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Informing Physician Strategies to Overcome Language Barriers in Encounters with Pediatric Patients

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Abstract

Objectives—To describe physician perceptions of differences in limited English proficient (LEP) pediatric encounters and the behavioral adaptations they make to provide quality care to LEP pediatric patients.

Methods—We conducted 30-minute, semi-structured interviews with 6 family physicians and 5 pediatricians in one health system. Audiotapes from each interview were transcribed verbatim then coded using content analysis.

Results—Multiple aspects of the LEP pediatric encounter were perceived by physicians as different from other encounters: trust and relationship between physician and LEP child/child's family, continuity of care, encounter's structure and flow, patient assessment, and communication barriers. Within each of these themes, physicians identified how they adapt their behavior to improve the quality of care provided to LEP children and families.

Conclusions—Physicians' made both positive and negative adaptations in LEP pediatric encounters that may impact the quality of care provided to these patients.

Practice Implications—By identification of specific positive and negative behavioral adaptations, this study emphasizes intervention targets, such as demonstrating interest in an LEP pediatric patient's family story and individuality and using common niceties in conversations with LEP children.

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1. Introduction

There are differences between pediatric encounters with a language barrier and those without a language barrier. Limited English proficient (LEP) patients speak no English or speak it “not well.” LEP parents perceive that their children do not receive timely care and are less satisfied with provider communication and their own lack of ability to participate in decision making [1,2]. Physician clinical decision-making, treatment plans, and utilization of resources differ between LEP and English proficient families, which may be due to the language barrier itself or changes in physicians’ behavior in LEP encounters [3,4].

Use of professional interpreters is increasing among pediatricians [5], and reactions to training on interpreter utilization and language courses have been positive [6–8]. Pediatric psychiatric providers modify their approach to encounters, considering interpreters to be “cotherapists” and stressing the importance of co-managing and capitalizing on the interpreter-physician relationship [9]. Previous research explored physician perspectives on triadic primary care LEP encounters, involving an interpreter, physician, and patient, and various methods to improve cross-cultural communication in primary care have been evaluated [10–11]. We know much less about how physicians adapt their behavior in the setting of language barriers in primary care clinical contexts.

We conducted a qualitative interview study of family practice and pediatric physicians to better understand how physicians adapt their behavior to provide quality care in pediatric encounters in which a language barrier is present. Learning from what physicians do in this context could inform interventions that improve the quality of care provided to LEP pediatric patients. Given the need for interpreter services in a variety of healthcare settings, the implications of our findings for interventions are far-reaching and may extend to any system in which interpreter services are utilized in pediatric care.

2. Methods

We conducted a qualitative interview study of family practice and pediatric physicians and analyzed the content of these interviews to understand whether, how, and when these providers discussed or perceived differences in how they approached encounters when a language barrier was present.

Participants

We recruited participants who provided pediatric care in outpatient settings in a large healthcare system in Wisconsin. We e-mailed all pediatricians and family medicine physicians in 2015, informing them about the study and inviting them to contact the research team to participate. The principal investigator gave presentations at provider meetings and asked interested participants to contact the research team. Non-resident physicians with experience working with LEP pediatric populations who contacted the research team were

invited to participate. We made an effort to have an approximately equal number of pediatricians and family medicine physicians. The study was ruled exempt by the University of Wisconsin Institutional Review Board. Each physician received \$50 for their participation.

Data Collection and Analysis

We conducted semi-structured interviews using fourteen open-ended questions (available upon request). We developed these questions based on our previous qualitative research interviewing physicians about providing care to adults with limited English proficiency and our understanding of pediatric practice. The interview guide was designed to elicit information about the LEP pediatric encounter itself and how the provider addresses the needs of patients in the context of a language barrier. We started with general questions about experiences caring for limited English proficient children and families and then delved deeper into how physicians approached the LEP pediatric encounter. Probes were used to have more in-depth discussions. The questions focused on outpatient and primary care encounters in which the provider could not speak to the patient or family in a language that they could understand, also known as language-discrepant encounters. One or two research team members attended each interview. Interviews were conducted in a private room in a clinic or research office building and audiotaped, and took about 30 minutes. Audio files were transcribed verbatim by a research team member, and all transcripts were reviewed for accuracy by a different member of the research team.

The final sample size was determined once the research team agreed that it had reached theme saturation. Using the constant comparison method as a basis, we proceeded with sampling, data collection, and preliminary data analysis concurrently. We ended further recruitment when the data became redundant and new themes could not be identified [12]. We used directed content analysis to analyze our data [13,14]. We developed a preliminary codebook with broad topics. Two study team members used this to code the interviews independently, and then they met to compare codes. Code definitions were refined and agreed upon by the team. Our complete codebook contained 91 codes, and all transcripts were coded using this final set. We used NVivo10 to catalogue and code our data.

3. Results

Five pediatricians and 6 family medicine physicians participated: 6 women and 5 men with an average age of 49 (range 40 to 61) years. They worked in 8 different primary care clinics and had different levels of experience with LEP patients. They spent the majority of their time in the outpatient setting and discussed their approach to addressing language barriers in general pediatric encounters, as well as urgent care encounters that took place in walk-in centers that were not in emergency departments. On average, 22% of the physicians' total pediatric patient population were LEP (range 5% to 65%). Physicians recalled various LEP encounters and discussed encounters in which only the parent(s) were LEP or in which the parent(s) and child were LEP.

Physicians' perceived that encounters with LEP pediatric patients and families are inherently different from encounters in which a language barrier is not present, and they modified their

behavior to adapt their care to address these differences. Below we describe the perceived differences and physician reports of how they address differences along five dimensions: relationship-building with the LEP child and/or child's family, building trust, addressing patient literacy, managing the structure and flow of the encounter, the assessment of patients, and barriers to communication (Table 1). The perceived differences by dimension are presented first, followed by physicians' adaptations in encounters where a language barrier was present.

Differences Between LEP Pediatric Encounters and Other Encounters

Relationship-Building—Connecting with pediatric patients may be challenging, whether or not they are LEP. “There’s a level of warmth and personal connection that you lose anyway” in pediatric encounters, one physician explained. “There’s a parent there that you’re trying to communicate through,” another acknowledged. The disconnect is “more noticeable in kids that don’t speak English.” In LEP encounters, physicians noticed a loss of nuances in communication, such as “tone of voice, with body language,” which impacts rapport. Another said that nuanced communication is “just not as effective,” that the “sense of humor, and ... intangible interaction type things... are often nonexistent in those relationships.” Physicians described the benefit of working in primary care settings, in which delicate issues can be further explored on a revisit and relationship-building continues over time. One physician said, “it’s just a matter of having multiple encounters, you know, that bond people.” “That’s the luxury of family practice, where there is a next time,” as one physician explained.

Building Trust—Although trust may be considered one aspect of a relationship, we consider it as a separate theme, because physicians discussed trust specifically and in detail. As one physician said, “trust is always the foundation of any doctor-patient relationship.” In LEP encounters, “the trust factor can be a big stumbling block,” as another physician described. Without trust, an LEP patient and family may not feel comfortable sharing important information or asking important questions. A physician said, “If you don’t have [trust] then it makes everything else more cumbersome, in terms of not [being] sure if people are understanding each other, not even sure people are going to ask you a question if they’re worried.”

Literacy—Many physicians identified patient literacy as an important aspect of encounters, and some considered it especially important among LEP pediatric encounters. Even though they recognized a difference in literacy, many providers did not assess literacy nor address literacy concerns among LEP families. One pediatrician said, when asked if literacy is an important factor to consider when caring for LEP patients, that it had not been an issue in their mind until just then, when the question was asked, and said “I should be.”

Structure and Flow of the Encounter—Although one family physician said the flow of a clinic visit is slower in LEP pediatric encounters, another family physician said, “it’s very dependent on that particular encounter.” In terms of structure, LEP encounters were described as chaotic by most physicians. One family physician said, “English encounters can be much more chaotic; people can interrupt, say things, ‘cause everyone understands the

language.” One family physician said that interpreted encounters are more rigid in structure and do not allow for last-minute “hand-on-the-door” questions and concerns.

Assessment of the Pediatric Patient—Providers described how their assessment was different in LEP encounters. One family physician said, “I don’t get a good history because it’s getting diluted” through the interpreter. Physicians often attain medical information from school-aged children rather than LEP parents, “because most of them are speaking English.” In pediatric adolescent encounters, communicating with the pediatric patient directly in English has its benefits. One family physician said: “We do a portion of the teenage visit without a parent in the room regardless of language. But it can kinda streamline actually some of that... they’re just like ‘let’s get them out of here’ without the parent knowing what they’re saying.”

Carrying out developmental screens and assessing language development is challenging in LEP patients. One family physician said, “the ability to do developmental screens...I can assure you it gets done worse in non-English.” Another family physician felt that the developmental assessment is mostly based on the child’s behavior, saying “it’s...something that I could readily assess, or I was confident to assess. It goes beyond language, honestly.” A family physician said, “when they’re bilingual anyway, they’ll have a superior understanding of language, but they’ll kind of go back and forth [between languages], and so it can be sort of difficult to assess them.”

Language, Cultural, and Social Barriers—Physicians described the challenge of language barriers in LEP encounters. One physician said it’s “a ton of scary, frustrating work, which is what you know, dealing in a different language can be...this extra labor, extra tension.” One physician said, “in addition to language barriers, there’s the increased risk of cultural barriers ... they don’t always go hand in hand, but they often do.” There are also added complex social barriers. One family physician said, “in the cross-cultural circumstance it can be more challenging, because it can be interpreted as you know ‘You don’t trust me because I’m this ethnicity,’ ‘You white doctor, [you] don’t believe me because I’m one down racially.’”

Time as a Barrier—Previous studies have identified time as a barrier, and physicians in our study did as well. A pediatrician said, “it’s more labor-intensive; I mean it takes longer,” and another noted that LEP encounters take “double the time.” Sometimes there is a negative attitude toward LEP encounters, because of the time these encounters take and the labor involved. A family physician said “I think rushed. I think nurses kind of, you know, dread trying to call somebody with an interpreter, just ‘cuz again, a lot of that’s time.”

Physician Adaptations or Changes in Behavior in LEP Pediatric Encounters

Relationship-Building—Physicians agreed that all children respond positively to certain interactions. One physician said, “You still can relate to kids in a sort of universal way... that non-verbal and playful interaction... no matter what language.” Speaking in the patient’s preferred language whenever possible with a few numbers or nouns was described as a helpful technique. A physician said, “People are just really appreciative of any effort

you make to communicate.” A pediatrician said, “The families get tickled. They’re like ‘Oh look at that, he knows these words!’”

Physicians described making efforts to understand patient and family perspectives. There are aspects of the patient-physician relationship “that really have nothing to do with the words, but a lot to do with how you understand that patient’s home environment, how you understand the demands put on them,” as one physician said.

However, they still expressed frustration in some aspects of relationship-building in the context of a language barrier. Physicians may not engage with LEP children with the light-hearted questions they use in other encounters, because they lose their effect through interpretation. A family physician said, “I tell the translator ‘Ask him what his favorite color is.’ And they say that, and the kid’s looking there, then mom says, ‘What’s your favorite color, Jimmy?’ ... I now stressed the kid out more.”

Maintaining a relationship with an LEP parent of an English-speaking pediatric patient was perceived as imperative, and one physician described efforts to address this: “The kids will sometimes interrupt their parents... I really try not to let the child supersede the conversation... I don’t wanna overstep my bounds or have the kid take more power than he or she is supposed to.” Another physician felt that connecting with LEP children younger than school-age is easier than connecting with parents because of her direct interaction with the child, being “hands-on and looking at them.”

Building Trust—It takes extra effort to build trust with LEP children and families. A physician said, “with English speakers...it’s much more straight-forward. It’s kind of the simplified model of, I’m providing a certain spectrum of care that they expect, and yeah, they trust me by default ... You know I don’t feel like I have to make that effort.” Physicians have some innovative means of building trust with LEP families. As one physician described “using my body language differently and extending myself ...to gain that trust and establish that trust.” She identified examples of her efforts to build trust: “...take a strong interest in their individuality; take a strong interest in their family story ...get an idea of what the lived landscape of their life is.”

Literacy—Some physicians use repetition to ensure families understand instructions. A family physician said that LEP families “may get a better end of the deal, because I am less likely to assume that they’re literate... so I may be more likely to ...repeat stuff.” To ensure understanding, another physician said, “I’ll repeat myself several times; if I’m really being good, I’ll ask the parents to tell me what I just said.” Not all physicians use repetition in LEP encounters. A family physician said that “with English-speaking [patients]...I have them repeat it to me, making sure they get it. And I can’t say that I do that with Spanish-speakers.”

Physicians also use other methods. One family physician said, “I will speak more slowly... the faster people speak, the harder it is to understand them.” A family physician said that it is useful to write down instructions in English, stating “even if they can’t read it, at least I’ve like put a picture of like what that word looks like.” Patients and their families could then

use the written medication names to either locate an over-the-counter medication at the pharmacy themselves or offer the information to the pharmacist directly for assistance. They also often have a bilingual family member or friend who can help them to use the information in English. While this is not a perfect solution, it does give the patient more information than not giving them any information at all.

Structure and Flow of the Encounter—Use of an interpreter may impact the flow of an encounter from the very start, so physicians developed strategies to minimize a potentially negative impact on flow. One physician said that knowing there is a telephone interpreter waiting on the phone line in the exam room, “I’ll go in quicker you know, because it costs money to use the interpreter.” Sometimes the interpreter is not ready, and the physician gets started with a patient, as one pediatrician described. One pediatrician discussed how she utilizes the time during which interpretation is taking place: “While the interpreter is delivering in Spanish, I will very quickly, you know, be typing up the prescription or whatever, while half-listening.”

Assessment of the Pediatric Patient—A less commonly identified adaptation was approaching patient assessment differently in LEP encounters. As one family physician said, in the structured clinical interview and physical exam, “Often times you just kind of dump the language.” In LEP encounters, a physician said, “there’s a tendency to do the exam differently than you would in another situation,” that the need to translate each aspect of the physical exam is “cumbersome,” and that translating “doesn’t go into the flow of a visit.”

Time as a Barrier—Not all physician adaptations made were positive. In-depth discussions regarding clinical concerns and life circumstances may not take place in LEP pediatric encounters because of time constraints. A family physician said: “The people that are lower socioeconomic, and they actually need more of the, you know, encouragements and resources, and maybe [we] don’t get to those kinds of things due to time constraints.” The kinds of issues that physicians address in an LEP encounter are different due to time constraints. A family physician said: “lower priority things, and the medium priority things, like well issues and prevention, might suffer compared to the complaint type of issues.” Physicians may not engage with pediatric patients using light-hearted questions because of the time limitations. A family physician said that for “time’s sake...all that sort of little patter talk you have with the kid...that seems like an extra effort to work that through a translator, and so you’re less likely to do that.”

4. Discussion and Conclusion

4.1 Discussion

Although the differences and adaptations we identified may not be unique to LEP and pediatric encounters, our findings highlight how physicians can improve their interactions with LEP children. Physicians in our study made positive adaptations to maximize the quality of care they provide in encounters with LEP children and families, but they also made not-so-helpful adaptations including: not engaging with LEP children using light-hearted, relationship-building questions often used in other encounters, not using words to

communicate during the physical exam, and not addressing what they considered lower priority clinical issues such as prevention items. Negative adaptations in the context of a language barrier might adversely impact the care of pediatric patients.

LEP children have worse health outcomes and receive lower quality care compared to English-speaking patients [15]. Access to care, insurance status, and socioeconomic status, and lack of interpreter services likely contribute to this disparity [1,16]. Investigators have identified language barriers to healthcare access in the U.S. and explored how providers views the interpreter's role in emotional support of patients [1,17–18]. Our study extends these findings by providing insight into the perspectives of primary care pediatric providers about how language barriers impact the encounter and how they care for these patients and either overcome these barriers or make negative adaptations. Similar to providers of adults, they recognized multiple barriers, including time limitations, that pose a challenge to building rapport with patients. LEP parents and providers often rank their priorities differently [19], and an important contribution of our study is the identification of challenges unique to pediatric care, particularly around managing conversations with both children and parents, the challenges language poses to conducting developmental assessments, and the positive and negative adaptations physicians make when faced with the challenge of a language barrier.

Language and cultural barriers are significant challenges for primary care physicians around the world. Barriers to effective communication between healthcare providers and patients impact the provision of quality of health care and result in poorer health outcomes internationally. Despite the development of professional guidelines and training initiatives to reduce barriers to effective communication, implementation is not widespread. A study involving six European countries (RESTORE, REsearch into implementation STRategies to support patients of different ORigins) used a combination of social theory and participatory learning and action research to better understand how implementation of these strategies could be improved [20]. Our findings contribute to the findings of the RESTORE study and others by providing additional strategies for enhancing communication with children and families who do not speak the language of their new home countries.

As our respondents reflected, physicians can and do adapt their behavior to develop positive relationships with pediatric LEP patients and families. They recognize complicated family dynamics and take an interest in LEP families' stories and cultures. As several physicians described, they spoke words in the patient's native language whenever possible, asked about a patient's family story and lived landscape, and demonstrated appreciation for a patient's individuality. These findings are consistent with previous physician-patient relationship studies [21]. They also align well with American Academy of Family Physician guidelines for Cultural Competence [22], which include knowing a few words in the language of the patient in order to build rapport and utilizing interpreters regularly for majority of the encounter.

As many physicians in our study described, providing quality care to LEP families is complex and would remain so even if interpretive services were readily available [2,23]. Our findings shed light on how physicians identify, manage, and overcome the multifaceted

challenges of these encounters. For example, the issue of literacy and its potential impact on the health of pediatric patients is critical to addressing health disparities. To address this issue most physicians in our study made an effort to speak more slowly, evaluated comprehension through repetition, and created written instructions for families. These adaptations, as well as the others, outline the ways by which physicians overcome challenges in LEP pediatric encounters. Inaccuracies in medical interpretation are common in LEP pediatric encounters, and identifying these adaptations is of the utmost importance to providing improved care in these clinical encounters [24]. Understanding physician perceptions of these challenges and their behavioral adaptations in LEP pediatric visits, enables healthcare providers, public health professionals, and health services researchers to develop interventions to improve the quality of the LEP pediatric encounter and address health disparities among LEP families.

Since the purpose of this study was to understand how providers of our health system perceive differences in LEP encounters compared to other encounters, our findings may not be generalizable across every health system. Access to interpreter services varies across systems, and recruiting locally and in one system helped to keep that factor constant in our study. This study only contains physician interviews, and our recruitment strategy could have primarily attracted physicians who are interested in issues related to the LEP population, leading to a potential selection bias. This was work conducted in the U.S. and may not be generalizable to all settings outside the U.S. Despite these limitations, this study provides novel information on perspectives from different types of providers who interact with pediatric patients.

4.2. Conclusion

To address health disparities experienced by LEP children and families, it is imperative that the quality of healthcare provided to LEP children be enhanced. With perspectives of primary care physicians on their perceptions of challenges and their behavioral adaptations to overcome these challenges, this study identifies and emphasizes potential aspects of the LEP pediatric encounter that could be targeted in the development of effective interventions and solutions. LEP pediatric encounters would greatly benefit from longer periods of time scheduled for each clinical visit and physician training on approaches for developing relationships and building trust with LEP children and their families. They should also be enabled to participate in cultural competency education workshops and consultations with representatives of local cultural organizations and community health worker programs. Future research aimed at understanding the intricacies of an interpreted LEP pediatric encounter, from an interpreter and patient perspective, may provide additional valuable details as to how services may be optimized.

4.3. Practice Implications

Our respondents described both positive and negative behavioral adaptations when taking care of children in the context of a language barrier. Other physicians, health professionals, educators, and practice leaders can use this information to adapt and encourage the behaviors that successfully address language barriers and avoid those that might contribute to disparities.

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Table 1

Themes identified and associated physician perspectives on differences in encounters with LEP pediatric patients and physician's behavioral adaptations in LEP pediatric encounters. Causal or directional hypotheses are not implied.

Theme	Differences between LEP pediatric encounters and other encounters	Physician adaptations or changes in behavior in LEP pediatric encounters
Relationship-Building	<ul style="list-style-type: none"> ■ Disconnect between physician and patient ■ Nuances lost in translation ■ Nuanced communication not as effective as it is in language concordant encounters 	<ul style="list-style-type: none"> ■ Physicians choose not to use niceties in LEP encounters ■ Demonstrate the importance of the physician relationship with the parent(s) ■ Demonstrate interest in the child's family life ■ Use a few words in the pediatric patient's preferred language
Building Trust	<ul style="list-style-type: none"> ■ Trust is the foundation of the patient-physician relationship ■ Lack of trust could be a stumbling block to communication ■ Patient may not share important information or ask important questions without trust 	<ul style="list-style-type: none"> ■ Body language is different in LEP encounters ■ Take an interest in child's family story and individuality ■ Additional effort is made to build trust
Literacy	<ul style="list-style-type: none"> ■ Literacy issues may be present among all patients or may be a bigger issue among LEP patients ■ Some physicians assess literacy while others do not 	<ul style="list-style-type: none"> ■ Repetition of instructions to the child and family ■ Physicians may be less likely to assume LEP children and parents are literate ■ Speak slowly with children and parents ■ Provide written instructions in English to the family
Structure and Flow	<ul style="list-style-type: none"> ■ LEP encounters may be more chaotic or more rigid in structure compared to others ■ No opportunity for hand-on-the-door concerns in LEP encounters 	<ul style="list-style-type: none"> ■ Enter exam room quickly since an interpreter may be waiting ■ Write notes while interpreter translates to be efficient with time
Assessment of Patient	<ul style="list-style-type: none"> ■ Sometimes the history is diluted in LEP encounters ■ May or may not be difficult to assess child development and language proficiency in bilingual children 	<ul style="list-style-type: none"> ■ Physicians may not use much oral communication during the pediatric physical exam in LEP encounters ■ Since it may be cumbersome to use an interpreter during the physical exam, physicians may conduct the exam differently
Language, Cultural, and Social Barriers	<ul style="list-style-type: none"> ■ Extra labor to communicate effectively and appropriately in LEP encounters ■ Extra tension present in LEP encounters ■ Increased risk of cultural barriers 	
Time as a Barrier	<ul style="list-style-type: none"> ■ LEP encounters are rushed ■ Because they are labor-intensive, more time is needed for LEP encounters 	<ul style="list-style-type: none"> ■ Fewer in-depth discussions with patient and family ■ Limitation on the type of issues that are addressed in LEP encounters ■ Fewer niceties are used in conversations with LEP children