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Research paper

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 min, 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.

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.

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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.

2.1. 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.

2.2. 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-disconcordant 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 min. 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.

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	• Disconnect between physician and patient • Nuances lost in translation • Nuanced communication not as effective as it is in language concordant encounters	• 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	• 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	• 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	• 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	• 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	• 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	• Enter exam room quickly since an interpreter may be waiting • Write notes while interpreter translates to be efficient with time
Assessment of Patient	• Sometimes the history is diluted in LEP encounters • May or may not be difficult to assess child development and language proficiency in bilingual children	• 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	• 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	• LEP encounters are rushed • Because they are labor-intensive, more time is needed for LEP encounters	• 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

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