Improving Communication Skills in Health Care

Lynda Katz Wilner

ESL RULES
Reisterstown, MD
Successfully Speaking
Owings Mills, MD

Marjorie Feinstein-Whittaker

ESL RULES
Reisterstown, MD
The Whittaker Group
Brookline, MA

Abstract

Hospital reimbursements are linked to patient satisfaction surveys, which are directly related to interpersonal communication between provider and patient. In today's health care environment, interactions are challenged by diversity — Limited English proficient (LEP) patients, medical interpreters, International Medical Graduate (IMG) physicians, nurses, and support staff. Accent modification training for health care professionals can improve patient satisfaction and reduce adverse events. Surveys were conducted with medical interpreters and trainers of medical interpreting programs to determine the existence and support for communication skills training, particularly accent modification, for interpreters and non-native English speaking medical professionals. Results of preliminary surveys suggest the need for these comprehensive services. 60.8% believed a heavy accent, poor diction, or a different dialect contributed to medical errors or miscommunication by a moderate to significant degree. Communication programs should also include cultural competency training to optimize patient care outcomes. Examples of strategies for training are included.

Hospitals and medical centers in the United States are rich with diverse providers, ancillary staff, and patient populations. Each culture has its own value system, communication style, and beliefs about health and illness. A diverse medical staff can help bridge the cultural gaps that exist. However, given some patients' limited health literacy and lack of diverse providers in some settings, there is the potential for miscommunication and medical errors. To address this demographic trend, the United States Department of Health and Human Services' Office of Minority Health established Culturally and Linguistically Appropriate Services (CLAS). These guidelines were enhanced in 2013 to reflect ongoing changes over the last decade. CLAS identified fifteen mandates, guidelines, and recommendations to make health care associations and medical

practices more culturally and linguistically accessible (Office of Minority Health, 2013). These standards are categorized under three domains: (a) Governance, Leadership and Workforce, (b) Communication and Language Assistance, and (c) Engagement, Continuous Improvement, and Accountability.

These diverse providers and patient populations provide a growing niche for speech-language pathologists (SLPs) and other communication consultants to provide communication training in the workplace (Feinstein-Whittaker, Wilner, & Sikorski, 2012). Health care providers must communicate as effectively as possible. Therefore, training should be all encompassing and go beyond the traditional "accent modification" segmental approach of vowel and consonant pronunciation. The authors define accent modification broadly as a comprehensive suprasegmental approach to communication skills enhancement. This includes pronunciation, stress and intonation, understanding and working knowledge of figurative language and idiomatic speech, auditory discrimination, active listening skills, a general vocabulary outside of one's specialized field, sensitivity to nonverbal communication, and an understanding of the numerous cultural considerations affecting one's daily interactions (Wilner, 2002; Wilner & Feinstein-Whittaker, 2007). It is clear that providers, who speak with patients, family members, staff, and most importantly, LEP patients, must possess these skills. Given the dramatic cultural changes the health care environment is continuing to experience, linguistic and cross-cultural communication is paramount.

In health care settings, there are three primary communication scenarios: health care provider with patient or family member, health care provider with staff, and the triad of health care provider, LEP patient, and interpreter. Within the health care provider group, there are likely non-native English speaking physicians and nurses, who may further complicate the communication process. Although internationally trained health care providers often have a high level of language proficiency due to their medical training, mastery of Medical English does not ensure successful communication with patients, family, and staff. Lack of awareness of idiosyncratic stress and intonation rules that guide the pronunciation of numbers (e.g., 15 mg vs. 50 mg) can lead to miscommunication regarding prescriptions, dosages, dates, times, and other medical measurements, and ultimately affect patient care outcomes. A 2002 study by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) documented that communication was the root cause of more than 65% of hospital deaths and injuries and 55% of medication errors (Editorial Desk, 2002). Although these consequences may include written, as well as oral communication, and it is unclear whether more problems exist with native or nonnative speakers, the deleterious outcomes of communication breakdown have litigious and costly consequences for both the medical staff and venue.

Comments revealed in a 2005 survey by Wilner, Feinstein-Whittaker, and Sikorski highlight such communication breakdowns. For example, "I watched a doctor with an accent give a verbal order to a nurse. When the doctor walked away, she turned to a co-worker and asked if she thought the doctor said, 'Tramadol.' Then, she wrote the order for what she thought the doctor said" (Wilner et al., 2005). Clearly, ineffective communication by all parties involved can potentially result in life-threatening errors. Similar observations in published works substantiate these findings:

> Language barriers may affect the delivery of adequate care through poor exchange of information, loss of important cultural information, misunderstanding of physician instruction; poor shared decision-making or ethical compromises, such as difficulty obtaining informed consent . . . there is significant evidence that language affects variables such as follow-up compliance and satisfaction with services. (Smedley, Stith, & Nelson, 2009)

A careful look at the United States reveals a changing landscape that is strongly reflected in the health care environment. United States born and United States trained providers reflect additional cultural, ethnic, racial, and linguistic diversity, further adding to the richness of the

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United States health care environment. Initiatives, such as the NIH-Funded Workforce Program (2013), have further diversified the medical workplace. IMGs represent 24% of the physician population in the United States (AMA, n.d.-a). The numbers of foreign educated nurses have grown from 6% in 2000 to almost 17% in 2007 (Pittman, Folsom, & Bass, 2010). According to the Bureau of Census (2010), 18% of the population over 5 years of age (47.0 million people) speaks a language other than English in the home. In the year 2050, the Hispanic population will grow from 13% in 2000 to 39% in 2050. Finally, the Bureau of Labor Statistics (n.d.) reports that the field of interpreting (spoken and sign language) and translating (written) is expected to grow by 42% (2010–2020). Izabel S. Arocha, Executive Director of the International Medical Interpreter's Association (IMIA), estimates that 80% or more of those working as medical interpreters are non-native English speakers (I. Arocha, personal communication, March 15, 2013). This data reinforces the need to address communication in a culturally diverse health care system.

Effective communication between professionals and patients, family members, and colleagues is critical to assure positive outcomes and avoid medical miscommunication that may contribute to errors, injury, and death. Studies have found that patient satisfaction is highly influenced by the interpersonal communication skills of the hospital staff and the patient. Hospitals receive reimbursements according to patient satisfaction surveys, which are measured by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). Results indicate that doctors and nurses comprise 34% of the inpatients' overall experience ratings and their influence rises to 43% in emergency settings. In the outpatient setting, the physician and other health care professionals encompass 50% of the patients' experience (Power & Associates Reports, 2012).

Both native and non-native English speaking health care providers must communicate effectively. Therefore, medical training programs have designated communication as an integral component of the Accreditation Council for Graduate Medical Education (ACGME) general competencies for medical residents. Efficient communication is reflected in the areas of patient care, interpersonal skills, and professionalism, but is also critical for demonstrating individual skills sets in medical knowledge and systems-based practice. In addition, the United States Medical Licensing Examination (USMLE), Step 2 (Clinical Skills component) addresses Integrated Clinical Encounters (ICE), Communication and Interpersonal Skills (CIS), and Spoken English Proficiency (SEP). These subcomponents incorporate questioning skills, information sharing, professional manner and rapport, pronunciation of consonants, vowels, intonation/prosody, voice projection, word choice, and grammar/syntax (Wilner & Feinstein-Whittaker, 2007).

All medical professionals must speak with clarity, effectiveness, credibility, confidence, and compassion. The challenge for some non-native English-speaking professionals is to learn the key communication rules that guide English pronunciation and effective communication. Providers can be explicitly taught how to use the rules of mainstream North American English (NAE), study figurative language and idioms likely to be encountered, learn accent modification techniques and strategies, and learn effective verbal and non-verbal communication skills. This heightened awareness and customized training will help non-native English speakers who need to improve, sound more fluent, personable, and understandable. In summary, focused training will reduce frustration and miscommunication when dealing with patients, family members, and colleagues. Most importantly, patient care outcomes and patient satisfaction will be enhanced.

Communication Skills Training Programs

SLPs possess unique skills to design and implement communication programs for non-native English speakers. However, other disciplines are also qualified to enter this specialty. Regardless of the trainer's professional background, a thorough understanding of and exposure to adult non-native English speakers and the health care environment is essential. Initially, a thorough communication skills evaluation is recommended in order design a customized program. Assessment of the health care provider's ability to pronounce medically related vocabulary and

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scenarios should be included (Wilner, 2003; Wilner & Feinstein-Whittaker, 2010). Traditional accent modification training focuses on the pronunciation of challenging consonants and vowels. Although this is important, the melody of English contributes substantially to overall effective communication. When the trainee learns the rules of stress and intonation, particularly in a medical context, significant changes can be demonstrated. Many practical rules can be readily incorporated into daily conversation (Wilner & Feinstein-Whittaker, 2007). Some of the most critical rules for health care communication are:

1. *Compound Nouns:* Compound nouns may be written as one word, a hyphenated word, or two separate words. Typically, compound nouns are two nouns that are combined to create a new word with a different meaning (e.g., eyeglasses, blood pressure). Other examples include adjectives + nouns (e.g., medical center, kidney disease). Examples of hyphenated compound nouns include, X-ray, pick-up. In compound nouns, the first part of the word is stressed with a higher pitch, louder voice, and longer vowel. Using correct stress patterns for the pronunciation of compound nouns will increase the clarity and effectiveness of the message. As a result, patient compliance may be improved, as important information is less likely to be overlooked or misunderstood.

2. *Proper Nouns:* Proper nouns are used to refer to the formal names of people, places, and things. The first letter of each word is capitalized and the primary stress is placed on the final word. Using accurate stress patterns for proper nouns will also enhance the delivery of the message. When pronounced properly, names of people, medical centers, locations, and other critical information are more likely to be understood and retained (e.g., Dr. Shah, Johns Hopkins, New York, Multiple Sclerosis).

3. *Acronyms/Initializations:* Acronyms and initializations are abbreviations for frequently used terms. Often avoided to prevent confusion and potential mistakes, many procedures and diagnoses use them for efficiency. Acronyms are pronounced as a complete word (e.g., GERD, MRSA). Initializations stress the last letter with a higher pitch, louder voice, and longer vowel (e.g., CVA, MI).

4. *Numbers:* It is extremely important to be accurate when using numbers to describe lab results, medication dosages, temperature and blood pressure readings, appointment dates, times, etc. Proper stress patterns for numbers are critical for preventing medical errors and life threatening consequences (e.g., 15 mg vs. 50 mg). When used to describe amounts, teen numbers stress the last part (fifteen) and "tens" numbers stress the first part (fifty) of the number.

5. *Questions:* How one asks a question, both in phrasing and intonation, can affect the patient's response. Raising pitch at the end connotes friendliness and sociability, but the speaker is giving "control" to the patient and they may have difficulty limiting the patient's responses. Lowering pitch at the end of the question may make one sound more authoritative, but the patient's responses may be brief (which may or may not be desired). Certain pitch patterns should be used for specific types of questions. Wh-questions utilized a downward pitch at the end of the question (e.g., "When did you eat your last meal?"). Adherence to these rules will help the trainee gain better control of the interview process, obtain the desired information, and present oneself in a confident and powerful manner.

There are cultural considerations with yes/no questions. For example, members of certain cultures may be reluctant to respond with "no" and this may affect patient compliance. In addition, some may say, "yes" without intentions to follow recommendations. Understanding these cultural communication preferences will help the provider effectively gather and convey critical information.

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Additional training activities to reinforce these important rules include oral reading scripts. The trainee can rehearse the proper nouns, compound nouns, numbers, acronyms/initializations, and other rules while reading a script with relevant biographical and workplace information, including pager numbers, department names and mail stops, questions, etc. Ultimately, trainees will begin to use these new patterns in dictations and conversation.

A comprehensive accent modification program should address skills for efficiency, adaptability, clarity, credibility, active listening, and empathy. To increase efficiency, health care providers should learn to paraphrase complex information, use more transition statements to make the conversation easier to follow, and learn more general vocabulary terms.

Adaptability can be integrated by teaching the provider to supplement messages with graphics, gestures, and additional written information. The health care professional can simplify complex information by using explanations and examples.

Accurate pronunciation is the goal for achieving clarity. Relevant medical terminology and the idiosyncratic pronunciation, stress, and grammar rules should be the core of training materials (e.g., focusing on numbers to convey medication dosages, temperature and blood pressure readings, laboratory results, appointment times, etc.).

Credibility helps foster a positive relationship with patients and colleagues. This can be addressed by learning appropriate sentence stress patterns, rate of speech, volume, phrasing, and pausing.

Active listening can be incorporated via role-playing exercises and dialogues. Communication repair strategies are essential for dealing with challenging situations.

Empathy skills will help develop rapport with clients. Small talk, idiomatic expressions, and developing cultural competency for each patient's heritage will foster a more positive relationship.

Communication Challenges Involving Medical Interpreters and LEP Patients

Medical interpreters are becoming an integral link in the medical team in these culturally and linguistically diverse settings. An understanding of the role of these interpreters and developing training to ensure accurate information exchange will improve overall patient care outcomes and satisfaction. In addition to multi-language proficiency, medical interpreters must know medical terminology, rules of engagement to ensure an unbiased communication between health care provider and patient, and non-verbal communication that may affect the outcome of the interchange (e.g., positioning in the room, eye contact). Most importantly, they must speak clear and understandable to ensure that information is accurate.

The authors conducted a preliminary survey of medical interpreters and trainers of medical interpreting programs to determine the existence and support for communication skills training in hospital settings (Wilner & Feinstein-Whittaker, 2012a). The 2012 survey included 165 respondents. There were at least 10 participants from each of the seven regions of the United States (New England, Mid-Atlantic, Southeastern, Mid-western, Northwestern, Southwestern, and West Coast). 66% were non-native English speakers; 33% were trainers or directors of interpreter programs; 44% were in-house medical interpreters; 40% were freelance medical interpreters. Length of typical provider-patient encounters when using an interpreter was estimated to be less than 45 minutes by 88% of the respondents.

On a five point Likert Scale, (1=never and 5=always), 74.1% of the medical interpreters experienced communication challenges in a range of "sometimes" to "frequently." 66.5% of the medical interpreters reported communication difficulties due to language/accent with non-native English speaking health care providers "sometimes" to "frequently," and 60.8% believed a heavy

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accent, poor diction, or a different dialect contributed to medical errors or miscommunication by a moderate to significant degree. Only 10.2% of non-native English speaking interpreters believed their accent interfered with their interpreting and 43.5% of interpreters considered accent modification training at some point in their career. More significant are some of the comments.

"Technically, English is not my first language but I do not have an accent when speaking in English. I do feel that heavy accents can interfere greatly in the interpreting field."

"Yes, I'd like to get some training to improve my pronunciation."

"I took an accent modification course already to improve some areas of my pronunciation. I am continuously trying to improve my accent. I've been told is minimal."

Follow-up conversations with instructors/trainers of medical interpreter training programs confirmed the premise that communication training (including pronunciation/accent modification) is highly regarded as a necessary professional development activity to ensure optimal communication between the key individuals in the communication loop. Medical interpreters were not consistently insightful about their own communication strengths and challenges. Therefore, the authors are conducting a follow-up survey with trainers only to obtain a more realistic assessment of the communication needs of the interpreters in their programs.

The authors anticipate that this will create another venue for accent modification training by SLPs. There are several strategies to improve communication when medical interpreters are involved (Salimbene, 2005). These tips can be incorporated into the communication skills training for physicians: (1) speak with the interpreter ahead of time, and summarize the gist of what will be discussed with the patient, (2) pose questions and offer explanations in various ways, (3) speak in short, simple sentences, (4) pause frequently to allow the interpreter time to process and speak, (5) take turns; avoid interrupting the interpreter, (6) be patient; explanations may take longer in another language, (7) keep eye contact with the patient, not the interpreter, (8) use natural but animated facial expressions and gestures, (9) watch the patient's reactions (upset, confused, nervous, etc.), and (10) be aware of cultural taboos and rely on the interpreter's experience and knowledge.

Izabel S. Arocha, Executive Director of the International Medical Interpreters Association (IMIA) and an interpreter trainer, stated:

An individual's pronunciation evaluation should be a mandatory component of language proficiency screening, especially when evaluating an applicant's potential for working as a medical interpreter. Proper pronunciation is key for understanding. Mispronunciation, just as improper grammar, can be a common cause of misunderstanding in patient-provider communications. This might need to be worked on before a candidate undertakes a medical interpreter program. (I. Arocha, personal communication, June 30, 2012)

In response to this interest in utilizing tools to screen prospective interpreters and identify those at risk, the authors developed The Pronunciation Screening Tool (PST; Wilner & Feinstein-Whittaker, 2012b). Through conversational speech samples, oral sentence and script reading, and rating scales, the trainer can assess a variety of critical communication areas. For example, the PST helps to identify the pronunciation of vowels and consonants, stress patterns of mainstream NAE, auditory discrimination skills for vowels and consonants, and other key areas.

It is expected that communication breakdowns may occur when caregivers, patients, and families don't speak the same language, or don't have the same level of proficiency in a common language (Salimbene, 2005). Some strategies for communicating successfully with LEPs include: (1) speak at a normal, but slightly slower rate, pausing frequently to allow the patient time to process information, (2) use natural but animated facial expressions, gestures, and body language, looking directly at the patient, (3) speak in short, simple sentences, avoiding technical/medical terminology and figurative expressions, (4) repeat, rephrase, and summarize important information, (5) utilize words, pictures, charts, graphs, photographs, or other media to supplement the

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information, (6) ask Wh-questions to gather information, (7) use yes/no questions to clarify information, being aware of the cultural implications with this question form, and (8) use the "teach-back" or "show me" models to ensure that the patient understands instructions.

Cultural Competency in Health Care

With the influx of immigrants into the United States, economic, linguistic, and social disparities are becoming more apparent. For a multitude of reasons, many individuals in these groups may face numerous health care challenges. These include chronic illnesses, infectious diseases, accidents, and mental health issues. General health literacy can be a challenge, along with the lack of access to diverse providers. Any disruption in communication can adversely affect the patient's well-being and quality of services provided.

Aside from the language barriers as described, another consideration for communication breakdown occurs in the realm of cultural understanding. Health care providers need to understand, and know how to appropriately respond to the unique social, cultural, religious, and economic influences affecting their patients. Sir William Osler, father of modern medicine describes this best: "It is much more important to know what kind of person has a disease, than what kind of disease a person has" (Yehieli & Grey, 2005).

It is likely that many health care providers and patients have culturally distinct views of health and illness and preferred communication styles. Richard D. Lewis classified cultures into three distinct categories: Linear-Active Cultures, Multi-Active Cultures, and Reactive Cultures (Yehieli & Grey, 2005). Although the following are generalizations, an understanding of typical worldviews and communication styles is helpful to understand how we can best communicate and satisfy our patients' needs in the health care realm.

Linear-Active Cultures: This group is exemplified by mainstream Americans and Western Europeans. They reportedly value empirical science over religion, tend to be goal-oriented and organized, and prefer to communicate in a direct manner.

Multi-Reactive Cultures: This group is predominantly comprised of African-Americans, Latinos, and those from the Middle East, including Arabs and Jews. They tend to value emotional bonds, prefer direct and expressive communication, act in an impulsive manner, and are usually uncomfortable with silence. Nonverbal communication is typically characterized by close physical contact/touching and direct eye contact.

Reactive Cultures: Groups in this classification include Asian-Americans, Pacific Islanders, and Native Americans. They tend to be more proper, reserved, and ritualized. Members of this group typically prefer indirect communication, value silence, and prefer harmony and agreement. They usually prefer more personal space and typically avert their gaze. They tend to be less comfortable with physical contact.

In addition to understanding their own, as well as their patients' cultural and communication styles, providers are encouraged to learn about their patients' attitudes toward health and illness, traditional health care practices, religious and dietary influences, family constellations, aging and death, and other factors that may impact the provision of care and patients' reactions to it.

A care plan that takes these cultural influences into account will result in enhanced patient compliance and trust in the provider and health care system in general (Salimbene, 2005). This will ultimately result in more favorable patient satisfaction, which will likely be reflected in the HCAHPS surveys. Training programs should address: (1) knowledge about cultural preferences for respectful and compassionate behavior, (2) understanding of "equality" and informality; begin with more formal interactions, and adjust accordingly, (3) understanding of patients' attitudes toward eye contact, speaking with authority figures, and provider-patient power distance, (4) objective attitudes about patients' assumptions; use thoughtful questioning to find out how they feel about health, illness, and treatment, (5) withholding judgment about a patient's belief that

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may be contrary, (6) respecting patients' attitudes about supernatural influences on their health or healing, (7) involving family in the decision-making process, (8) discussing negative consequences of treatments or medications; some patients may view that as a self-fulfilling prophecy for undesirable outcomes, (9) considering traditional medication or beliefs in the treatment plan when feasible, and (10) allowing families to include their cultural practices without interfering with medical care.

In response to changing demographics and practical challenges to our health care system, an increasing number of states are passing cultural competency laws. These bills state that medical licensing boards must mandate continuing education credits in the area of cultural competency, in order for providers to remain licensed. According to the U.S. Department of Health and Human Services, six states, including Washington and California have already enacted this law, with New York, Ohio, Georgia, and Arizona currently considering a similar bill. Health care providers need to understand and know how to appropriately respond to the unique social, cultural, and economic influences affecting their patients (Gray, 2013).

This cultural competency training would ensure that health care professionals take cultural attitudes into consideration when providing treatment, or counseling patients on health and lifestyle issues. Recently, the American Medical Association (AMA, n.d.-b), through its Ethical Force Program, developed the Communication Climate Assessment Toolkit (C-CAT). The C-CAT is a series of surveys, assessment instruments, protocols, and data tools to help organizations understand where literacy, foreign languages, and culture are making it difficult for staff to communicate with patients. There are a series of assessment instruments designed for patients, staff, and executives. These surveys ask about overall experiences with the hospital personnel. Data is collected around topics such as patient-centered and effective communication by staff, availability of language services, and hospital resources and training. Areas for improvement are highlighted along with plans to address areas, such as community engagement, availability of communication aids, nutrition, translated documents, and health literacy among others (AMA, n.d.-b).

In summary, improved health care and cultural communication impacts the overall experience for both the English speaking and LEP patient, IMGs or United States Medical Graduate physicians, and the diverse nursing and support staff. Consequently, patient satisfaction, delivery of positive outcomes, the facility's reputation, and decreased risk exposure of the hospital are the end product of effective language and cultural communication. In the new health care model, this will ultimately improve the sustainability of medical systems in the United States. As SLPs, we can have a substantial and positive impact facilitating clear, understandable, and compassionate communication amongst all of the parties involved.

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