Comprehension on Family-Centered Rounds for Limited English Proficient Families

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ABSTRACT

OBJECTIVE: To describe communication with limited English proficient (LEP) families during family-centered rounds (FCR); to examine differences in family understanding of diagnosis and plan by English proficiency and provider and interpreter rounding behaviors.

METHODS: Forty-one English proficient (EP) and 40 LEP parents of pediatric inpatients participated in a prospective cohort study from January to October 2011. Eligible LEP families self-reported a preference for medical communication in Spanish, Somali, or Vietnamese. Rounds were observed; families were interviewed afterward. Parent- and provider-reported diagnosis and plan were compared and classified as correct, incorrect, or incomplete by 3 blinded investigators. Logistic regression adjusted for potential confounders.

RESULTS: Fifty percent of LEP rounding encounters involved interpreters filtering information conveyed to families; 43% involved initial medical discussions without families present (vs 12% for EP, $P = .002$). Providers more frequently provided a plain language summary for LEP families (88% vs 56%, $P = .001$). LEP and EP families had similar ability to correctly name the child's diagnosis (70% vs 83%, $P = .17$) and all plan elements (38% vs 39%, $P = .88$). Results were unchanged after adjusting for parental characteristics and hospital day. Among LEP families, naming the correct diagnosis was positively associated with experience with a hospitalized child (odds ratio 5.11, 95% confidence interval 1.04–24.9) and may be negatively associated with interpreter filtering (odds ratio 0.22, 95% confidence interval 0.05–1.13).

CONCLUSIONS: Having initial medical discussions without the family and information filtering are common for LEP patients; filtering may be associated with poorer diagnosis comprehension. Experience with a hospitalized child is associated with increased comprehension among LEP parents.

KEYWORDS: communication barriers; family-centered care; language; pediatric hospital; physician–patient relations; teaching rounds

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WHAT'S NEW

Medical discussions without the family and relying on the interpreter to filter information are common for limited English proficient (LEP) patients on family-centered rounds. Among LEP families, previous hospital experience is associated with increased comprehension; filtering may decrease comprehension.

FAMILY-CENTERED ROUNDS (FCR) are the standard of care in the academic pediatric inpatient setting.[1–3] FCR occur when daily rounds actively involve the attending physician and residents, the bedside nurse, other care providers, and the patient or family. Benefits reported include improved communication between families and providers, better family understanding of the child's illness and management, enhanced education and role modeling for residents, and better interdisciplinary teamwork.[2,4–8]

FCR for families with limited English proficiency (LEP) are more challenging. Professional interpretation is the gold standard for providing high-quality, equitable care to LEP patients and families,[9–12] but there is no accepted model for interpretation during FCR. Many factors make interpreting for FCR difficult, including medical jargon, technical data, and conversations between providers. A qualitative study of mostly LEP parents reflecting on their experience with FCR reported poor comprehension of what was transpiring due to language barriers and lack of explanation; many families did not feel empowered to participate or expressed lack of understanding.[13] Language barriers are associated with disparities in health care and patient outcomes in multiple settings.[11,14–16] These findings suggest that FCR may be another setting in which LEP families are not receiving equitable care.

At present, little is known about how medical teams and interpreters conduct FCR with LEP families, and whether a disparity exists in what LEP families understand from FCR compared to English proficient (EP) families. The objectives of this study were to describe practices for providing FCR for LEP patients at our institution and to examine differences in family understanding of the child's diagnosis and daily plan by English proficiency and by provider and interpreter rounding behaviors.

METHODS

This was a prospective cohort study conducted at a freestanding children's hospital in the Pacific Northwest between January and October 2011. All resident-staffed medical teams had been conducting daily FCR since 2004. Rounding appointment times were introduced in 2010, which allowed reliable scheduling of in-person interpreters. Typically multiple team members communicated with the family via the interpreter at some point during FCR. Only professional interpreters were used on FCR, the majority of which were hospital staff (21 total, of whom 5 interpreted for FCR most frequently). Agency-based interpreters were also used. All have received state certification as professional medical interpreters and agreed to a code of ethics, which includes "thoroughly and faithfully render[ing] the source language message, omitting or adding nothing."[17] In addition, hospital staff interpreters have 2 or more years' experience in medical interpreting, 30 or more hours of additional training, and annual performance reviews that include provider feedback. Faculty and residents were trained to work with interpreters. No FCR-specific training occured for providers or interpreters, given the lack of standards to guide it. The hospital institutional review board reviewed and approved all study procedures.

PARTICIPANTS

Parents or guardians (hereafter referred to as parents) were eligible for enrollment during the first 3 days of a child's admission to 1 of 3 general pediatric resident teams. We excluded parents of children admitted primarily for social reasons or who had previously participated.

Families were considered LEP if their self-reported preferred language for medical care was not English, as documented in the electronic medical record. We enrolled families with a preference for Spanish, Somali, or Vietnamese who had a professional interpreter present for at least part of FCR. Enrollment occurred 1 to 3 days per week, according to investigator availability. Families were purposively recruited by language, with a goal to enroll equal numbers of EP and LEP families.

STUDY PROCEDURES

Parents consented to participation before rounds. For LEP parents, telephone-based professional interpreters were used, and translated documents were provided.

For each FCR encounter, 1 to 2 trained observers noted provider, interpreter, and parent behaviors using a standard template. Observer teams included a clinician or an experienced clinical research associate. The behaviors noted focused on elements suggested by the literature to be important to families, including introductions, an explanation of rounds, a summary of the plan in lay terms, and an invitation to ask questions.[4,13] For interpreted encounters, we also noted the timing and frequency of pauses by providers to allow for interpretation, along with the timing and frequency of interpreter speech. The diagnosis and medical plan for the day, as explained by the providers on rounds, were recorded.

Immediately after FCR, interpreters were asked to describe their method of interpretation. Options included interpreting most or all of what the team said; summarizing the medical discussion for the family; interpreting just things said directly to the interpreter or the family; or other. They were invited to provide as much detail as possible in describing their approach. Interpreters verbally consented before participation, but no identifying information was collected from them.

After rounds, we interviewed the parent who had participated that day using a structured questionnaire. Telephone interpretation was used for LEP parents. Given that the telephone equipment precluded participation by more than 1 parent, we limited participation to 1 parent for both groups. We collected information on the highest level of education completed, ever having had a health care–related job, and previous experience with a hospitalized child. We asked LEP parents to report their ability to speak English using the following US Census categories: not at all, not well, well, or very well (less than "very well" is considered LEP).[18] We then asked the parent to name or describe the child's diagnosis and daily plan. If needed, diagnosis was explained as "the name for your child's current illness" and plan as "what the doctors told you would be happening today."

COMMUNICATION ANALYSIS

Provider behaviors were categorized on the basis of previously described criteria from the literature. Providers received credit for introductions, explaining rounds, or eliciting questions if any team member was noted to perform the behavior, regardless of its perceived quality or effectiveness. Summaries were considered to use lay terminology if the nonphysician observer easily understood all the words.

The term *filtering* was used to describe encounters in which the interpreter, rather than the medical providers, determined what information the parents were told. Filtering information or summarizing discussions without being instructed how to do so, rather than interpreting word for word or idea for idea, is outside the scope of interpreter practice and professional standards.[17,19,20] Encounters were classified as including filtering only if the interpreter was noted to be speaking less frequently than providers and reported filtering or substantial summarizing.

To determine diagnosis and plan concordance, 3 study investigators (KCL, MM, GT), blinded to participant language, independently compared the diagnosis and plan presented on rounds to those which the parents reported. Disagreements were resolved by discussion. Diagnoses were coded as correct, incorrect, or incomplete/vague according to whether a follow-up provider would reasonably know the child's diagnosis from the parent-provided information. Medical terminology was not required. For example, for a child with bronchiolitis, "a virus in the lungs" was considered correct, "a virus" too vague, and "asthma" incorrect. For patients with an unclear diagnosis, the principal symptoms or presenting complaint discussed by the team was used as the standard.