data in the Masterfile by asking physicians with the validated six-point adapted ILR-scale for physicians to indicate their level of proficiency for each language besides English in the healthcare settings. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/09/19

References
15. Liaison Committee on Medical Education. Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the MD Degree. Effective Academic Year: 2019-20. http://lcme.org/publications/ Published March 2018.
RELEVANT AMA POLICY

Support of Multilingual Assessment Tools for Medical Professionals H-160.914
Our AMA will encourage the publication and validation of standard patient assessment tools in multiple languages.
Citation: (Res. 703, A-12)

Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924
AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care; (2) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (3) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid LEP patients' involvement in meaningful decisions about their care; and (4) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements.
Citation: BOT Rep. 8, I-02; Reaffirmation I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation A-09; Reaffirmed: CMS Rep. 5, A-11; Reaffirmed in lieu of Res. 110, A-13; Reaffirmation: A-17

Interpretive Services H-215.982
Our AMA encourages hospitals and pharmacies that serve populations with a significant number of non-English speaking or hearing-impaired patients to provide trained interpretive services.
Citation: (BOT Rep. D, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11; Modified: Res. 702, A-12

Medical School Language Electives in Medical School Curriculum H-295.870
Our AMA strongly encourages all Liaison Committee on Medical Education- and American Osteopathic Association-accredited US medical schools to offer medical second languages to their students as electives.
Citation: Res. 304, A-07; Reaffirmed: CME Rep. 01, A-17

Increasing Access to Healthcare Insurance for Refugee Populations H-350.956
Our AMA supports state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, to minimize gaps in health-care for refugees.
Citation: Res. 006, A-17

Interpreter Services and Payment Responsibilities H-385.917
Our AMA supports efforts that encourage hospitals to provide and pay for interpreter services for the follow-up care of patients that physicians are required to accept as a result of that patient's emergency room visit and Emergency Medical Treatment and Active Labor Act (EMTALA)-related services.
Citation: (CMS Rep. 5, A-11

Patient Interpreters H-385.928
Our AMA supports sufficient federal appropriations for patient interpreter services and will take other necessary steps to assure physicians are not directly or indirectly required to pay for interpreter services mandated by the federal government.
Citation: (Res. 219, I-01; Reaffirmed: BOT Rep 8, I-02; Reaffirmation I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation A-09; Reaffirmation A-10; Reaffirmation A-14

Availability and Payment for Medical Interpreters Services in Medical Practices H-385.929
It is the policy of our AMA to: (1) the fullest extent appropriate, to actively oppose the inappropriate extension of the OCR LEP guidelines to physicians in private practice; and (2) continue our proactive,
ongoing efforts to correct the problems imposed on physicians in private practice by the OCR language interpretation requirements.

Citation: BOT Rep. 25, I-01; Reaffirmation I-03; Reaffirmed: Res. 907, I-03; Reaffirmation A-09; Reaffirmation: A-17

Interpreters For Physician Visits D-90.999
Our AMA continues to monitor enforcement of those provisions of the ADA to assure that physician offices are not subjected to undue burdens in their efforts to assure effective communication with hearing disabled patients.

Citation: (BOT Rep. 15, I-98; Reaffirmation I-03; Modified: BOT Rep. 28, A-13; Reaffirmation A-14

Appropriate Reimbursement for Language Interpretive Services D-160.992
1. Our AMA will seek legislation to eliminate the financial burden to physicians, hospitals and health care providers for the cost of interpretive services for patients who are hearing impaired or do not speak English.
2. Our AMA will seek legislation and/or regulation to require health insurers to fully reimburse physicians and other health care providers for the cost of providing sign language interpreters for hearing impaired patients in their care.

Citation: Res. 209, A-03; Reaffirmation A-09; Reaffirmation A-10; Appended: Res. 114, A-12; Reaffirmed: Res. 702, A-12; Reaffirmation A-14; Reaffirmation: A-17

Certified Translation and Interpreter Services D-385.957
Our AMA will: (1) work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act; and (2) advocate for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services, with a progress report at the 2017 Interim Meeting of the AMA House of Delegates.

Citation: Res. 703, A-17

Language Interpreters D-385.978
Our AMA will: (1) continue to work to obtain federal funding for medical interpretive services; (2) redouble its efforts to remove the financial burden of medical interpretive services from physicians; (3) urge the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement; (4) consider the feasibility of a legal solution to the problem of funding medical interpretive services; and (5) work with governmental officials and other organizations to make language interpretive services a covered benefit for all health plans inasmuch as health plans are in a superior position to pass on the cost of these federally mandated services as a business expense.

Citation: Res. 907, I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation A-09; Reaffirmation A-10; Reaffirmed: CMS Rep. 5, A-11; Reaffirmed in lieu of Res. 110, A-13; Reaffirmation: A-17

E-8.5 Disparities in Health Care
Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patientsclinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

To fulfill this professional obligation in their individual practices physicians should:
(a) Provide care that meets patient needs and respects patient preferences.
(b) Avoid stereotyping patients.
(c) Examine their own practices to ensure that inappropriate considerations about race, gender identity, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
(e) Encourage shared decision making.
(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system. The medical profession has an ethical responsibility to:

(g) Help increase awareness of health care disparities.

(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.

(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

AMA Principles of Medical Ethics: I, IV, VII, VIII, IX

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

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