



Rethinking the Term “Limited English Proficiency” to Improve Language-Appropriate Healthcare for All

Pilar Ortega¹ · Tiffany M. Shin² · Glenn A. Martínez³

Accepted: 20 July 2021 / Published online: 30 July 2021

© The Author(s), under exclusive licence to Springer Science+Business Media, LLC, part of Springer Nature 2021

Abstract

The concept of limited English proficiency (LEP) presents significant challenges when applied to the healthcare needs of the diverse and growing multilingual population in the U.S. We expound on the following ways in which the concept of LEP is problematic: the ethnocentric notion of a “primary language,” the ambiguous idea of “limited ability,” and the deficit-oriented construct of “language assistance.” We provide examples that illustrate the negative healthcare impact of LEP terminology, including the unaccounted-for complexities of health communication within the concept of “primary language,” the “limited abilities” of health professionals whose language skills are often unassessed, and the ignored role of “language assistance” resources such as interpreters as essential collaborators. Finally, we propose rethinking LEP by (a) reframing patient language using the term non-English language preference and (b) assessing health professional non-English language skills. These actionable strategies have the potential to improve language-appropriate healthcare for diverse populations.

Keywords Limited English proficiency · Language barriers · Language assistance · Healthcare communication · Patient-centered communication · Medical interpreters · Language concordance

Introduction

Since its creation in 2000, the concept of limited English proficiency (LEP) has driven numerous policy decisions across the spectrum of social and public services, including the provision of healthcare for immigrant populations. President Bill Clinton’s Executive Order 13,166 [1] enshrined LEP in the lexicon of the federal government and inextricably linked it to the long-standing panoply of civil rights protections codified in the Title VI of the Civil Rights Act of 1964 [2]. The Federal Interagency Working Group on LEP proposed a definition: “Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can be

limited English proficient, or ‘LEP.’ These individuals may be entitled to language assistance with respect to a particular type of service, benefit, or encounter” [3]. This definition has been operationalized by numerous federal agencies including the Department of Health and Human Services in its successive renditions of the National Standards for Culturally and Linguistically Appropriate Care in 2001 and 2013 respectively [4].

However, the term LEP presents significant challenges when applied to the healthcare needs of the diverse and growing multilingual population in the U.S. and contributes to ambiguity in health policies related to language services, subtly absolving agencies and health systems of their own deficiencies. In this manuscript, we expound on the following ways in which the concept of LEP is problematic: the ethnocentric notion of a “primary language,” the ambiguous idea of “limited ability,” and the deficit-oriented construct of “language assistance.” We then discuss the healthcare implications of LEP terminology. Finally, we present recommendations for alternative terminology as a strategy to improve language-appropriate healthcare access.

✉ Pilar Ortega
PORtega1@uic.edu

¹ Departments of Medical Education and Emergency Medicine, University of Illinois College of Medicine, 808 S. Wood Street, MC 591, Chicago, IL 60612, USA

² Department of Pediatrics, Wake Forest School of Medicine, Winston-Salem, NC, USA

³ Department of Modern Languages and Literatures, University of Texas at San Antonio, San Antonio, TX, USA

Problematic Assumptions of the LEP Conceptual Framework

Primary Language

The concept of “primary language” makes the assumption that people’s lives are ordered by the language that they speak. Early studies of bilingualism recognized a distinction between successive and simultaneous language acquisition [5]. Successive language acquisition occurs when a person learns one language after having acquired another one first. Simultaneous language acquisition, on the other hand, is when a child learns two languages at the same time as native or first languages. The vast majority of the world’s multilingual population acquires languages in this manner [6], challenging popular conceptualizations of bilingualism.

Many casual observers regard bilingualism as the ability to switch effortlessly between two languages and to be able to communicate in a range of situations in either one. However, researchers note that bilinguals are not necessarily equally versed in both languages but rather that they distribute their languages along a continuum of domains [7]. Some topics may be more easily discussed in one language than the other.

Bilinguals, therefore, tend to distribute their languages in ways that are meaningful in their own lives. This observation entails that not all bilingual speakers have exactly the same linguistic repertoires in both languages. Furthermore, it makes the concept of primary language problematic. In her groundbreaking ethnographic study of language use in New York City’s *El Bloque*, Ana Celia Zentella vividly recalls that when she asked neighborhood children what language they spoke, they confidently retorted: “*hablamos los dos*” (we speak both) [8]. Researchers since then have come to understand that far from ordering their lives by the languages they speak, multilingual speakers order their languages to suit their own lived realities and draw on multiple linguistic repertoires in unique and creative ways in order to fulfill their own expressive needs and desires. The concept of translanguaging—the use of combined, fluid, spontaneous, or hybrid linguistic practices that involve mixing languages—has been used to capture this dimension of bilingual lives [9]. Within a translanguaging frame, the identification of a “primary language” becomes difficult if not impossible.

Limited Ability

The concept of “limited ability” also presents a series of difficulties. The official definition of LEP considers limited

ability to speak, read, write, or understand English as a signature feature of the LEP individual. Fundamentally, speaking, reading, writing, and understanding English vary considerably from context to context. In one context, the ability may be sufficient; yet in another, it may be limited. Secondly, speaking, reading, writing, and understanding are not inextricably linked skills. Some skills may be less limited compared to others. Finally, the conceptualization of “limited ability” is cast in an individual frame. A person’s ability to read and write, for example, may be limited but even so that person’s engagement in literacy practices (reading and writing) is often collaborative rather than individual. Spanish-speaking parents, for example, may depend on their English-speaking children to fill out forms and engage in other literacy practices. More than constituting a limitation in ability, these practices point to uniquely community orientations of engaging the written word.

Language Assistance

The notion of “language assistance” in the official definition of LEP encases language in a deficit orientation. Assistance itself presupposes a deficit or a handicap that must be remedied. In the early twentieth century, education researcher Manuel talked about the “language handicap” that Spanish-speaking children in Texas brought with them to schooling [10]. Manuel’s disciple George I. Sánchez objected to the use of the term “language handicap” noting that it was a subtle way of placing blame on children and their families. Instead, he proposed the term “dual language handicap” [11]. With this, Sánchez sought to highlight the deficiencies present in school systems by shedding light on their inability to appropriately educate Spanish-speaking children. These debates from the field of education are applicable to the conceptualization of “language assistance” present in the official definition of LEP. By identifying individuals in need of “language assistance,” the definition subtly absolves agencies and systems of their own deficiencies in fulfilling their mission.

Implications for Healthcare

Healthcare for linguistic minorities must consider the linguistic practices of the target population in order to successfully provide language-appropriate services. The two main approaches to providing language-appropriate care are: language-concordant care (services provided by a clinician who speaks the same language as the patient) and interpreter-mediated care (a medical interpreter participates as a linguistic conduit between the patient and clinician). Language-concordant care has been demonstrated to improve patient

outcomes, lower healthcare costs, increase satisfaction, and reduce medical errors [12]. Professional medical interpretation during language-discordant health encounters also has demonstrated significant benefits in the care of linguistic minorities but is widely underutilized [13]. We present several key examples that illustrate the negative healthcare impact of LEP terminology, including the unaccounted-for complexities of health communication within the concept of “primary language,” the “limited abilities” of health professionals whose language skills are often unassessed, and the ignored role of “language assistance” resources such as interpreters as essential collaborators.

Primary Language and the Complexities of Health Communication

The LEP construct does not appropriately characterize the complexities involved in communication of health-related issues. For example, medical visits involving multigenerational family members may be challenged by the simultaneous presence of individuals who may prefer to communicate in English (e.g., younger generations) and others (e.g., older members) who may prefer to communicate in another language. In some cases, individuals may prefer one language for speaking with the clinician and another for receiving written instructions or reading material, since they may rely on family members to review forms and documents.

The use of linguistic practices such as Spanglish or Portuñol, among other ways of translanguaging, are part of the day-to-day lives of multilingual individuals, and a single language category may not adequately describe their language needs or preferences during a medical visit [14]. For instance, the best word to express a specific concept, such as a medical symptom, may defy direct translation to the dominant language. In this instance, it is not the patient’s proficiency in English which is necessarily limited, but rather the English language itself which is limited in expressing the concept that the patient would like to communicate to the clinician.

Similarly, even among patients who report the same language preference, multiple words may be used to describe the same health concept, with national, regional, neighborhood, and even family-specific variations. This complexity in divergent health terminology or pronunciation is not unique to non-English languages; English-speakers from different regions or countries may also encounter such challenges in health communication which are not related to LEP [15].

Relatedly, data suggest that Hispanic/Latinx patient primary language self-identification may not appropriately account for individuals who may have some English skills but have significant difficulty communicating health concepts in English [16]. Further, available data on patient language may not be accurate

[17]. It is possible that fear of discrimination and concerns about quality of care that patients will receive if they report a different primary language, as well as the cultural tendency to defer to medical authority figures (including their language preferences), may prevent them from reporting non-English language needs. The way patients are asked about language preference (e.g., whether the patient’s language is used and how the question is phrased) may further impact the patient’s response. For example, if asked whether they speak English, patients may respond affirmatively, even though their English would not suffice for participating in health-related conversations. Even individuals who speak sufficient English to not fit current classifications of LEP may still encounter difficulties communicating complex health concepts, particularly under circumstances of illness, stress, or emergency.

Healthcare Professionals’ Unassessed Limited Ability

The concept of “limited ability” is used in LEP terminology to refer to the language limitations of patients but is seldom applied to the language abilities of clinicians. In fact, although a vast majority of U.S. hospitals report regularly providing care to patients who prefer to communicate in languages besides English [18], few hospitals assess the language proficiency of their healthcare staff [19]. Instead, the responsibility of language skills assessment and the decision about calling a medical interpreter is placed upon the clinicians themselves without clear guidance or training. As a result, many clinicians, including students and resident physicians, report using their own limited language skills to “get by” during encounters with linguistic minority patients [20]. Further, even when collected, physician language proficiency in non-English languages is seldom requested by institutions beyond a binary choice (e.g., do you speak another language? yes/no), whereas, in reality, physicians may have a range of communication skills in any one language. Without more nuanced efforts towards understanding and incentivizing physician language skills, health professionals with some bilingual skills may feel unsupported, frustrated, and overburdened [21]. By focusing on “limited ability” rather than on communication strengths or progressive skill development, the view of language highlighted by LEP terminology undermines the value of competent multilingual physicians and health professionals who are able to provide high quality care to patients in more than one language.

Language Assistance Resources as Essential Collaborators

The current concept of LEP is consistent with the unfortunate reality of medical practice that portrays “language

assistance” as solely benefiting the patient and therefore being an extra burden for clinicians and health systems, rather than as a medical tool that empowers clinicians to provide equitable care to all patients. History-taking alone during medical encounters has been demonstrated to lead to a diagnosis 75% of the time [22], demonstrating the power of language as a diagnostic tool. Despite the critical role of language-appropriate communication in diagnoses, ad hoc interpreters remain in widespread use, such as the use of family members and untrained medical staff, even when professional interpreters are available. Researchers have identified obstacles to using professional interpreters including time and lack of accessibility [23] as well as lack of training on interpreter use [24]. A recent analysis of data from the CLAS Physician Survey found that only 30% of physicians report regularly using professional interpreters [13].

The concept of LEP draws attention to patients’ language assistance needs only, rather than on the collective communication needs of the patient and the clinician. In the current framework, language resources such as professional interpreters are not given the attention, funding, and position they deserve as healthcare team members and active contributors in patient care. As a result, physicians are not routinely taught to work properly with interpreters, and interpreters themselves may view their roles as inappropriately minimized by clinicians. Hsieh and Kramer propose viewing medical interpreters as “smart technology” rather than “passive instruments” to be used by clinicians [25]. As reflected by the challenges of telemedicine care during the COVID-19 pandemic, interpreter services may not be taken into consideration in the development of new technologies or healthcare solutions, such as telehealth [26]. In fact, as health disparities for ethnic, racial, and linguistic minorities are magnified in the context of the pandemic, individuals who previously relied on medical interpreters for health communication are encountering more rather than fewer obstacles to care [26]. A new conceptualization of language skills beyond LEP is needed in order to effectively promote language-appropriate communication as a tool necessary for clinicians to perform their job at the same caliber as they would for patients that speak the dominant language.

Recommendations

Rethinking the term “LEP” is necessary to improve language-appropriate healthcare access, quality, and outcomes for individuals whose healthcare would be best achieved in languages besides English. In the field of education, a shift in terminology has led to wider use of the term “English language learner.” We propose a similar shift in healthcare and favor the concept of “non-English language preference” rather than LEP. We provide guidance in operationalizing

this shift in terminology and approach to linguistic minority patients. Additionally, we propose assessment of health professional language skills and further study regarding non-English language proficiency for health professionals interested in enhancing and enriching their relationships with linguistic minority patients, families, and communities.

Non-English Language Preference

Replacing the term LEP with the term “non-English language preference” (NELP) more accurately and effectively describes individuals presenting to the healthcare setting. Drawing upon the existing definition of LEP [3] as a frame of reference, we propose this updated definition for operationalizing NELP: “Individuals who prefer a non-English language with respect to a particular type of service, benefit, or encounter.”

The new terminology emanates from a patient-centered framework that is not characterized by or based on the attitude that one’s own group is superior. This appropriately recognizes the variety within the U.S. of languages, language abilities, and the fluidity of language application. It also emphasizes the approach of meeting patients where they are, rather than an attitude of appraising or labeling their proficiency.

Describing patient language by preference is accurate and feasible. Since the intent of using the terminology is to provide language-appropriate care, language should be approached as a descriptor of patients’ needs and preferences when presenting for healthcare, rather than seen as an assessment of patients’ skills or as a rigid, permanent label. A person’s language preference can be detailed further by specifying preferences for verbal communication (speaking and listening) and literacy practices (reading and writing). To operationalize new terminology regarding language preference, healthcare staff should inquire about patient language preferences at each encounter, and documentation should reflect that these preferences may change depending on the content and context of the interaction. Specifically, staff should be trained in how to ask questions about NELP in a non-judgmental and inclusive manner, as well as how to efficiently access and work effectively with medical interpreters.

All institutions should work with clinical and language experts to develop language access plans and ensure effective implementation, at minimum providing clear guidance for interpretation access and bilingual providers and staff. The Affordable Care Act of 2010s Section 1557 [27] and its Final Rule of 2020 [28] specify steps that healthcare systems should take to ensure “meaningful access” to language-appropriate care, including that systems are required to post signage regarding patients’ rights to communication assistance and that they are encouraged

to create and implement a “reasonable” language access plan that ensures system preparedness to provide meaningful access. Although these documents provide some practical guidance regarding implementation of language-appropriate health services, they continue to operate on the assumption that language services are for patients with “limitations” rather than to address systemic or clinician limitations in providing equitable care to diverse populations, thereby overlooking important consequences of inadequate language services that may be more meaningful in driving health system change.

Shifting to a focus on patient preference and away from vocabulary such as “limited proficiency” and “language assistance” highlights a strengths-based approach to caring for linguistic minority populations. It emphasizes the responsibility and need for agencies and systems to consider the linguistic practices of the target population and provide language-appropriate care not only to benefit a subset of patients who have been historically marginalized but also to improve healthcare efficiency, reduce costs, and improve clinical productivity. The words that we use when describing and caring for patients matter greatly, and our language and terminology should appropriately reflect the value, abilities, and diversity of patients. For example, future updated guidelines for implementation of language-appropriate services that meet federal requirements should explicitly reframe language services as not only benefiting patients with NELP but also enabling clinicians who lack skills in non-English languages to safely and efficiently communicate with this growing population.

While cost savings analyses included in the 2020 Final Rule address the cost savings of removing the health system burden of providing tagline translations in their top 15 languages [28], future analyses should also address the cost savings of implementing accessible medical interpretation and/or language-concordant services compared to the added costs that result from linguistically inadequate communication, including inappropriate healthcare utilization (e.g., due to excessive testing or hospital admission, readmission, delayed diagnosis of more costly advanced disease, or prolonged length of stay) [29], medical error [12, 29], and physician dissatisfaction [24]. Presenting a summary of such evidence-based data regarding health system consequences may help operationalize recommendations that health systems may otherwise consider “unreasonable” due to the initial financial burden they entail. Examples of such measures that can improve long-term health system efficiency and benefit patient outcomes include providing accessible certified medical interpretation services and incentivizing the hiring and retention of language-concordant clinicians in geographic areas where they are most needed.

Health Professional Non-English Language Skills

As we move toward a more nuanced understanding of patient linguistic preferences beyond the constraints of monolingual spaces, we must also teach, assess, and incentivize health professional language skills that expand beyond the dominant language. Drawing again from existing language constructs, we propose that we not only consider patient NELP but that we also explicitly address clinician “non-English language skills” (NELS). Many students and health professionals invest their own time and finances in gaining NELS to improve communication with their patients, but these practical patient-centered skills are often undocumented and unassessed in their practice settings [30]. Coupled with data regarding the underuse of medical interpreters, the lack of assessment of physician NELS raises concerns about the potential miscommunications and medical errors that may take place in clinical settings due to unchecked use of limited skills [31].

Like other clinical skills, medical communication skills in second languages can be expected to be gained (or lost) over time, depending on the degree of exposure, practice, and accountability. Students and healthcare professionals should be taught and expected to periodically self-assess their NELS using rapid, validated tools—such as the Interagency Language Roundtable scale modified for physicians [32] or the National Council of State Supervisors for Languages and American Council on the Teaching of Foreign Languages’ Can-Do Statements [33]. The requirements specified by the Final Rule of 2020 [28], stating that “translators or interpreters provided in order to comply with the law must meet specific minimum qualifications, including ethical principles, confidentiality, proficiency, [...] and the ability to use specialized terminology as necessary in the healthcare setting,” should be applied similarly to healthcare providers with NELS. Moreover, all health professionals should be trained and encouraged to work with medical interpreters as necessary collaborators whenever their limitations in a particular language have been reached. Health professionals should be trained to appreciate and utilize language resources as an essential medical tool to deliver quality patient care. Medical language courses, such as medical Spanish, are reported in most U.S. medical schools, but even despite these educational efforts, most schools lack assessment methodology for students who wish to use non-English skills in patient care [34]. In addition to periodic self-assessments, developing a standardized, validated performance assessment in non-English languages has been proposed as a strategy for more objective skills certification, similar to the clinical skills examination that U.S. physicians are required to pass for medical licensing [35]. Physicians who pass such an examination should benefit from employer financial incentives for being certified as a bilingual clinician.

Communication skills training in medical education and clinical practice settings should intentionally move beyond the constraints of English as the sole dominant language to more appropriately reflect and care for our diverse patient populations in the U.S. Transitioning away from the limitations imposed by the artificial construct of LEP to viewing language preferences (NELP) and skills (NELS) of both patients and clinicians as fluid and dynamic is critical to putting person-centered care in its deserved place, at the forefront of medicine.

Author Contributions The first outline of the manuscript was written by Pilar Ortega, and all authors contributed to the writing of the first draft. All authors read and approved the final manuscript.

Declarations

Conflict of interest Dr. Ortega receives royalties from Saunders, Elsevier for a textbook. All other authors declare no conflicts of interest relevant to the content of this article.

Ethical Approval Not applicable.

Research Involving Human Participants and/or Animals This manuscript does not report research involving human participants or animals.

Informed Consent Not applicable.

References

- Improving access to services for persons with limited English proficiency, Executive Order 13166, Federal Register. 2000; 65(159).
- Office for Civil Rights, Office of the Secretary, U.S. Department of Health and Human Services. Nondiscrimination in health programs and activities: final rule. Federal Register. 2016; 81(96), Part IV, <https://www.gpo.gov/fdsys/pkg/FR-2016-05-18/pdf/2016-11458.pdf>.
- US Department of Justice: Limited English Proficiency. www.lep.gov.
- US Department of Health and Human Services, Office of Minority Health: National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. <https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf>.
- Weinreich U. Languages in Contact. New York: Linguistic Circle of New York; 1953.
- Grosjean F. Life with two languages: an introduction to Bilingualism. Cambridge: Harvard University Press; 1982.
- Heller M. Bilingualism: a social approach. New York: Palgrave; 2007.
- Zentella AC. Growing up Bilingual: Puerto Rican children in New York. New York: Wiley; 1997.
- García O, Li W. Translanguaging. In: Chapelle C, editor. Encyclopedia of applied linguistics. Hoboken: Wiley; 2018. p. 1–7. <https://doi.org/10.1002/9781405198431.wbeal1488>.
- Manuel H. The education of Mexican and Spanish-speaking Children. Austin: The University of Texas Press; 1930.
- Blanton CK. George I. Sánchez: the long fight for Mexican American integration. New Haven: Yale University Press; 2015.
- Diamond L, Izquierdo K, Canfield D, Matsoukas K, Gany F. A systematic review of the impact of patient-physician non-English language concordance on quality of care and outcomes. *J Gen Intern Med.* 2019;34(8):1591–606. <https://doi.org/10.1007/s11606-019-04847-5>.
- Schulson LB, Anderson TS. National estimates of professional interpreter use in the ambulatory setting. *J Gen Intern Med.* 2020. <https://doi.org/10.1007/s11606-020-06336-6>.
- Ortega P, Prada J. Words matter: Translanguaging in medical communication skills training. *Perspect Med Educ.* 2020;9(4):251–5. <https://doi.org/10.1007/s40037-020-00595-z>.
- Brooks TR. Pitfalls in communication with Hispanic and African-American patients: do translators help or harm? *J Natl Med Assoc.* 1992;84:941–7.
- Zun LS, Sadoun T, Downey L. English-language competency of self-declared English-speaking Hispanic patients using written tests of health literacy. *J Natl Med Assoc.* 2006;98(6):912–7.
- Azar KM, Moreno MR, Wong EC, Shin JJ, Soto C, Palaniappan LP. Accuracy of data entry of patient race/ethnicity/ancestry and preferred spoken language in an ambulatory care setting. *Health Serv Res.* 2012;47(1 Pt 1):228–40. <https://doi.org/10.1111/j.1475-1475->
- Huang J, Jones K, Regenstien M, Ramos C. Talking with patients: How hospitals use bilingual clinicians and staff to care for patients with language needs (Issue brief: Survey findings). Washington, DC: Department of Health Policy, School of Public Health and Health Services, The George Washington University; 2009.
- Diamond LC, Wilson-Stronks A, Jacobs EA. Do hospitals measure up to the national culturally and linguistically appropriate services standards? *Med Care.* 2010;48(12):1080–7.
- Andres E, Wynia M, Regenstien M, Maul L. Should I call an interpreter?—How do physicians with second language skills decide? *J Health Care Poor Underserved.* 2013;24:525–39.
- Ortega P. Spanish language concordance in medical care: a multifaceted challenge and call to action. *Acad Med.* 2018;93(9):1276–80. <https://doi.org/10.1097/ACM.0000000000002307>.
- Lown B. The lost art of healing: practicing compassion in medicine. New York: Ballantine Books; 1999.
- Diamond LC, Schenker Y, Curry L, Bradley EH, Fernandez A. Getting by: under-use of interpreters by resident physicians. *J Gen Intern Med.* 2009;24(2):256–62.
- Karliner LS, Pérez-Stable EJ, Gildengorin G. The language divide: the importance of training in the use of interpreters for outpatient practice. *J Gen Intern Med.* 2004;19:175–83.
- Hsieh E, Kramer EM. Medical interpreters as tools: dangers and challenges in the utilitarian approach to interpreters' roles and functions. *Patient Educ Couns.* 2012;89(1):158–62. <https://doi.org/10.1016/j.pec.2012.07.001>.
- Ortega P, Martínez G, Diamond L. Language and health equity during COVID-19: lessons and opportunities. *J Health Care Poor Underserved.* 2020;31:4.
- US Department of Health and Human Services. Section 1557: ensuring meaningful access for individuals with limited English proficiency. <https://www.hhs.gov/sites/default/files/1557-fs-lep-508.pdf>.
- US Department of Health and Human Services, Centers for Medicare and Medicaid Services. Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority. Federal Register 85 FR 37160, 2020; 85(119): 37160–37248.
- Karliner LS, Jacobs EA, Chen AH, Mutha S. Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health Serv Res.* 2007;42(2):727–54. <https://doi.org/10.1111/j.1475-6773.2006.00629.x>.
- Flores G, Mendoza FS. ¿Dolor aquí? ¿Fiebre?: a little knowledge requires caution. *Arch Ped Adolesc Med.* 2002;156(7):638–40.

31. Diamond LC, Jacobs EA. Let's not contribute to disparities: the best methods for teaching clinicians how to overcome language barriers to healthcare. *J Gen Intern Med.* 2010;25(Suppl 2):S189–93.
32. Diamond L, Chung S, Ferguson W, Gonzalez J, Jacobs EA, Gany F. Relationship between self-assessed and tested non-English-language proficiency among primary care providers. *Med Care.* 2014;52(5):435–8. <https://doi.org/10.1097/MLR.0000000000000102>.
33. National Council of State Supervisors for Languages and American Council on the Teaching of Foreign Languages: 2017 NCSSFL-ACTFL Can-Do Statements: performance indicators for language learners, <https://www.actfl.org/resources/ncssf-actfl-can-do-statements>.
34. Morales R, Rodriguez L, Singh A, Stratta E, Mendoza L, Valerio MA, Vela M. National survey of medical Spanish curriculum in U.S. medical schools. *J Gen Intern Med.* 2015;30(10):1434–9. <https://doi.org/10.1007/s11606-015-3309-3>.
35. Ortega P, Diamond L, Alemán MA, Fatás-Cabeza J, Magaña D, Pazo V, Pérez N, Girotti JA, Ríos E. Medical Spanish summit: medical Spanish standardization in U.S. medical schools: consensus statement from a multidisciplinary expert panel. *Acad Med.* 2020;95(1):22–31. <https://doi.org/10.1097/ACM.00000000000002917>.

Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.