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“It’s just another added layer of difficulty”: Language access equity and inclusion in pediatric interpreted medical encounters — Provider and interpreter perspectives

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Abstract

Limited English proficient or language-diverse patients and families in pediatric interpreted medical encounters (IME) are susceptible to health disparities and inequities in the US compared to English proficient patients and families in language-concordant medical encounters. Policies to improve access to language services intend to bridge this gap, yet evidence suggests that significant inequities still exist. This study explores perspectives of interpreters and pediatric critical care medical providers to better understand the complexities of IME in pediatric settings. Qualitative data were analyzed from two interview studies with medical interpreters and providers using thematic coding and inductive analysis. Several factors were identified by both interpreters and medical providers that negatively affected communication, equity, and inclusion. These included systems-level factors (e.g., time constraints and language variety), interpersonal factors (e.g., difficulties with communication and mistrust), and intrapersonal factors (e.g., implicit biases and judgements). These results highlight multiple layers of potential inequities which adversely affect patients and families in pediatric IME.

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Keywords: language access equity, language access inclusion, pediatrics, medical interpreters, interpreted medical encounters

1. Introduction

English is not federally recognized as the national language of the United States, yet it is the common language used in institutions in the US, including the medical system. In this context, majority-language speakers use English to navigate health systems, while language-diverse communities navigate systems in non-English languages for a variety of reasons (e.g., degree of comfort or proficiency in English). In US pediatric hospitals and other medical settings, health disparities are well documented among language-diverse populations (often designated as Limited English Proficient in clinical practice and research) when compared with English-dominant populations (e.g., Eneriz-Wiemer et al. 2014, 133–134; Jimenez et al. 2014, 7-8; Zurca et al. 2017, 12).

Medical interpreters bridge the language and cultural gaps between English-speaking medical providers and language-diverse patients and their families to mitigate inequities stemming from language barriers. Studies demonstrate that interpreting services improve patient and family understanding of medical problems (Flores 2005, 295), quality of care, and health outcomes (Karliner et al. 2007, 743–744). However, underuse of language services "creates and perpetuates disparities" for language-diverse populations (Lion et al. 2021, 2) and maintains barriers to accessing health information (Diamond et al. 2008, 260). As such, language access and health literacy have been argued to be social determinants of health in these populations (Mellinger 2022, 117).

The foundation for language access rights in the US lies in Title VI of the Civil Rights Act of 1964, which prohibits discrimination in federally funded programs based on "race, color, or national origin" (Pub. L. 88–352, title VI, §601, July 2, 1964, 78 Stat. 252). Title VI's national origin stipulation covers discrimination based on language proficiency in English (US Department of Justice 2020) and paved the way for executive orders and other regulations that increased interpreting services provision in healthcare and other settings. The Affordable Care Act (ACA) of 2010 specifically identifies the need for hospitals to provide “qualified” interpreters who abide by “interpreter ethics and confidentiality,” have “proficiency in English and at least one other spoken language,” and have “the ability to effectively and accurately use the necessary terminology required by a certain interpreting situation” (United States 2010, Public Law 111–148). The ACA’s “qualified interpreter” guidance is essential for protecting patients and families against discrimination based on language use and promoting equity for linguistically-minoritized patients and families. Hospital systems support health equity by allocating resources, such as interpreting services, that promote equal access to healthcare and counteract historical injustice, minoritization of patient populations, and inequitable practices (Brownson et al. 2021, 2).

Despite the provision of language services, language-diverse communities interacting with the health system may experience minoritization due to language-based racialization and discrimination in clinical settings. Racialization is a process by which “racial meaning is attached to something that is perceived as ‘unracial’” (Gonzalez-Sobrino & Goss 2017, 505), such as language use. Linguist and educator Tove Skutnabb-Kangas (1990, 77) asserts that racialization of language use is a “sophisticated form of racism” in which linguicism (discrimination based on language use), racism, and ethnicism (discrimination based on ethnicity) work together to uphold unequal divisions of power within and among communities. Additionally, language-diverse communities in the medical system may experience racialization based on perceived immigrant status or assumptions of illegality (Anderson & Finch 2017, 220). Consequently, language-diverse communities may be multiply minoritized in US medical settings, where language use “has been solidly placed in the cultural category of racial/ethnic indicators” (ibid.) and intersects with elements of racial, ethnocultural, and socioeconomic identities.

Discrimination based on intersecting identities has been shown to result in inequitable access to health services (Anderson & Finch 2017) and may exacerbate health and health communication inequities (López & Gadsden 2016, 2–3). Even when language services are provided, discrimination, inadequate health communication, and provider dismissal of patient and family concerns may persist in medical encounters. Researchers have identified encounter-level inequities and systemic factors that represent obstacles to health equity for language-diverse communities; these include the underutilization of interpreters (Diamond et al. 2008, 259–260; Lion et al. 2021, 6–8) and provider trust concerns regarding interpreter neutrality and accuracy (Hsieh et al. 2010, 15–17). Such inequities persist in clinical settings despite the availability of interpreting services. Another obstacle to language access equity in interpreted medical encounters (IME) is securing quality interpreting services for languages of lesser diffusion (LLDs), which are languages used by small numbers of native speakers, ethnic minorities, asylum seekers or refugees who may also have limited written resources (Mikkelson 1999, 362) and special healthcare needs (Gmünder et al. 2020, 7; Brandenberger et al. 2021, 2). Additionally, systems barriers to language access include a lack of training for diverse hospital staff on working with interpreters, provider and staff ignorance of mandates for providing language services (Rodrigues 2020, 175–176), ineffective interpreter scheduling processes (ibid. 198–200), and a lack of both federal and institutional funding for language services programs (ibid. 31, 164). Apart from these issues, little is known about other factors that exacerbate language access inequities in pediatric medical contexts, especially interpersonal (i.e., relational) and intrapersonal (i.e., within the individual) considerations at the encounter-level.

To address the above-mentioned gaps in research, this study analyzes data from two independent qualitative interviews, one with medical interpreters and the other with critical care providers from the same pediatric hospital. The two interviews were designed separately to understand the perspectives of each group regarding distress communication and emotional wellness in pediatric hospital settings. Although these interview studies were designed and analyzed separately, researchers with crossover research team membership intended to compare responses to obtain a better understanding of stressful IME from various stakeholder perspectives. The combined analysis of interpreter and provider data discussed here revealed systemic, interpersonal, and intrapersonal factors that impede equity and inclusion in IME despite the provision of language access resources, such as interpreting services. These factors include provider and interpreter concerns about language resources, appraisals of IME, biases and stereotypes, mistrust, and concerns about teamwork in IME. Based on the results, the authors conclude that the presence of interpreters in IME is not sufficient for equitable language access for language-diverse patients and families. Medical providers and interpreters must work together to understand each other's communication aims and processes. Moreover, providers and systems administrators must advocate for interpreters to be viewed and treated as integral parts of the treating team, and systems administrators must promote a culture of language access equity and inclusion, which includes fostering appreciation of interpreters and their work as access facilitators. Results from interpreter and provider interviews are presented together below and are summarized in Appendix A.1.

2. Methods

2.1 Positionality

Positionality refers to the "stance or positioning of the researcher in relation to the social and political context of the study—the community, the organization or the participant group" (Coghlan & Brydon-Miller 2014, 628). Positionality influences assumptions about the study, as well as research and methods design (Creswell 2014, 3) and is interconnected with the researcher's personal and philosophical views. The research team involved in this project included diverse perspectives and clinical experiences, which allowed teams of practician-researchers to conduct transdisciplinary research in interpreting studies (Mellinger 2020, 96). Yet, researcher positionalities that aligned with participant positions in this study risked introducing "implicit biases in the research, including what is commonly referred to as confirmation bias," as Mellinger suggests (ibid.). Thus, the research team regularly revisited their positionalities and biases during the research process. Research team positionalities are described as follows: Amy Olen is a White, American, multilingual woman who has worked as a Spanish-English medical and community interpreter since 2005, and who researches and teaches Translation & Interpreting Studies at a US university; Paulina Lim is a predominantly English-speaking, multilingual Asian-American woman, a 1.5 generation immigrant, and a pediatric psychology resident; Charles B. Rothschild is an English-speaking, White, American man and a physician practicing Pediatric Palliative Care and Critical Care Medicine; Matthew Scanlon is an English-speaking, White, American man and physician in Pediatric Palliative Care and Critical Care Medicine; Kathryn Balistreri is a White, American, cisgender woman and a clinical psychology graduate student; W. Hobart Davies is an English-speaking, White, American man and a pediatric psychologist. PL, CBR, MS, and KB have experience working with interpreters in pediatric clinical settings. AO has worked as a medical interpreter in both pediatric and adult population healthcare settings.

2.2 Procedures

The research described in this article originated in the interdisciplinary research group Pediatric CREWS (Collaborative for Resilience and Emotional Wellness Science) and was conducted by two research teams with crossover membership (PL, CBR, MS, WHD were on both teams; AO was on the interpreter-focused team, and KB was on the provider-focused team). The teams independently developed mixed-methods, qualitative interviews on communication with distressed families in pediatric settings and drew from two participant pools (interpreters and medical providers) from the same pediatric hospital. Both participant groups were asked about identification and communication of family distress, their emotional wellness in distressing pediatric encounters, and the resources they use to cope with distressing content. The procedure for participant recruitment and data collection for qualitative interviews with interpreters was approved by the University of Wisconsin–Milwaukee Institutional Review Board (IRB # 20.124). Interviews with medical providers were part of a quality improvement initiative. The Children's Wisconsin Institutional Review Board reviewed the project and determined it to be exempt.

One research team conducted interviews with 13 Spanish-English medical interpreters who had between 3–20 years of interpreting experience in pediatrics and who mostly identified as Latina or Hispanic women. One question in the interpreter interview was: "What are things medical providers do that make your job easier or more difficult?" Another research team conducted interviews with 37 pediatric critical care medical providers, consisting of 12 nurse practitioners, 13 fellow physicians, and 12 attending providers. Interviewed medical providers mostly identified as White (73%) and female (78%) and had between 3–39 years of clinical experience. One question in the provider interview was: "Tell me about your experiences working with distressed families while using an interpreter."

Although these research questions were analyzed separately, researchers with crossover membership intended to compare responses to obtain a better understanding of stressful IME from various stakeholder perspectives. These two questions were analyzed together in the present study because participant responses described working with the other party in IME. The research team identified aspects of these descriptions as interpersonal factors affecting health communication access for language-diverse populations.

2.3 Data Coding and Analysis

AO and PL coded both data sets separately and in two cycles: In vivo coding was used in first cycle coding to prioritize and honor the participant's voices (Saldaña 2016, 105–110), and focused coding was used in second cycle coding to develop salient categories in the data (Saldaña 2016, 239–244). Once codes were categorized and finalized for each data set, comparative analysis was used to compare codes from interpreter and provider responses. After this analysis, AO, PL, and CBR used an inductive thematic analysis approach. Additionally, AO, PL, and CBR discussed affinities among provider and interpreter responses to minimize confirmation biases (Mellinger 2020, 96). Themes were then shared and discussed with the broader research team (AO, PL, CBR, MS, WHD, KB) using a consensus building approach to finalize parallel themes in the two data sets.

3. Results

Interpreters were asked about helpful and unhelpful provider behaviors. Participants mentioned both types of behavior in their interviews, but they elaborated almost exclusively on unhelpful provider behaviors. Providers' responses to the open-ended question about working with interpreters were almost exclusively negative (one out of 37 providers responded that working with interpreters was helpful for understanding diverse patients' needs, but even this participant later articulated challenges of working in IME). The few instances of positive descriptions are reported in section 3.7 Interpreter-Provider Teamwork. Shared themes that emerged in the two data sets presented below are divided into interpreter perspectives followed by provider perspectives per theme. Transcriptions of participant quotes below use ellipses to signal elided false starts, filler words, and clauses (e.g., "like, um,' "you know"), self-corrections, redundancies, and asides that researchers determined did not impact the meaning of the point being made in the cited quotation. Brackets are used to specify pronouns, nouns, verbs, and conjunctions referred to in participant speech segments which could be unclear to readers (e.g., "they're" is specified as [the doctors are]).

3.1 Language services resources and use concerns: interpreter perspectives

Interpreters expressed concerns regarding factors that impact medical providers' use, or failure to use, interpreting services. First, interpreters noticed providers' time constraints and their health communication as linked and as affecting how interpreting takes place in IME. For example, one interpreter noted,

> "I don't want the doctor to feel like, 'Oh my God, the interpreter's here. This appointment is going to take . . . double of time because they're just talking double.' So, I'm always trying to use the space between their conversation to just add my information there, interpreting there . . . You need to be able to get into the empty spaces the doctor used to talk and be able to [interpret] right there."

Another interpreter said,

> "What makes it harder, I feel, are the providers who . . . you can tell they're very, very, very busy people and [they] just stop by for five seconds and they blurt everything out and they leave, and I feel they don't take those few extra seconds to make the family feel comfortable. They come in and out and they speak very fast and they dump all this information and then they leave. That makes it harder . . . I can tell you that most of the time it leaves the family . . . with questions but I think that behavior intimidates families to ask anything because they feel [the doctors are] in a rush and they don't want to take any more of their time and then they don't want to ask any questions. But then they'll make comments afterwards like, 'well he was in a rush, so I didn't want to ask anything.'"

Another subtheme emerging from the interpreter data was interpreters' concerns that providers make assumptions about a patient or family's language proficiency, which then affects whether providers use language services. These concerns may also relate to providers' time constraints. For example, an interpreter said,

> "I had a situation where a dad understood but mom didn't, so I had to talk to the provider. I was like, 'yeah dad understood but mom doesn't understand and, you know, both of the parents have to understand so it's not ok for you to go in there without an interpreter there.'"

Another interpreter said that some providers think families understand English, which may not be the case. The interpreter commented that, nonetheless, based on this assessment, some providers don't use interpreters. The interpreter said,

> "I would have situations where the provider wants to speak to a family without an interpreter present just because they think they [the family] have some understanding, but that doesn't mean they fully understand what they [the providers] are saying."

Another interpreter noted providers' disregard for families' language preferences, which may extend to how providers perceive interpreters' roles as language facilitators. This interpreter said,

> "A lot of providers don't have much appreciation for the role of an interpreter and so they will just have a complete conversation with the patient. Especially if they [the pediatric patient] speaks English, and they think that parents should speak English too. There's a lot of opinionated doctors like that and so they have no regard for the parents and their language barrier."

3.2 Language services resources and use concerns: provider perspectives

Providers expressed concerns regarding interpreting services related to availability of interpreters, length of the appointment, means of accessing an interpreter, and interpreting services quality. Providers also acknowledged differences in communication practices depending on whether they are treating language-diverse or majority-language patients and families.

Regarding availability of interpreters, providers identified that the time required to get interpreting services or services in LLDs is a challenge. For example, one provider said,

> "Some languages are very difficult to find, especially the refugee ones. There are even some indigenous people from Guatemala or other countries—we speak Spanish to them, expecting them to know Spanish, but they may not. They may actually be from an indigenous native tribe that speaks their own language. And that's really difficult because now you're interpreting twice."

Another provider said,

> "Sometimes you need [the interpreter] there and it's going to be 15 or 20 minutes. Not usually, but once in a while, there's a delay in getting them there, and so I think that can be hard if a parent is really distressed; they need someone there now to have that conversation. If you have to wait on the technology piece for that, that's not ideal."

Regarding concerns about the length of the appointment with interpreters, providers noted that the general rule of thumb that appointments take double the amount of time does not hold, and sometimes "it takes four times or even five times as long as an appointment in English."

Next, providers had uniformly strong opinions regarding the means of accessing an interpreter and the quality of interpreting services. Almost all providers preferred in-person interpreters to video remote or telephonic interpreters, in that order. Providers expressed frustration related to accessing interpreters. For example, a provider shared,

> "It's a nightmare to try to use the phone interpreter. It's not user friendly at all and it's usually a 20-minute process and now I'm already feeling behind on stuff I [have to] get done for the patient and so by the time I actually get to talk to the interpreter, I'm annoyed."

Providers noted a difference in the quality of interpreting LLDs. One provider noted that while Spanish interpreters, for example, "are easier to work with," interpreters working with languages that are "not as common" or that are "more obscure are a little bit harder because those individuals don't [interpret] as frequently . . . it does make it a lot more challenging because of the language barrier. It's just another added layer of difficulty."

Finally, providers commented on difference in communication practices with families that use interpreting services compared to families that do not. One provider said,

> "I don't have any data to back this up, but I do feel like people who are harder to interact with because you need an interpreter probably get less face-time in general than straight English-speaking families."

While another provider reported,

> "We spend less time with families just because the setup to get an interpreter there takes time and it's all these added steps. We spend less time talking to families and making sure that they understand what's going on. Or we give them [a lot] of information, and it's a lot to handle, but we do it all because we have the interpreters here, so we get it all out in one conversation . . . A family that's English speaking, we can give a little bit of information, come back, update with more information, come back, and so they can absorb it in smaller pieces. And that's just really difficult to do with a family that doesn't speak English and you have to use an interpreter."

3.3 Appraisals of working in IME: interpreter perspectives

Despite being asked different questions in the interviews, both providers and interpreters indicated appraisals (e.g., assessments, estimations, or value judgements) about working in IME. Interpreter appraisals emerged in response to the question, "What are things which medical providers do that make your job easier or more difficult?" Interpreters appraised provider behaviors in IME in both positive and negative terms (e.g., it is helpful when providers speak in short phrases, versus it is unhelpful when providers speak in long, rambling sentences). Interpreters who elaborated on appraisals overwhelmingly discussed medical provider behaviors in IME that negatively affect families and health communication. Therefore, the results here focus on those negative elaborations. Interpreters reported provider lack of respect, provider microaggressions and bias toward families in IME, instances of provider linguicism, and provider dismissal of family concerns. Regarding microaggressions and linguicism, microaggressions were classified as such when they were insults directed toward the language-diverse person that were not clearly and directly related to language use (e.g., education level, immigrant status). The research team decided to keep microaggressions and linguicism as separate codes after determining that the team did not have enough information to suggest that microaggressions were acting as a proxy for linguicism or language bias.

Regarding respect, one interpreter said that providers' lack of respect is exclusionary toward families IME, for example when providers direct communication toward interpreters in IME, as opposed to patients and families. The interpreter noted,

> "Some providers that don't show the level of respect that they potentially show to an English-speaker. So just the way that they relate to the patient, like looking directly at the patient versus looking at me as the interpreter, that level of connection, human being to human being, should be between the provider and the patient or the guardian of the patient, not with the interpreter."

Interpreters also discussed instances of medical provider microaggressions and biases; how they impact families and interpreters; and whether interpreters convey provider microaggressions and biases to families in IME. Regarding an encounter with a provider, an interpreter disclosed,

> "That doctor was being very inconsiderate to this mom. I've worked with her in . . . several clinics, and I know that . . . mom doesn't read English or Spanish. The doctor was a little nasty. He asked, like, 'So you don't know how to write?' . . . 'That's what happens when you don't go to school,' . . . and I think I skipped it because mom was very humble, and she was very concerned."

In this case, the interpreter may have omitted the provider's comment because of a perceived need to minimize harm to the mother.

Interpreters also reported provider linguicism, understood as linguistic discrimination or unfair treatment based on language use and characteristics of speech, including first language, accent, size of vocabulary, modality, and syntax. On this topic, an interpreter said,

> "A provider made a comment about the mom needing to learn English because she had already been here in the US for 20 years and it was about time she learned English. This was really tough . . . that made my job difficult, but I did what I had to

> do. I did report that situation. Disrespectful to the mother and degrading as she felt really bad."

Finally, interpreters described provider dismissal of family concerns in IME. For example, one interpreter said,

> "Caregivers feel like, 'Certain medication, I feel, is not good for my child, or it's not doing the job that it's supposed to do,' and the providers kind of just brush it off instead of addressing the concerns and approaching it in a more caring way. It's just kind of, 'Give it some time. It'll be fine.' [These are] instances where the families don't feel like they're being heard."

3.4 Appraisals of working in IME: provider perspectives

Provider appraisals were overwhelmingly negative (only one provider had an initial positive appraisal of working in IME) and manifested in the terms they used to describe working in IME (which include negative expressions) and in their perception of different kinds of loss when communicating through interpreters.

When providers were asked, "Tell us about your experience working with distressed families while using an interpreter," providers responding by stating that it is "tough," "tricky," "challenging," "it sucks," "it's the worst," and "it never goes well." Providers also said, "honestly, I hate it," and "I hate that I can't understand everything they're saying and respond in kind."

Providers expressed experiencing loss when communicating with families in IME, which included a failure to establish rapport or connection with the family (which was characterized as a "loss" is IME), loss of emotional content being conveyed or understood, and/or a loss of meaning through tone or intonation. In terms of failure to establish rapport, a provider said, "You will lose a lot of that personal connection that you're trying to establish with a family when working with an interpreter." Similarly, another provider said, "so much of the relationship building happens [when] you're just making conversation . . . That builds relationship and trust and so I think . . . sometimes it's just not there" when communicating with interpreters.

Regarding loss of emotional content, one provider commented, “I think that you definitely can lose a lot of the empathy that is provided in conversations over an interpreter,” while another provider noted, “I think some emotions can be missed.” Finally, providers also appraised working in IME through loss of emphasis. One provider said,

> “The biggest problem with an interpreter can be that things get toned up or toned down in that the adjectives I use are not communicated exactly in that I might say the child is very sick, and they might just drop the very. And that makes a difference.”

Another provider stated,

> “I think there’s like different inflections in our language that we definitely pick up on, but if it’s somebody else, if it’s another language, I’m not able to pick up on that. And the interpreters aren’t able to communicate that to me either so, I think [that] definitely makes it more difficult.”

3.5 Mistrust and strangers to the care team: interpreter perspectives

Another common theme among interpreters and providers regarding working in IME is the view of the interpreter as an outsider vis-à-vis the medical treating team. Interpreters expressed that medical providers do not treat them like part of the care team, and they feel that medical providers do not understand or appreciate their role and work as interpreters.

Interpreters also reported that they anticipate provider mistrust when working in IME and they explained how they attempt to manage mistrust among provider colleagues. One interpreter described,

> “Like if [providers] ask, ‘What did you drink,’ and then I translate that, and then [the parents] say, ‘a sandwich,’ then I’m like, they didn’t hear me right. That’s not what I asked, so I would say, ‘Oh, what did you drink?’ Otherwise, the provider might look at me and they might think that I interpreted wrong.”

Interpreters also felt that providers may lack a sense of teamwork when working with interpreters. Some interpreters reported feeling they are viewed as an annoyance or a hinderance, as opposed to a colleague. This can affect health communication. One interpreter said,

> "Sometimes they just give a long rattle and if there's complex medical terms in there, depending on how familiar I am with those medical terms, I have to work backwards in my mind to figure out how to say the word or term. If I haven't it used for a while, I have to dig deep in my brain to surface the right translation for that word, so if they're respectful of my time, that helps. Sometimes providers will cut me off while I'm still interpreting what they just said. They're not patient enough. So that doesn't help with clear communication if they're cutting me off."

3.6 Mistrust and strangers to the care team: provider perspectives

Provider responses implicitly or explicitly indicated mistrust of or frustration with perceived interpreter inaccuracy and interpreter neutrality in IME and a view of interpreters as strangers to the care team. Regarding interpreter inaccuracy (sense/meaning loss), one provider said,

> "We often feel on our side that the interpreter didn't say things the way we wanted them to or didn't say everything we meant and we judge that mostly by, well, I don't speak any foreign languages with any fluency, so I can't say this from my own knowledge of the language, but I'll say what I think is two sentences and the interpreter will say what sounds like much less than two sentences."

Another provider, who did not indicate having language proficiency in a non-English language, reported that, "you have to always question, do they really just say what I said because it seems like they said three words and I said 20." Other providers report proficiency in the non-English language and critique interpreters' interpretations based on their perceptions. For example, a provider noted, "Having some proficiency in Spanish, sometimes I've noticed that I can follow what they interpret for me and they're not saying the right thing, and I find that really frustrating." Providers also noted that perceived interpreter inaccuracy is frustrating expressly because providers are intentional about the ways they communicate and the words they use when speaking with families. For example, a provider said, "I get so mad. They're not saying what I'm saying. I try to be so deliberate with what I say and how I say it. I get frustrated when they don't stick to that because I chose those words and that delivery for a reason."

Next, some providers expressed mistrust in the form of doubting interpreter neutrality in IME, believing interpreters' agendas are contrary to those of providers in IME. For example, a provider expressed, "Even if they're a known interpreter . . . I don't know if our trust is the same in them and they're perhaps inserting their own, I don't know if bias is quite the right word, but their own piece of what we're saying and that may not be what we mean." More directly, a provider shared that "part of the struggle is that the interpreters can have their own agenda."

Providers perceived interpreters as outsiders to the care team and described interpreters (even hospital-employed interpreters or "known interpreters") as a third person, as "strangers," "outsiders," and "an extra or random person in the room." Another provider said, "I think the difficult part is really gauging how much [families] understand . . . because you're using a third person and it's really hard." Finally, another provider shared,

> "I just feel like I'm not actually having a conversation with the family . . . there's this other random person in there and so it also is kind of hard to have conversation about emotional aspects when there's a third person in there that's not really involved in the situation but they're still there and I just think it's kind of of like having an outsider watch a more intimate conversation."

3.7 Interpreter-provider teamwork

A minority of interpreters and providers provided examples of positive working relationships between providers and interpreters, in which interpreters were consulted on their experiences with a given patient or family circumstance, or when providers understood the role of the interpreter and best practices for communicating with patients and families in IME. For example, one interpreter highlighted providers who consult with interpreters, and said,

> "Sometimes the provider will ask me questions. As the interpreter, they've asked me if I worked with the family before and, like I said, most of the time I am very familiar with some of our families so . . . they will ask me, 'what do you think has landed so negatively' or 'what do you think of this' . . . We know all of this information because we interpret for different providers and different people throughout the hospital. So, I think the providers have questioned me and if I feel there's something that needs to come to light, then I'll discuss it with the provider."

A provider discussed having learned best practices for communication in IME and an understanding of interpreting as a practice,

> "I've learned along the way, ideally, how you work with an interpreter. I think generally it is—especially if I'm alone with a parent and interpreter—I think it goes well. I've learned that ideally you talk to the interpreter without the parent beforehand especially if you're talking about end of life or other sensitive topics, and I've learned to [use] the standard ways of pausing, and talking to the parent and not the interpreter, and that type of thing. But also, not using euphemisms or gray areas because that often doesn't translate and, even in English, it often doesn't translate, but I've learned with different languages you need to be even more concrete, and also trying to ask the parent to explain back to us what their understanding was."

Another provider articulated the importance of preparing interpreters for difficult discussions so that they aren't traumatized, thus viewing them as a member of the care team,

> "One thing that I do think we could do better . . . is [to] have a little huddle before we go into the room because I think if the interpreter doesn't know what bomb is about to be dropped on that family, they're still human, they . . . could be a mom or dad themselves."

4. Discussion

4.1 Modeling levels of inequities in IME

Data in this study indicate that providing interpreting services alone in pediatric medical encounters is necessary but insufficient for attaining equitable and inclusive health communication for language-diverse families. Inequities persist due to language resource concerns, mistrust, and biases about interpreting services, interpreters, and families in IME, all of which prevent equitable language access despite language services provision. These sources of inequities manifest within a nested ecological system, such that inequities exist in and across systemic, interpersonal, and intrapersonal levels. Multilevel factors work together to deepen language access inequities and differential levels and depths of health communication for language-diverse families. Below we discuss several of these sources of inequities in more detail and suggest approaches for mitigating them.

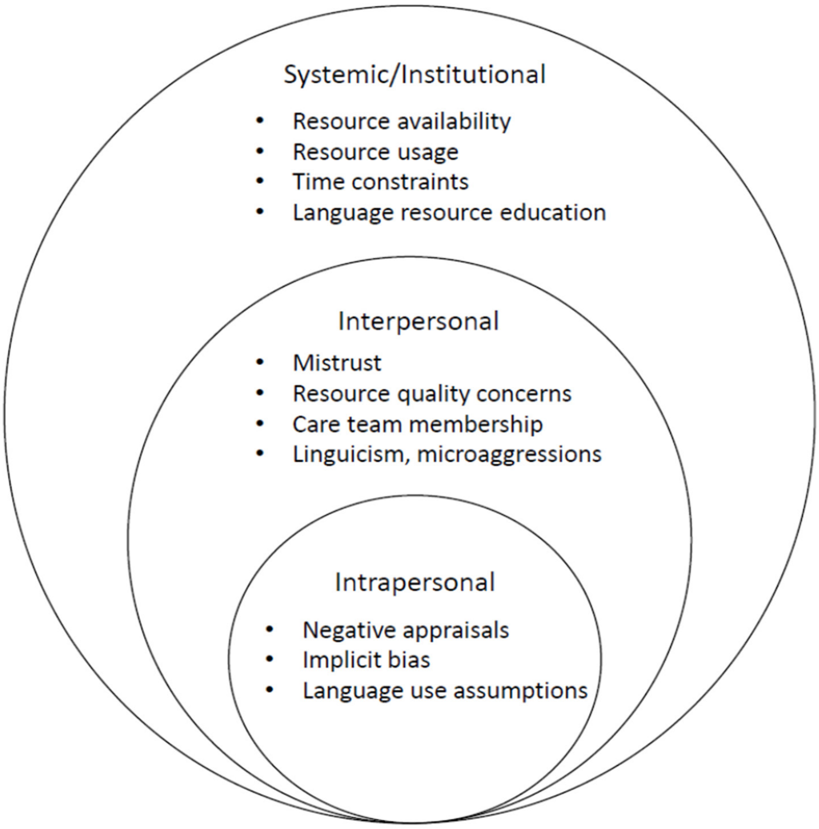

Fig. 1. Sources of inequities at systemic, interpersonal, and intrapersonal levels

4.2 Time concerns

Studies in adult and children's hospitals indicate underuse of interpreting resources attributed to medical provider time constraints and concerns (Davidson 2000, 380; Diamond et al. 2008, 260; Lion et al. 2021, 6; Granhagen Jungner et al. 2021, 1988). Pediatric providers in this study have similar concerns, particularly regarding the length of IME and the time needed to wait for or schedule an interpreter, suggesting that these are systemic or institutional issues affecting the interpersonal level in IME. Interpreters and providers in this study recognized that time constraints resulted in inequitable health communication since providers reported spending less time or giving less information to families in IME than to English-speaking families. Study participants also reported that providers give large amounts of information to families that may not be fully understood, and interpreters noted that family questions are not addressed due to provider time limitations. Interpreters also noted that provider time constraints affected how interpreters convey information to families, and that accommodating provider time concerns led to abbreviated or gist interpretations that could be quickly conveyed in pauses. Prior research has shown that provider time constraints are placed on interpreters in encounters, which forces them to edit content (Davidson 2000, 380). Such practices may be used to "keep the interview 'on track' and the physician on schedule" (ibid. 400) but may also result in inadequate or incomplete interpretation and/or patient and family understanding. Hospital systems should direct resources to hiring additional providers and interpreters, and/or increasing time allotted for pediatric IME to mitigate time constraints. Interdisciplinary teams should also study and create interventions to address time usage and concerns in both language-concordant and interpreted encounters.

4.3 Resource quality concerns

Providers identified remote interpreting resources (e.g., video and telephonic) as less effective and resulting in lower quality health communication for families in IME compared with in-person interpreter services. Providers said that accessing interpreters via remote modalities is still a time-consuming, frustrating endeavor even though such resources are often provided to minimize time constraints, a finding that is reflected in other studies on interpreting service modalities (Rodrigues 2022, 216–217). Providers also suggested that unreliable availability of LLD interpreters and poor quality of LLD interpreting in all modalities affected interpersonal interaction in IME and resulted in diminished health communication.

Interpreter concerns regarding resource use focused on providers' underuse of interpreting services, an observation that aligns with existing data in adult population hospitals (e.g., Rice 2014; Hsieh 2015; Basu, Phillips Costa & Priyank 2017), and pediatric settings (Kuo et al. 2007, e925). However, interpreters in this study connected provider assumptions about family language needs to their underuse of interpreting services, which links to studies suggesting that providers incorrectly gauge patient language needs (Davidson 2000, 400). Together, providers and interpreters highlighted resource quality concerns that can be difficult to solve and that require significant investments at the systems level, such as hiring more in-person and on-site interpreters, mechanisms for managing provider time with families, and systems for accurately identifying appropriate language needs. Efforts to create trainings and resources for LLDs, such as those by the National Council of Interpreting in Healthcare LLD Working Group, may provide pathways toward easing LLD resource concerns, yet more work is needed.

Providers in this study also identified interpreter accuracy as a resource concern. Literature has documented inaccuracies in interpreted content (Pham 2008, 6–8), however, Davidson (2000, 400) suggests that interpreter alterations in content and form are part of the broader linguistic and social roles interpreters play in medical encounters. Therefore, a narrow focus on linguistic accuracy as a determinant of interpreter quality misses key contextual considerations regarding interpreting work (e.g., conveying meaning in the context of provider time constraints or in fast-paced emergency situations). Provider concerns about accuracy may also relate to providers' lack of understanding of the language transfer process (addressed in section 4.4 below). Provider accuracy concerns may also reflect uneven training requirements for interpreters on ethics, standards of practices, and language-specific content in both common non-English languages and LLDs in the United States. Together, the medical interpreting certification options in the US offer language-specific certification in Arabic, Cantonese, Korean, Mandarin, Russian, Spanish, and Vietnamese. Interpreters of other languages who seek certification are tested on knowledge of ethics, standards of practice, and medical terms in English only. Until language-specific certification becomes available in more languages, uneven access and quality of interpreting may continue to present concerns for both providers and interpreters. However, equally important is education and socialization at the systems level so administrators and providers understand the complexities of interpreting linguistic and cultural content while also balancing social, relational, and environmental factors specific to a given IME context. Systems leadership and provider advocacy for education on the interpreting process and for LLD interpreter development could steer resources toward research and interventions to address these concerns.

4.4 Interpreting loss

Interpreting loss, or a deficit view of interpreting, for service users has been documented in medical settings, especially in the case of non-professional interpreters (Flores et al. 2012, 551). Providers in this study expressed concerns about loss when working with interpreters in IME (e.g., loss of connection, meaning, emotional expression) yet it is unclear what providers base these perceptions on, except in the case of meaning loss. Providers perceived meaning loss based on the length of statements interpreted, a measure that has been used in research to determine health communication quality in IME (Thornton et al. 2009, 3–4). However, this measure is problematic from a translation and interpreting studies vantage point because service users may report a sense of loss in interpreted statements even when language professionals have "done a remarkable job" (Gandin 2009, 77). The results of this study align with prior research citing that a lack of training in working with interpreters leads to provider "difficulties in evaluating the interpreter's professional abilities" (Granhagen Jungner et al. 2021, 1988). In the present study, providers expected "word for word" or "literal translation," yet interpreters know that due to structural, grammatical, and other differences among languages, such approaches result in nonsensical content. Interpreting requires balancing different communicative (e.g., meaning, emphasis, emotional expression, register, culture-specific concepts, etc.) and grammatical features in one language in order to gain sense accuracy in the other language. For these reasons, interpreted statements do not match source statements in, for example, length, lexical cognates, sentence structure, etc. Thus, service users may perceive meaning loss even when interpreters accurately and completely convey statements into the target language.

A lack of provider understanding of how interpreters convey meaning, but also of what interpreters are trained to convey, is clear in this study (e.g., regarding emphasis, one provider reported that "the interpreters aren't able to communicate that to me," which interpreters can and do communicate in their work). Without this knowledge, providers may become frustrated if they perceive that their communication goals are not being met, which is concerning given the care with which providers report choosing their words and crafting their statement delivery. This suggests that providers' notions of loss (e.g., of sense, emphasis) in interpreting may be eased if medical providers better understood the language transfer process.

Further, it is likely that providers and interpreters are unaware of each other's communication goals and aims, and that the flow and quality of communication in IME could improve if providers understood the interpreting process and interpreters understood providers' communication aims and rational for delivery choices. Joint trainings in which interpreters and providers dialogue about and role play their communication approaches and aims are imperative for mutual understanding and better health communication. Such dialogue could help raise awareness of communication best practices across languages and cultures at the interpersonal level and could foment advocacy for education on the interpreting process, interpreter roles, and standards of practice at the systems level. Providers might also advocate for more resources to train interpreters on language-specific concepts and vocabularies in specialized hospital clinics.

Shifting thinking from interpreting as loss to interpreting as gain or a value added may help providers shift the deficit lens through which interpreting is viewed. The authors suggest that to build collaboration between providers and interpreters, researchers should move away from publishing work that highlights inaccuracies in interpreting and should move toward studying the linguistic and contextual complexities of interpreting in hospital settings (Meyer 2002, 169). This is a way to raise awareness among provider populations regarding factors affecting interpreting (e.g., linguistic, extralinguistic, contextual) and to work toward developing joint trainings that address perceived loss and the interpreting process in IME.

4.5 Mistrust

Data from this study suggest that mistrust between providers and interpreters shifts IME stakeholders' attention away from patients and families onto one another. Provider mistrust of interpreter neutrality (e.g., interpreters having "agendas" or changing content) may result in providers becoming hyper-focused on interpreters in IME. Additionally, providers' perceptions of their own abilities in languages other than English, coupled with a misunderstanding of language proficiency and the interpreting process, may exacerbate provider mistrust of interpreters. When providers mistrust interpreter accuracy and completeness, they may become distracted and forget what they want to communicate next, omit instructions or additional information, forget to ask families if they have questions, or experience feelings of frustration, anger, or disempowerment due to their perceptions of interpreter inaccuracy. These experiences may affect provider health communication with families, and present additional language access inequities and exclusion of families in IME.

In this study, interpreters noted adjusting how they interpret (e.g., directing families to answer "correctly") to mitigate provider mistrust. These practices may affect language access equity and family inclusion in IME when interpreters independently repeat or restate questions to elicit what they believe providers will perceive as appropriate responses. Such interpreting practices limit both families' and providers' abilities to address one another directly and may also exacerbate providers' beliefs that interpreters are interpreting inaccurately or adding their own content to their renditions.

To address the above, interpreters should be trained to navigate situations in which they perceive provider mistrust so they don't feel the need to compensate for it in their interpreting practice and so it can be addressed appropriately outside of the IME. Interpreters must have the backing of language services managers and systems directors because, as other studies have demonstrated, they may not feel they have systems-level support to address trust concerns with providers (Rodrigues 2022, 220–221). Additionally, hierarchical power dynamics among providers and interpreters may dissuade interpreters from addressing mistrust. For their part, providers should have outlets for discussing their concerns about interpreting quality in meaningful ways that lead to further education on the process of interpreting or to rectifying uneven quality in language services resources. Whether at the individual or institutional level, providers and interpreters should have opportunities to get to know one another, understand each other's communication aims, and build trust, as trust is essential in facilitating health communication (Crezee & Roat 2019, 3) for all parties in IME. Finally, consistency in interpreter-provider teams could also build trust through familiarity among providers and interpreters.

These suggestions depend on increased or redirected resources and systems-level support to grow and strengthen interpreting programs and their appropriate use in hospitals. Further, hospital management advocacy is key to creating a culture of understanding and appreciation of interpreters and interpreting services across system departments and units. Educating hospital staff about roles interpreters play in facilitating language access and their importance for improved health communication could foment a culture of trust among providers and interpreters that is rooted in patient care.

4.6 Care team membership

In line with provider perceptions of mistrust, providers in this study referred to interpreters as "outsiders," indicating that some providers do not view interpreters as members of the medical care team. Interpreters expressed feeling like outsiders to the care team when they expressed feeling mistrust. It is plausible that interpreters are perceived as outsiders to the medical care team due to social group identification based on intersecting social identities (i.e., profession, language use, gender, race, ethnicity), and due to a misunderstanding of their professional training and roles. As the othering of individuals based on perceived social group membership is a well-documented phenomena (Tajfel & Turner 1979, 38–43), interpreter otherness to the care team could be mitigated by fostering a shared sense within care teams of ensuring patient and family language access. Moreover, systems-led interpersonal and intrapersonal explorations of social and professional identities, as well as professional and cultural communication approaches, can further promote mutual understanding and respect, leading to stronger teamwork in IME and better health communication for patients and families. As noted in the results, a minority of providers and interpreters discussed experiencing positive teamwork, such as briefing interpreters before appointments, practicing best communication practices, and soliciting interpreters' cross-cultural expertise. Systems leadership should promote these practices as care team norms so that providers recognize and utilize the value interpreters bring to cross-cultural provider-patient communication. If systems do not value interpreters, providers may not perceive a mandate to value them either (Davidson 2000, 402).

5. Call to action and advocacy

One way to address language access inequities is simply getting interpreters in the room, yet this cannot address language access inequities in pediatric systems and among pediatric IME stakeholders. The authors argue that to disrupt discriminatory practices in IME, care team members should be trained to identify and acknowledge their own biases regarding language use and language access services. Training should include recognizing how those biases result in discriminatory practices while working to prevent discriminatory practices from occurring. Research has documented that microaggression training decreases the frequency of provider microaggressions against patients of color (Kanter et al. 2020, 9–10). Trainings that address microaggressions toward language-diverse communities could improve health communication and language access equity and inclusion in IME.

While individual change at the encounter level is fundamental, it is equally important for systems-level leaders and management to allocate their power, influence, and leverage to promoting a cultural shift throughout the health institution regarding language access rights and services. The authors call on systems leaders to educate themselves on interpreter roles and practices, and to develop trainings for hospital personnel that emphasize language access services as a civil right and a prerequisite for improved health outcomes for language-diverse communities. Training on working with interpreters and their contributions to ensuring equitable, inclusive healthcare must begin early in providers' careers, in medical schools and training programs (Granhagen Junger et al. 2021, 1989). In a similar vein, hospital leaders ought to prioritize research funding, training, and education on language access services as a key component of hospital and medical school diversity, equity, and inclusion efforts.

Increased allocation of resources to language access services on the systemic, interpersonal, and intrapersonal levels is imperative to improving language access equity. At a minimum, hospital systems should invest in research to determine the language services needs in the system and evaluate whether the resources currently allocated to language services are adequate for covering needs. Once basic needs are met, systems should invite all stakeholders in IME (including administrators, interpreters, medical providers, and families using the services) to the table to develop opportunities to understand stakeholders' communication needs and goals, and interventions aimed at these needs. Finally, the authors call for interdisciplinary teams to undertake community-engaged research on provider, interpreter, administrator, and family perspectives regarding language access services to create interventions that strengthen language access equity and inclusion.

6. Limitations and future directions

Limitations to this study include the small sample size of both interpreters and medical providers. Providers and interpreters were from a single institution, which might impact the generalizability of findings to other centers. Interpreters who participated were exclusively Spanish–English interpreters, so further study is needed to delineate whether these themes apply similarly to other language pairs. Participant group responses were not based on the same questions and thus explore different, albeit related, aspects of communication with families in pediatric IME. The present work is exploratory and developed in response to parallel themes emerging in data sets. Further studies with focus groups in which interpreters and providers dialogue about working in IME, or interviews with both groups that ask the same questions might reveal additional insights. Additionally, many observations made by interpreters in this study regarding provider communication practices likely occur in language-concordant encounters. Further research should delineate similarities and differences of these phenomena in IME versus in language-concordant encounters, as other studies have (e.g., Hsieh & Terui 2015; Davidson 2000). Such research could identify provider communication characteristics that occur in language-concordant encounters but that represent special challenges in communication across languages and cultures. Inclusion of patient and family perspectives in this research is imperative for understanding patient/family experiences of language access barriers and working with interpreters and providers in IME, as “the use of interpreters may be viewed differently by health care workers and patients” or families (Brandenberger et al. 2019, 8). Additionally, a medical records review to gauge the time providers are billing for IME compared to language-concordant encounters may shed light on provider time constraints in these settings.

Further research on the layers of inequities noted in this paper can help delineate the relative contributions of the identified themes, their generalizability across different settings and language pairs, and factors that may exacerbate or reduce these inequities. Ultimately, this knowledge should serve to improve existing systems, and where necessary, build new ones to better support language-diverse patients and families.

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Appendix

A.1. Summary of interpreter & physician themes

Theme 1: Concerns with language resources and their use	
Interpreter perspectives:	Time constraint and communication linked Patient/family language assumptions Disregard for family language preference
Physician perspectives:	Availability of interpreters Length of appointment Means of accessing interpreter Interpreting service quality Difference in communication practices
Theme 2: Appraisals of working in IME	
Interpreter perspectives:	Lack of respect for families Provider microaggressions and bias Provider linguicism Provider dismissal of family concerns
Physician perspectives:	Negative expressions Failure to establish rapport Loss of emotional content Loss of emphasis
Theme 3: Mistrust & outsiders to the care team	
Interpreter perspectives:	Interpreter as an outsider Anticipate provider mistrust Lack sense of teamwork
Provider perspectives:	Interpreter inaccuracy (sense/meaning loss) Interpreter neutrality Interpreters as strangers to the care team

Theme 4: Interpreter-provider teamwork	
Interpreter & physician perspectives:	Consult with interpreters Best practices for communication in IME Understanding the interpreting process

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