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Healthcare Provider Practices and Perceptions during Family-Centered Rounds with Limited English-Proficient Families

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Abstract

Objective: To increase understanding of current practices and perceptions of family-centered rounds (FCR) by providers for limited English-proficient (LEP) families relative to English-proficient families.

Methods: Using grounded theory methodology, we conducted ethnographic observations of FCR for LEP and English-proficient families on the pediatric wards at an urban teaching hospital. Focused coding of observation fieldnotes was performed independently, followed by regular group meetings to discuss discrepancies, refine codes, and identify theoretical direction. Data informed development of an interview guide used to conduct interviews with pediatric physicians, nurses, and interpreters. The iterative analysis process continued with interview transcriptions.

Results: FCR of 36 unique patient families were observed, of which 10 were LEP families. We conducted 20 interviews with 7 residents, 3 attendings, 5 nurses, and 5 interpreters. Major themes included: 1) Standardization of FCR is needed to address equity issues for LEP families, 2) Redefining the roles of medical interpreters would enhance the interpersonal interactions and relationships between families and healthcare providers, and 3) Improving resources to allow for interpreters to be used consistently will increase equity for LEP families.

Conclusions: Many differences exist in FCR for LEP versus English-proficient families. FCR for LEP families may be optimized with standardization and training, redefining the interpreters' roles, and improving access to interpreters.

Keywords

family-centered rounds; limited English-proficiency; physicians; nurses; interpreters; pediatrics; hospitalization

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Family-centered rounds (FCR) have been endorsed by the American Academy of Pediatrics as a means to provide family-centered care[1]. In particular, the AAP recommends conducting rounds in patients' rooms with nursing and family in order to share "complete, honest, and unbiased information with patients and their families on an ongoing basis and in ways they find useful and affirming, so that they may effectively participate in care and decision-making to the level they choose"[1]. FCR with multidisciplinary teams improve family involvement and understanding of medical plans, team communication, length of stay, patient safety, and medical education[2–7].

FCR with English-proficient families almost always includes standardized elements that optimize family engagement[4]. These elements include ensuring that necessary members of the healthcare team are present (including the nurse), introductions of team members, discussing the assessment and plan for the day, reviewing goals of discharge, asking both family and medical team for questions, and reading back orders. However, FCR with limited English-proficient (LEP) families may include conducting part of the medical discussion before inviting parents to participate and interpreters who filter information relayed to families[8]. Filtering refers to instances when the interpreter as opposed to the healthcare providers determines what information is told. Existing research suggests that LEP patients have a more difficult time accessing healthcare and are more likely to suffer from adverse events[9–11]. LEP parents of children with chronic medical conditions are less likely to report being taught how to manage their child's condition by health care providers[9]. To address disparities in health outcomes, it is essential to optimize FCR so LEP families can receive the benefits of FCR as English-proficient families do[10,12,13].

There have been studies investigating the perspectives of families, both English-proficient and LEP, on FCR[8,14–17]. However, fewer studies have been done on healthcare provider perspectives on FCR. Provider perspectives are equally important, as providers are the individuals coordinating and conducting FCR. Physicians and nurse feedback has helped identify obstacles to performing FCR such as the physical constraints of large team sizes or variable approaches to FCR and teaching for medical learners depending on attendings[18,19]. Their perspectives can also facilitate improvements such as the implementation of appointment-based FCRs[20]. Given the key role that interpreters play during FCR for LEP families, their perspectives on FCR would provide particularly valuable information. Our objective was to increase our understanding of current practices and perceptions of FCR for LEP families relative to English-proficient families and develop solutions for optimizing FCR for LEP families from the perspective of providers including physicians, nurses, and interpreters.

METHODS

The research team included two pediatric hospitalists with extensive experience in qualitative research, three pediatric residents, and the manager of Medical Interpreting Services. We used grounded theory methodology to conduct a two-phase qualitative study[21]. Phase 1 used ethnographic observations; phase 2 used in-depth interviews. We conducted our study at a tertiary care urban teaching hospital with medical interpreting services in 19 languages for in-person interpreting, and additional languages available from a third-party

vender by phone. Our study focused on pediatric inpatient wards. FCR on wards includes a pediatric attending, senior pediatric resident, interns, medical students, and nurses. Our protocol was approved by the University of California Davis Institutional Review Board. Verbal consent was obtained from all participants of FCR during phase 1 and all interview participants during phase 2.

For phase 1, we observed FCR for LEP and English-proficient families on pediatric inpatient wards to identify common practices used or omitted during FCR. For ease of identification of LEP families, we used the presence of an interpreter during rounds as indication of LEP. The observer recorded objective and subjective fieldnotes on a template and answered post-observation questions immediately following rounds (Supplement 1). After the first observation session, the coding team (JC, CW, VJ, SL, JR) independently performed open coding of fieldnotes and post-observation answers. We then created initial categories and codes for the codebook and adapted the template for fieldnotes and post-observation questions accordingly.

After each subsequent observation session, the team conducted independent memo-writing and focused coding of fieldnotes and post-observation answers based on developed categories in the codebook. Focused coding used the most significant and frequent initial codes to develop the most salient categories, while remaining open to all possible theoretical directions. We compared codes, discussed discrepancies until we reached consensus, and revised the codebook, fieldnote template, and post-observation questions as needed. We identified major themes and developed a draft conceptual model to inform the interview guide we used in phase 2. We stopped ethnographic observations after reaching theoretical saturation, which was the point during analysis when no new properties, dimensions, or relationships emerged.[22]

Phase 2 consisted of semi-structured interviews with pediatric physicians, nurses, and professional medical interpreters. Participants were recruited via email and an informational flyer in the nurse common space. We gathered demographic information on each participant (role, age, number of years of experience, frequency of use of FCR, whether they spoke an additional language other than English, and whether they self-assessed themselves as fluent (advanced or native in a language other than English). Interviews were conducted either in-person or by phone using a standardized interview guide (Supplement 2). We purposefully sampled to ensure diversity of participants regarding clinical role to further explore topics that arose in the initial interviews[23].

Interviews were audio recorded and professionally transcribed. Participants received a $15 Amazon gift card. We analyzed transcribed interviews using independent focused coding, followed by team meetings after every fifth interview to compare codes and refine the codebook and interview guide. Once theoretical saturation was achieved, we identified major solution-based themes and developed a conceptual model with our entire research team (including EM). We solicited individual feedback from all of our interviewed participants on our themes via email[24]. Figure 1 shows an overview of our methodology. We used Dedoose version 8.0.35 for all data management and analysis (SocioCultural Research Consultants, LLC).

RESULTS

We performed 7 FCR observation sessions, with 1 to 9 FCR encounters per session. We observed a total of 36 FCR encounters, 10 with LEP families. Observed FCR encounters with English-proficient families had a mean duration of 6.8 minutes (range 3 to 12); observed encounters with LEP families had a mean duration of 14.4 minutes (range 7 to 33). We conducted twenty ~30-minute interviews with pediatric residents (n=7), pediatric attendings (n=3), pediatric nurses (n=5), and interpreters (n=5), after which theoretical saturation was achieved. Of participants who were not interpreters, 33% self-identified as fluent in another language (Table 1).

Our observations and interviews suggested that there were differences between FCR that were provided to English-proficient versus LEP families. To address this inequity, we identified three major solution-based themes: 1) Standardization of FCR is needed to address equity issues for LEP families, 2) Redefining the roles of medical interpreters would enhance the interpersonal interactions and relationships between families and healthcare providers, and 3) Improving resources to allow for interpreters to be used consistently will increase equity for LEP families (Table 2).

Theme 1: Standardization of FCR is needed to address equity issues for LEP families

Our ethnographic observations and interview participants identified several systemic barriers and strategies that can improve the consistent and effective use of interpreters during FCR for LEP families. We found that interpreters were not always present for FCR with LEP families, do not always interpret the correct language for LEP families, often do not interpret everything that is spoken in the room, and are not consistently used to assess health literacy of LEP families to better conduct FCR.

Participants explained that interpreters are not always used with every FCR encounter with LEP families. They stated that it is often easier to omit the interpreter and instead try to get one’s point across in English for short encounters when families speak or understand some English. Participants shared how interpretation in these cases can become laborious and time-consuming as families nod along and give signs of understanding English.

Participants also shared examples of when the appropriate language and mode of interpretation was not always solicited during intake on admission and confirmed when ordering an interpreter affected care. We heard multiple examples of language discordant interpreters being used, whether it was the incorrect dialect such as Cantonese instead of Mandarin or using a regular American Sign Language interpreter when a certified deaf interpreter was preferred by family.

Our participants also described many situations when not everything spoken was interpreted. This encompassed the medical team telling the interpreter that the presentation of lab values or other objective data was just for the benefit of the team and did not need to be interpreted for the family as well as side conversations amongst the medical team. It also included scenarios where English-speaking relatives dominated FCR and their conversations with the medical team were not interpreted for the non-English speaking primary caregivers. An

English-proficient family would be privy to all audible conversations within the room; our observations and interviews suggested that LEP families do not consistently have that same opportunity.

In addition, our participants recognized that assessing the health literacy of LEP families was a gap in providers' skillset. They shared how while they more easily and reflexively gauge the level of health literacy of English-proficient families, many participants assume the lowest level of health literacy for LEP families. The rationale for this default assumption was that they do not have the benefit of the instant feedback loop that is present with English-proficient families to adjust the communication as an encounter proceeds.

Theme 2: Redefining the roles of medical interpreters would enhance the interpersonal interactions and relationships between families and healthcare providers

Participants shared thoughts about how to best use interpreters to conduct FCR for LEP families by redefining the role of interpreter as a member of the health care team. Participants felt it would be valuable to standardize including medical interpreters in the brief huddle prior to entering the room. Multiple interpreters mentioned how helpful it is when they receive a brief overview about the medical case before beginning a FCR encounter. They stated how this becomes especially true when there are sensitive subjects or more complex pathophysiology being discussed. Interpreters reported that this time allows them to prepare themselves for the expected terminology they may use depending on the case and briefly refresh themselves on terms if needed. It also provides the time for mental and emotional preparation. Including interpreters in a brief huddle would allow for dissemination of important information as well as help to enmesh interpreters as a crucial player on the medical team.

In addition, establishing interpreters as members of the medical team empowers them to ask clarifying questions of and provide feedback to the medical team when needed. One interpreter expressed a hesitancy to ask clarifying questions of healthcare providers for fear of appearing incompetent. Participants felt that treating the interpreter as a full-fledged member of the team that is able to speak up and ask questions during FCR would improve healthcare.

Finally, while every interpreter characterized their role as acting as a conduit of information —to exactly interpret what is said by families and providers in their purest and unaltered sense, participants expressed that interpreters possess extensive skillsets which may include acting as patient advocates and cultural and emotional brokers. Participants gave examples of interpreters acting as patient advocate. For example, if interpreters realize the patient is not fully understanding the conversation despite accurate interpretation, they can voice this to the medical team. One interpreter shared an incident of reviewing printed material that the medical team had provided to the patient's family and realized that the family could not read but had been too embarrassed to admit it.

Participants also shared examples of interpreters serving as cultural broker. Participants expressed how acting as cultural broker facilitates situational awareness and can help avoid potentially uncomfortable or even disrespectful scenarios. Additional cultural context

engenders a deeper understanding that may not be achieved by pure conduit interpretation. Similarly, healthcare providers noted how interpreters also function as emotional brokers. Participants felt it can be difficult to ascertain tone in a different language that is then filtered through another person. Interpreters can assist providers with this by highlighting emotions that may be affecting the interaction that providers may otherwise miss. Another participant described how a parent with whom they were able to communicate with on a basic level had repeatedly emphasized that they were fine but finally shared their emotions of anxiety, stress, and worry when the interpreter was present. The willingness to broach and further interpret this cultural and emotional context for providers was not only seen as a positive experience but also helped to build a stronger bridge between families and the medical team than would have been created with just interpretation of the words that were said alone.

Participants felt that healthcare providers should be trained to utilize these additional skills in order to provide the best care for their patients and families. While some healthcare providers received some form of training on cultural competency and the use of interpreters during their schooling, our participants shared that conducting FCR for LEP families is a unique challenge that requires different demands from providers.

Theme 3: Improving resources to allow for interpreters to be used consistently will increase equity for LEP families

Nearly all participants mentioned how the coordination required to schedule interpreters was a major barrier leading to inconsistent interpreter use during FCR. In spite of scheduling in advance, oftentimes the interpreter or medical team was left waiting due to the unpredictability of rounds. Challenges with coordination between the medical team, interpreter, and nurse disrupted overall workflow of rounds, and imposed temporal pressure that impacted how FCR was conducted for LEP families. At times, the medical team and interpreter were unable to connect, and FCR was skipped all together.

One solution mentioned by nurses was to schedule all appointments for FCR, both those using interpreters and those not, so that there is a predetermined schedule and workflow for the entirety of rounds. The use of a schedule would facilitate consistent connection between all members of the medical team, the interpreter, and families. Hiring more interpreters and increasing telephone and video access to interpreters were perceived to be additional solutions to improve overall access to interpreters and lead to more consistent use during FCR. Increasing telephone and video capacity is particularly useful on weekends and holidays when there are limited in-person staff.

DISCUSSION

Our ethnographic observations and interviews showed that there were differences in FCR for LEP and English-proficient families. This included not only obtaining an interpreter in order to conduct FCR, but also changes with the structure of FCR itself with omission of certain parts (most often objective data) and in-room side conversations among the medical team that were not interpreted. The LEP families that we observed received different and inequitable care during FCR compared to their English-proficient counterparts. We focus on

providing solutions to the obstacles precluding FCR from being conducted with interpreters for all LEP families.

In a study of Spanish-speaking families, LEP families who experience FCR provided positive feedback and expressed appreciation at feeling more involved in their children's care[25]. Other studies have found that LEP and English-proficient families have similar understanding of medical plans; however, LEP families are less confident in their ability to report understanding of these plans[8,17]. This suggests not a lack of comprehension but rather a lack of confidence, possibly stemming from diminished rapport between team and family. In our study, many providers found building rapport with LEP families challenging and felt that absence of rapport could lead to LEP families asking fewer questions and not voicing concerns. Participants noted that having interpreters bridge the language gap between family and team was the most basic step to begin developing rapport. Embedding interpreters into the team would help providers better establish rapport with LEP families and improve trust between the medical team and interpreters. This integration could be accomplished through increasing the visibility of interpreters through proper introductions and making sure that the interpreter is part of the brief huddle that occurs prior to entering a room.

Our study and prior studies demonstrate that while some think interpreters should remain a neutral conduit of information, others feel that they should be an advocate, cultural broker, and emotional broker[26,27]. Though interpreters in our study reported that acting purely as a conduit was considered the gold standard for interpreting, they also endorsed the importance of these other roles. Similarly, while healthcare providers wanted interpreters to act as a conduit by interpreting everything verbatim, they also wanted interpreters to fulfill the additional roles of advocate, cultural broker, and emotional broker. This was thought to facilitate the development of rapport between family and medical team as well as improve overall quality of care for LEP families. Interpreter roles can be clarified with interpreters during formal training with emphasis placed on the fact that providers feel that the additional roles that interpreters play are beneficial.

Regarding access to and consistent use of interpreters, telephone and video interpretation should be integrated more fully into the everyday workflow, not only for hard-to-find languages or weekend and holiday schedules but for smaller non-FCR interactions as well that can help build rapport. Video interpretation has been shown to provide equivalent caregiver satisfaction as in-person interpretation on FCR[28]. In addition, the creation of a standardized and centralized process to schedule interpreters has successfully increased the use of in-person interpretation by cutting through the difficulties of coordinating schedules to streamline workflow and save time[29].

Limitations

Our study had several limitations. During our ethnographic observations, we classified LEP families as those where interpreters were used for FCR. There were families where the medical team offered the use of an interpreter (presumably due to concern for LEP) but interpreters were declined by the family. It is possible that some English-proficient families in our observations were actually LEP. It is possible that interview participants were more likely to have stronger opinions on this subject compared to those that did not choose to

participate. As our study was done at one urban tertiary care institution, it may not be transferable to other settings. However, the literature has shown similar findings at other centers in the country, albeit not specifically with regards to FCR[26,30–32].

CONCLUSION

FCR is an evidence-based process that has been shown to improve outcomes and patient satisfaction on the inpatient pediatric wards[4–6]. Our study identifies some of the discrepancies between FCR when conducted for LEP versus English-proficient families. By providing formal training for physicians and interpreters, standardizing FCR for LEP families, integrating interpreters into the medical team, and investing in interpreters and their support infrastructure, we can work towards optimizing FCR for LEP families and minimizing the discrepancies between LEP and English-proficient families.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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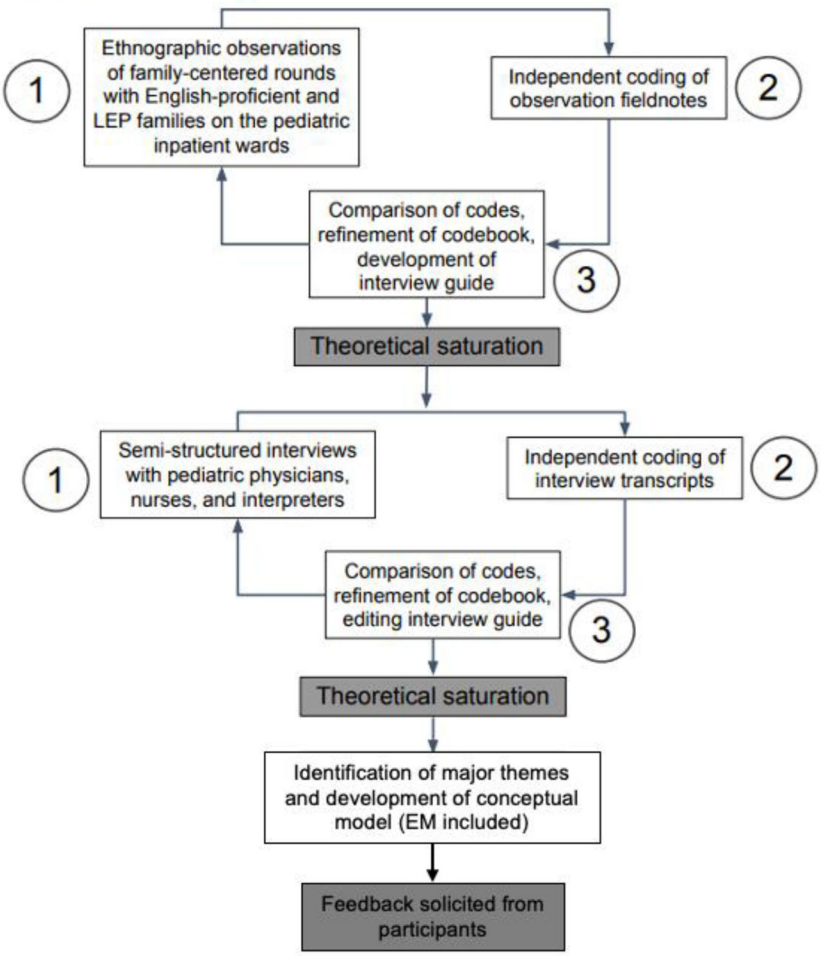

Figure 1:
Methodology
LEP = limited English-proficient

Table 1.

Demographic Characteristics of Interview Participants

	Age in years ***Mean (SD)***	**Years of experience** ***Mean (SD)***	**How often do you participate in FCR during clinical practice? (1 = infrequently, 2 = majority of days, 3 = every day)** ***Mean (SD)***	**Number who speak another language** ***n (%)***	**Number who are fluent in another language (advanced or native)** ***n (%)***
Residents (n=7)	27.7 (1.6)	1.4 (0.5)	3 (0)	5 (71%)	3 (43%)
Attendings (n=3)	39.3 (9.2)	12.3 (9.3)	3 (0)	2 (67%)	1 (33%)
Nurses (n=5)	38.8 (7.9)	14.1 (5.6)	2.2 (0.8)	0 (0%)	0 (0%)
Interpreters (n=5)	41.6 (10.3)	12.3 (10.2)	2.4 (0.9)	5 (100%)	5 (100%)
Total (n=20)	**35.7 (9.1)**	**9.0 (8.4)**	**2.7 (0.7)**	**12 (60%)**	**10 (50%)**

Table 2.

Themes and Categories with Supporting Interview Quotations

Theme 1: Standardization of FCR is needed to address equity issues for LEP families.
Consistently confirm the appropriate language and interpretation needed
"We just need to make sure that we have the right type of interpreter. Because it was the CDI [certified deaf interpreter] used, as mom explained it later, that she could understand… We obviously ordered the wrong one for rounds… I called to get the CDI interpreter for interpreting services, and of course it was on a Sunday. And interpreting services said, no we don't have anyone available." (N1)
Ensure that interpreters will always be present in the room during FCR
1. "They speak English, but maybe aren't proficient, that then there's missing knowledge down. Like something that was important to communicate didn't get across, because maybe they just didn't understand that… So that's why I think it is important to use an interpreter every time you round. And especially with important updates." (N5) 2. "Sometimes there are patients who have limited English proficiency so they understand some of what we're saying but not all… we're stuck between a rock and a hard place because they'll get frustrated that the interpreter is interpreting every word because they sort of understood what we said and they just want to be able to use their limited English, but we're sort of forcing the interpreter because we're afraid they don't fully understand." (A3) "My patient was on chemo… He was feeling nauseous all night… but yet mom said, she's okay and he's okay. Interpreter came, and then she was worried. She started crying… I felt like I was able to connect with mom a little bit more on that level because that language barrier, it's really difficult to get to know how they're really feeling if they can't really express it… But that really stood out because I was like, oh, she had a lot of feelings inside that I didn't know about that I couldn't get her to communicate that with me. And for the most part, I would have known if there was an interpreter there." (N2)
Ensure that everything spoken during FCR is interpreted
1. "Sometimes the wife may not speak English, but the husband does. And that sometimes causes problems because there tend to be side conversations in between the English-speaking sibling or the parent and the doctors because they start asking questions, and they skip the interpreter, and the other person doesn't understand." (I2) 2. "It's usually when the family members are there… they tend to cut us off no matter what…. And we have some aggressive ones, too… the aunties and uncles, they will know how to speak the language and they will just be, like, 'no, no, no, this is not how you should do it,' and then they will just be talking to the doctor directly, and the family - the parents will just sit there and not talk anymore." (I3) 3. "When the doctor is talking to the family, I get along just fine. It's when doctor is talking to doctor and I'm trying to interpret what doctor is saying to the PA or the other doctor. That's when I get tripped up. And sometimes I'll ask them, what did that mean? Or, can you repeat that word? And they'll usually say something like, 'Well, I was talking to him.' And I'm like, 'Well, I'm here to interpret everything in the room'…. Like if that was a hearing person, they would have heard it." (I5)
Assess for health literacy of LEP families
1. "I would say that 90 percent of the families are immigrants that have a low level of education… and they might not understand numbers. So, if you say creatinine level was this and that, they don't understand that. So, sometimes I think that it's better… Just maybe tell your numbers between yourselves, the residents and all the medical stuff. And then when we go inside, [give] the family kind of like a summary and just point out things that might be abnormal, the plan, and that's it… Sometimes they don't really know to read or write in Spanish. They are in survival mode, so they don't understand any medical, or not even sometimes they don't even know the organs of the body." (I2) 2. "I think I would be a little more willing in English, a little more willing to assume a higher degree of health literacy in the family if they're English speaking because I can very quickly react if they look confused or if they have any questions or if they look like they're not following… Whereas, with an interpreter, you're talking like several minutes, at this point before you can see a response… in order to save time, just inherently, you have to assume the lowest degree of health literacy and then build from that." (R7) 3. "It's like we treat people who are limited in English as if they're limited in knowledge… That's how we treat, sometimes, people who speak a foreign language. Even though they could be very intelligent and capable of understanding more information." (R5)
Theme 2: Redefining the roles of medical interpreters would enhance the interpersonal interactions and relationships between families and healthcare providers.
Inform interpreters on the clinical scenario prior to beginning FCR
"I think it works well to do a little huddle outside of the room first with the interpreter and just sort of explain, 'Here's what we're going to do, and are you okay with that?'… sort of get on the same page first before we go in the room and then having the interpreter meet the family first, I feel like also builds some rapport between them so that then that helps the dialogue flow more smoothly." (R2)
Encourage interpreters to serve as a member of the medical team to provide input and ask questions
"I was having a conversation with a parent, and I was trying to get something across to her. And the interpreter looked at me and he's like, I don't know how to translate that… That was one of the few experiences I've had where the interpreter is like, 'I don't know how to translate that.'… I think that the interpreter being comfortable enough to say that to me, I think was really key and important." (A1)
Train interpreters to act as advocate for families rather than solely as conduits of information
Conduit 1. "You have to say exactly the information that is given by the doctors to the families and back. I mean it has to be exactly what both sides are saying. You cannot omit anything. You cannot add anything. It should be as precise as possible. The information is forward, back and forth. That's the number one rule." (I4) Advocate

Theme 1: Standardization of FCR is needed to address equity issues for LEP families.
2. “If I sense like the family doesn’t get or something… Or maybe a doctor does not get the culture or something. I mean interpreters have to sense, have a good sense, not to only know the language well… but to sense the situation… Because of course I can go like a robot and interpret both ways. But sometimes I can sense that the patient doesn’t get it, even in simple language. So I would say to the doctor, ‘You know, I don’t think she gets it.’… Because she has a right to know. She has a right to all information. So you have to sense the situation, just the culture and everything, and be like a bridge, I think.” (I4) 3. “In American culture, they like to have the family help clean up the patient when they pass, but in our culture, we don’t do that. Like, that’s kind of something that is against our culture… the nurses and the doctors ask the family, ‘Hey, do you want to help clean up?’ And when I interpret for them, they will be, like, ‘No, I’m not going to do that.’ And then sometimes the nurses and doctors will come back and ask me, ‘Why were they so harsh about, like, why were they against it?’ And I had to explain all over again, like, this is how our culture is, yeah.” (I3)
Theme 3: Improving resources to allow for interpreters to be used consistently will increase equity for LEP families.
Schedule all appointments for FCR, including those with interpreters, to improve workflow and coordination with all members of the healthcare team
1. “The interpreter could only stay for a short period of time because they have appointments and they have other things to do…” (N1) 2. “Sometimes, the in-person interpreter is not available when we are doing rounds… or a previous patient took longer than we expected, so the time that we had scheduled the interpreter didn’t work out.” (R6) 3. “I think the only barrier is what we’ve touched upon earlier, which is just time and just being aware of people’s time. Like setting an appointment and keeping that. I think for me, I didn’t realize how hard it was as a patient to be like, the doctors will be here anywhere from 8:00 to 1:00. Like that is a huge window and spans two meals. So we’ve had many families, and they’re not willing to leave. Because the minute they leave, that’s when everyone shows up. And you can’t grab the family and bring them back.” (N1)
Hire more interpreters and increase access to telephone and video interpreters to improve access to and availability of interpreters
1. “We are usually pretty short-staffed. With the Spanish team, I know that they are so backed up that sometimes as soon as this interpreter is done with this patient you just see that interpreter running to another department. And sometimes because of the short staff, I feel like it delays patient care, but it’s just something that we can’t control.” (I3) 2. “And I know that other interpreters are fine to do it over the phone, too. If you guys need them right away, you don’t want to wait.” (I4) 3. “Sometimes we can’t get an actual interpreter in person because of staffing or because it’s the weekend. Or sometimes, it can take five minutes to get someone on the phone. That kind of takes a long time. Because we know there’s that wait…you’re less likely to do it, because it’s going to take more time…you never want to get behind on time in a hospital, because you’ll get super-behind.” (N3)

FCR: family-centered rounds; LEP: limited English-proficient; R: resident; N: nurse; I: interpreter; A: attending