Not Just "Getting by": Factors Influencing Providers' Choice of Interpreters

Elaine Hsieh, Ph.D

Department of Communication, University of Oklahoma, Norman, OK, USA.

BACKGROUND: Providers consistently underutilize professional interpreters in healthcare settings even when they perceive benefits to using professional interpreters and when professional interpreters are readily available. Little is known about providers' decision-making processes that shape their use of interpreters.

OBJECTIVE: To understand the variety of considerations and parameters that influence providers' decisions regarding interpreters.

DESIGN: A qualitative, semi-structured interview guide was used to explore providers' decision making about interpreter use. The author conducted 8 specialty-specific focus groups and 14 individual interviews, each lasting 60–90 minutes.

PARTICIPANTS: Thirty-nine healthcare professionals were recruited from five specialties (i.e., nursing, mental health, emergency medicine, oncology, and obstetrics-gynecology) in a large academic medical center characterized as having "excellent" interpreter services.

APPROACH: Audio-recorded interviews and focus groups were transcribed and analyzed using grounded theory to develop a theoretical framework for providers' decision-making processes.

KEY RESULTS: Four factors influence providers' choice of interpreters: (a) time constraints, (b) alliances of care, (c) therapeutic objectives, and (d) organizational-level considerations. The findings highlight (a) providers' calculated use of interpreters and interpreting modalities, (b) the complexity of the functions and impacts of time in providers' decision-making process, and (c) the importance of organizational structures and support for appropriate and effective interpreter utilization.

CONCLUSIONS: Providers actively engage in calculated use of professional interpreters, employing specific factors in their decision-making processes. Providers' understanding of time is complex and multidimensional, including concerns about disruptions to their schedules, overburdening others' workloads, and clinical urgency of patient condition, among others. When providers make specific choices due to time pressure, they are influenced by interpersonal, organizational, therapeutic, and ethical considerations. Organizational resources and guidelines need to be consistent with institutional policies and professional norms; otherwise, providers risk making flawed assessments about the effective and appropriate use of interpreters in bilingual health care.

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Professional interpreters—trained individuals who provide interpreting services through various modalities—are underutilized in healthcare settings.[1,2] Lack of time, interpreter availability, and interpreter accessibility are cited as primary barriers to providers' use of professional interpreters.[3,4] However, even when they perceive the benefits of using professional interpreters and when professional interpreters are readily available, providers in various clinical contexts, including emergency care, primary care, inpatient and outpatient settings, have consistently used professional interpreters for less than 20 % of patients with limited English proficiency (LEP).[2,5,6]

The use of interpreters is a complex issue that cannot be addressed by increasing interpreter availability alone.[6] Some researchers use the term "getting by" to describe physician behaviors when they interact with LEP patients with untrained interpreters or with their limited second language[2,6]; in contrast, professional interpreters were cast as the preferred choice. Although professional interpreters have positive impacts on the quality of care,[7] recent studies suggest that they may not be universally superior to other types of interpreters.[1]

Different types of interpreters and interpreting modalities have their unique strengths and weaknesses; consequently, strategic and appropriate use of a variety of interpreters may best meet the complex demands of healthcare settings.[8,9] For example, family interpreters are more persistent in maintaining patients' priorities, providing emotional support, and advocating patients' needs.[10–12] Although patient advocate is an official role that professional interpreters learn during their training, many refrain from advocacy behaviors due to concerns about institutional hierarchy or job security.[13,14] Bilingual staff interpreters have the advantage of familiarity with clinic-specific knowledge; however, they may not have sufficient linguistic skills for interpreting tasks and feel overwhelmed with other responsibilities.[15,16] Compared to professional on-site interpreters, remote interpreters (e.g., telephone and

videoconferencing interpreters) are more cost-effective, accessible, and equally accurate.[17–19] However, compared to on-site interpreting, telephone interpreting is often rated lower for interpersonal rapport due to a lack of nonverbal communication and problematic discursive style (e.g., repetition and slowed speech).[9,20–23] Providers using videoconference interpreting report less understanding about patients' cultural beliefs than those who use on-site interpreting,[19] making videoconference interpreting a problematic choice when cultural competency is important (e.g., end-of-life care).

The purpose of this study was to understand the variety of considerations and parameters that influence providers' decisions regarding interpreters. By using grounded theory to analyze semi-structured focus groups and interviews, I inductively generated a theoretical framework and the factors that shape providers' decision-making processes.

METHODS

All study procedures were approved by the Institutional Review Board of the University of Oklahoma.

Participants and Procedures

Providers were recruited at the OU Medical Center, a 784-bed academic medical center located in Oklahoma City and Oklahoma's largest hospital. Approximately 9.4 % of the local population have LEP.[24] At the time of this study, interpreter services included ten full-time Spanish interpreters, who received the industry-standard 40-hour training[25] and provided 24/7 on-site interpreting. Telephone interpreting in 146 languages was accessible with any phone any time through a contracted agency. There were no federal or state certifications for professional interpreters. There was no assessment or training for bilingual staff.

Participants in nursing (NUR) were recruited through women and newborn services. Physicians were recruited through the departments of obstetrics-gynecology (OB/GYN), emergency medicine (EM), oncology (ONC), and mental health (MH). All received $40 for research participation.

The author generated a semi-structured interview guide to explore providers' perspectives when working with interpreters based on a previous study of interpreters' performances[26] (Table 1). Providers had the option of focus group or individual interview participation. Two graduate research assistants (GRAs), trained in qualitative research methods, assisted by monitoring the interview process (e.g., taking notes about participant dynamics) and asking follow-up questions to encourage participant elaboration.

All focus groups and interviews were transcribed verbatim by the GRAs and were reviewed by the author for accuracy. CAPITALIZED text reflects speakers' emphases. Providers' expertise is noted below by abbreviated superscripts following participant pseudonyms.

Data Analysis

A qualitative research program (NVivo 10) was used to analyze the data using grounded theory, a constant comparative analysis with three coding phases.[27,28] In each phase, coder(s) analyzed the data independently while generating memos and codes. When multiple coders were involved, the research team held regular meetings to review memos and compare codes. Each code proposed by one investigator was then probed by others in a second pass through the data. We then combined similar findings; however, claims proposed by one investigator but not corroborated by other(s) were discussed in detail with further consultation of the data for evidence to support or contradict the claim. The process was repeated until all coders of the specific phase agreed on a finalized list of codes.

Four individuals (i.e., the author and three doctoral students, including the two GRAs) participated in coding. During the initial coding phase, the author and two GRAs independently reviewed all transcripts line-by-line to generate codes that emerged from close examination

Table 1. Interview Guide (Selected Questions)

Areas of inquiry	Interview questions
Providers' communicative needs	1. Do interpreters facilitate your work? In what way? 2. Do interpreters present challenges to your work? In what way? 3. Do you have problems coordinating the multi-party conversations when working with an interpreter? What are the problems? How do you usually resolve these issues?
Evaluation criteria for the success of bilingual health care	4. Were you ever in situations that you feel that the interpreter was not neutral? What happened? Did you do anything to manage the situation? 5. When you have miscommunication or conflicts with a patient, how should an interpreter manage the situation? Do you think that they should still translate all the emotions and possibly foul language? Why or why not? 6. What are criteria you use to evaluate the quality and success of a provider-patient interaction? Do you use different criteria if it's a cross-cultural, bilingual interaction?
Contextual factors that shape providers' expectations	7. Are there any situations that you will not talk to a patient without an interpreter? 8. Do you think your clinical specialty influence your expectations and needs for a medical interpreter? In what way?

of the data. Based on these codes, we identified a list of major theme, one of which was providers' complex reasoning for their choice of interpreters.

In phase 2, the author and the third doctoral student conducted focused coding,[29] a selective coding process that aims to generate conceptual categories related to the phenomenon of interest. We used all codes related to the providers' choice of interpreters developed in the initial coding (e.g., concerns about time and clinical urgency, among others) to recode all transcripts and to examine the adequacy of emerging codes. During this process, codes were fractured, combined, and reorganized to develop conceptual categories. We finalized a list of recurring codes that identify providers' choice/preferences of interpreters and their corresponding reasons.

Finally, using codes generated during focused coding, the author reviewed all transcripts and conducted axial coding (phase 3) by identifying and relating categories to subcategories and specifying the properties and dimensions of each category. For example, by clarifying the meanings of time constraint and clinical urgency (see Table 3), I explored providers' differing understandings about time in each category. The author then invited research team members and a senior researcher to conduct peer review by critically examining the perspectives, assumptions, and coherence of the proposed framework to ensure the validity of the findings.[30]

Table 2. Providers' Demographic Data

Category	Range	Number	%
Gender	Male	14	35.9
	Female	25	64.1
	Total	39	100.0
Age	18–30	8	20.5
	31–40	13	33.3
	41–50	4	10.3
	51–60	8	20.5
	61–70	6	15.4
	Total	39	100.0
Race	American Indian	1	2.6
	Black or African American	12	30.8
	White	22	56.4
	More than one race	2	5.1
	Unknown or not reported	2	5.1
	Total	39	100.0
Specialty	OB/GYN	8	20.5
	Emergency medicine	7	17.9
	Oncology	11	28.2
	Mental health	7	17.9
	Nursing	6	15.4
	Total	39	100.0
Language proficiency	Native language: English	39	100.0
	Language spoken other than English		
	None	31	79.5
	Spanish	4	10.3
	Others	3	7.7
	More than two	1	2.6
	Total	39	100.0
Experience with interpreters	Never	3	7.7
	1–5 times	2	5.1
	6–10 times	3	7.7
	>10 times	31	79.5
	Total	39	100.0

RESULTS

The author recruited 39 providers and conducted 8 specialty-specific focus groups and 14 individual interviews. The mean durations for focus groups and individual interviews were 73 (range 50–92) and 49 (range 33–82) minutes, respectively. Table 2 includes participant demographics. All were native English speakers and most (n=31) have worked with interpreters at least ten times. Table 3 provides a summary of findings, including a list of themes, related subcategories, and interview excerpts. Detail discussions are presented below.

Time Constraints

Disruption to providers' schedule and priorities. When discussing time constraints, providers' primary concerns centered on management of and disruption to their schedules. Ginger$^{OB/GYN}$ commented, "I prefer to have a professional but I feel silly calling them for a 20-second thing." Nancy^{NUR} explained her frustration when she had to explain to an interpreter, "You need to come. NOW! You don't understand. There are twenty people down in labor […] and they've got more people delivering in the hallway. So we need them discharged." Having to wait for a professional interpreter can delay care for other scheduled patients and create a snowball effect of task delays for an entire clinic.

Although telephone interpreters may appear readily available, they can still impose significant disruption to providers' tasks. Ginger$^{OB/GYN}$ explained,

> We tried to do it on the speaker-phone, but there's a lot of echo; so usually, I'll ask the question into the phone, and then hand the phone to the patient, who answers it, and then I get the phone back.

Emily^{EM} commented, "Having someone in the room with you makes a very much smoother conversation." Concerns about poor sound quality, awkward discursive style (e.g., passing the handset back and forth), and lack of interpersonal closeness (e.g., difficulties in establishing rapport) through telephone interpreting were shared by many providers.

Due to concerns about disrupting their schedules and priorities, many providers advocated for in-clinic interpreters (e.g., bilingual staff). Earl^{EM} explained, "I wish we had an interpreter that lived in our department. I wish we had one around the clock." Others used family interpreters, while still recognizing their many flaws. Gloria$^{OB/GYN}$ explained, "We go to the

Table 3. Factors Influencing Providers' Choice of Interpreters

Factors	Corresponding dimensions	Sample narratives
Time constraints	Disruption to providers' schedule and priorities	I would use [professional interpreter] SO MUCH MORE OFTEN if they were just right there where I could just say, "Hey, can you come here? I need to ask you something real quick," instead of having to call and wait 25 min for them to get up here. (Nora^{NUR})
	Increased responsibilities and competing demands	It is [an] unfair burden to carry on a regular patient load and then having to interpret for every family that needs it. […The bilingual staff/provider who should be] making medical decisions or parting medical therapy [is] now tied up doing interpretation. (Eric^{EM})
Alliances of care	Management of patient empowerment and patient receptiveness	[When disclosing poor prognosis,] I want somebody [who] stands in there WITH me. […] I just couldn't use a telephone [interpreter]. (Cecil^{ONC})
	Facilitation of provider agenda	PROFESSIONAL interpreter is supposed to be working for ME, as a go-between with the patient. Whereas the family member, may be working for themselves, or may be xworking for the patient, or who knows what. They are not THERE FOR ME. (Gloria$^{OB/GYN}$)
Therapeutic objectives	Clinical complexity	I would trust [bilingual nurses much more than professional interpreters]. Because they have more medical experience so they would know better how to explain exact procedures and diagnosis. (Eli^{EM})
	Clinical urgency	If somebody is critically ill, we will get whatever information we can whether that'll be a family member that speaks very little English, or even a younger child […] I have a few phrases of Spanish […] we will utilize what we can till we get an interpreter. (Ed^{EM})
	Patient privacy	[When working with family interpreters,] the obvious concern would be confidentiality issues. If the patient will not be forthcoming with the interpreter, then I cannot really ask [sensitive topics] I need to ask through a family interpreter. (Michael^{MH})
Organizational-level considerations	Resource limitations	I xagree that professional interpreters are our preference, but unfortunately, financially, it's nearly impossible to do that. (Gloria$^{OB/GYN}$)
	Ethical guidelines	You don't have to worry about somebody saying back later, "You never told me that. I was translating and you never said that." So, yeah, it's an extra level of protection to have a hospital hired [interpreter] as opposed to the family. The level of malpractice protection. (Cara^{ONC})

family member not knowing what was really communicated. That is FAR from ideal, but it's usually time constraints [that require use of family interpreters]."

Increased Responsibilities and Competing Demands. Several clinics managed the disruption to providers' schedules by hiring bilingual staff and/or bilingual physicians. Michael^{MH} commented, "If there is a medical personnel, either on my team or right there in the unit, who speaks the language, we grab them." Earl^{EM} explained that they used a bilingual clerk due to the need for immediate diagnosis, "Her role was to be a clerk, but she happened to be able to speak Spanish. And we needed someone at that point in time, so we borrowed her." The terms participants used to explain how these personnel were solicited (i.e., "grabbed" and "borrowed") imply asking for a favor both in instrumental use and in immediate response.

When asked if other providers or nurses solicited him to interpret for them, Eli^{EM} , a bilingual physician said, "Oh, absolutely! All the time. I mean as soon as people knew I was pretty fluent in Spanish, that's [interpreting] come up like a second job." However, concerns for coworkers' increased workloads and responsibilities limit providers' choices. Norma^{NUR} explained that to minimize her impositions, she would only ask her bilingual coworker to interpret "a couple of things" but not discharge instructions because they "takes about 5–10 minutes." Michael^{MH} expressed his frustration in waiting for a professional interpreter, but commented that bilingual nurses will not do because "they usually do not have [45 min] to go through a more thorough initial evaluation."

Alliances of Care

Management of Patient Empowerment and Receptiveness. Alliances of care highlight the interpersonal dimension that shapes providers' choices. Providers manage the delicate balance between patient empowerment (e.g., encouraging autonomous decision-making and active participation) and patient receptiveness (e.g., feeling comfortable and agreeing to accept the proposed treatment), which may not always be compatible with one another and may be best achieved through different types of interpreters.

For our providers, patient empowerment denotes patients' informational needs (e.g., having accurate understanding of the situation), highlighting a preference for accurate information exchange achieved by professional interpreters. For example, Nydia^{NUR} explained, "If you're going to take the patient's baby away because [her] drug test was positive […] I make sure I have an [professional] interpreter and make sure [the patient] understood everything." Many providers also emphasized that professional interpreters are necessary to obtain informed consent for medical procedures.

In contrast, providers' concerns for patient receptiveness motivated them to consider patients' emotional needs, making providers more open to family interpreters. Ed[EM] explained, "To have an interpreter that can not only interpret but also assist in providing compassion and empathy is helpful." Many patients often come with trusted family members and friends who have served as their interpreters for years. Ed[EM] commented, "I will try to respect that unless I see that [the interpreter is] just totally inadequate." However, family interpreters can pose risks to patient autonomy. Nacia[NUR] observed, "The family gentleman was there, and I had to talk through him, and that's very annoying. But [the patient] didn't want me advocating for her." Providers commented that male relatives in certain cultures (e.g., Hispanic culture) are often decision makers for female patients, providing a comforting and reassuring presence to female patients. As a result, they argue that allowing the male relative to be the interpreter can facilitate patient receptiveness.

Finally, certain modalities of interpreting facilitate patient empowerment and/or patient receptiveness more than others. For example, several providers expressed concerns about using telephone interpreters because they pose a poor choice to meet patients' emotional needs. Norma[NUR] commented, "On-site interpreters make the patient feel better as opposed to [telephone interpreter, who are] just are more factual." Cecil[ONC] explained that when disclosing poor prognosis, "I want somebody [who] stands in there WITH me. […] I just couldn't use a telephone [interpreter]." As a result, there are situations where a provider may prefer an untrained on-site interpreter over a professional telephone interpreter, who is unable to provide the emotional support needed.

Facilitation of Provider Agenda. Providers evaluated their relationships with interpreters through alliances that allowed them to accomplish specific goals. Eric[EM] mentioned that he evaluated the success of a medical encounter based on whether the patient accepted his medical assessment; in addition, he claimed to rely "on the ability of the interpreter to repeat that salesmanship." Several providers mentioned that they have filed a complaint against an interpreter when they suspected the interpreter did not endorse their communicative agenda (e.g., the interpreter supported the patients' decision of not accepting a lumbar puncture or epidural).

From this perspective, providers prefer interpreters who are familiar with their procedures and who are willing to maintain their agenda. Ed[EM] commented, "[For interpreters I have worked] with for a long time, I am very comfortable with them redirecting the patient and stopping the patient." Interpreters' familiarity with clinic-specific procedures and knowledge allows them to serve as a provider proxy. Mandy[MH] added, "I think the more we could get someone that's familiar with mental health, the better." Cordell[ONC] agreed, "That's why I prefer somebody who I have a relationship with because they will be trained over time."

Therapeutic Objectives

Clinical Complexity. Providers often prefer interpreters who are familiar with the clinical complexities of patient care. Celia[ONC] explained, "We have some residents who are bilingual, and that can be very helpful sometimes too, 'cause they have a lot of medical knowledge." Mira[MH] explained, "We need to know the psychosocial details about the patients […] whether the patients' complaint is typical or normal in that particular culture."

Providers' assessments of clinical complexity highlight the spectrum of tasks requiring trained interpreters. For example, Ginger [OB/GYN] explained, "When it's just something like 'roll on to your back,' I'm not going to call an interpreter up just for two sentences." Cecil[ONC] explained, "If all I need to do is put a needle in […] I can get an okay from the patient, and he understands what I'm gonna do, then I don't need an interpreter." Providers made calculated decisions on what was considered minor (e.g., pain management) versus major procedures (e.g., discharge instruction) and tried to weigh various options related to asking for interpreter assistance (e.g., wait for a professional interpreter versus provide some pain medication immediately). Natalie[NUR] noted, "It's one thing for me to use the family to see if they like to crochet […] but it's another to ask if they are allergic to something […which] could potentially be a life threatening issue." Grace[OB/GYN] explained, "Dead babies. Cancer. You know, life altering situations, I will not do it without [professional] interpreters." From this perspective, clinical complexity also includes difficulties in providing culturally-sensitive care as certain topics (e.g., death and dying) often are infused with cultural values, resulting in diverse communicative practices in different communities.[31,32]

Clinical Urgency. Different from the impacts of clinical complexity, where providers make educated decisions for their best option in a given context, clinical urgency leaves providers few choices in deciding the type of interpreters they would work with. Mira[MH] noted, "Trust for our patient is such an important issue that I just don't think [a] telephone interpreter is a good solution unless it's an emergency." Gloria[OB/GYN] also commented, "If you are in a fairly urgent situation, where you have to make a decision doing an emergency C-section or something like that, you go with what the family member says and you don't think about it."

Patient Privacy. Several providers noted that family interpreters do not always facilitate provider-patient communication or patient receptiveness to their treatment recommendations. Gloria[OB/GYN] said that refusing a family interpreter and requesting a professional interpreter is necessary if "the husband is controlling and manipulating, and you are concerned about domestic abuse." Several providers also

commented on situations where they needed to find a professional or same-gender interpreter for the patient due to a sensitive topic (e.g., sexual background and HIV diagnosis) or procedure (e.g., pap smear).

Organizational-Level Constraints

Resource Limitations. Many providers have expressed their desire to have a full-time, professional interpreter stationed at their clinic. However, depending on patient demographics and clinical specialty, such a practice may not be feasible. Health organizations recruit bilingual staff to meet the challenges of LEP patients. For example, Cordell[ONC] explained, "We have hired specifically in our office and department some bilingual folks who have roles in our department as receptionist and data managers." Nevertheless, as discussed earlier, providers in our study also expressed reluctance to utilize bilingual coworkers due to concerns about increasing their coworkers' workload.

Ethical Guidelines. Whereas resource limitations restrict the options available to providers, ethical guidelines limit providers' choice of interpreters. For example, Eli[EM] explained, "The University has guidelines. […] I don't think you can get consent for going into the operating room without an official interpreter there." Mira[MH] explained, "Everybody worries about malpractice. I think interpreters REDUCE my risks." From this perspective, providers' concerns for ethical guidelines center on protecting themselves in case of potential litigation.

DISCUSSION

This is one of the first in-depth, qualitative investigations to examine providers' decision-making processes across various clinical specialties. Four factors influence providers' choices of interpreters: time constraints, alliances of care, therapeutic objectives, and organizational-level considerations. These findings provide insight into providers' calculated use of interpreters and the complexity of the function and impact of time in providers' decision-making processes.

Rather than "getting by" when communicating with LEP patients,[2,6] providers in our study employed specific factors in their decision-making processes.[33,34] Depending on the tasks involved, a specific type of interpreter may be acceptable, preferred, or even required. For example, informed consent requires professional interpreters; in contrast, on-site interpreters, regardless of training, often are preferred over professional remote interpreters when emotional support is needed. With only 10 weeks of medical Spanish, providers reduced their use of interpreters and experienced increased patient satisfaction.[35] In short, providers' underuse of professional interpreters should not be simply viewed as problematic[36,37]; rather, the different ways of communicating with LEP patients should be viewed as complementary, rather than competing or interchangeable.

Our findings highlight that the accuracy and appropriateness of providers' assessments are essential to quality care. If providers' basis for assessment was problematic, their decisions were inevitably flawed. For example, trusting bilingual staff as alliances can be risky when 1 in 5 dual-role staff interpreters had insufficient interpreting skills.[15] If untrained interpreters are unprepared for interpreting tasks, they may experience discomfort and even vicarious trauma.[10,38,39] If bilingual providers overestimate their linguistic skills or view communication as a means of gathering clinical information (rather than addressing patients' concerns),[6,33] patient satisfaction can be at risk.[40] If providers mistakes an interpreter's or their own linguistic and cultural competencies, they are likely to contribute to compromised care.

Lack of time and interpreter availability/accessibility, while seemingly obvious barriers,[3,4,41] confound a variety of factors that influence providers' decision making. For example, although bilingual staff members may be available and have adequate interpreting skills, providers may feel it unfair to overburden their coworkers with the task of interpreting. Interpreter waiting time can be influenced by a wide range of factors, including clinical urgency and clinical locations.[42] Extensive waiting for a professional interpreter before checking patients' pain levels may, in fact, add to health disparities in pain management in LEP patients. In short, when providers made specific choices due to time pressure, their choices were simultaneously influenced by interpersonal, organizational, therapeutic, and ethical considerations.

Our study has several limitations. First, providers who do not have access to the resources available in large medical facilities may be motivated by different factors that are not identified in this study. Second, the combined use of focus groups and individual interviews was necessitated by provider availability. We decided to recruit more participants and obtain richer data than we would have if we had used a single method.[43] We managed the study by analyzing the data separately. We did not find differences in the codes identified. Finally, although some factors (e.g., clinical urgency) may not initially appear to be applicable to primary care, it is important to note that psychiatric and OB/GYN care still has a fair share of cases that require immediate clinical interventions. In addition, many of the issues raised by our participants remain relevant in primary care settings where continuity and trust of therapeutic relationships are important.

In spite of these limitations, this study contributes to (re)conceptualizing the concept of time in interpreter-mediated encounters. Rather than viewing time as an inescapable constraint, it may be useful to examine the meanings, functions, and impacts of time on providers' decision making. For example, providers' concerns about disruptions to their schedules is not simply about interpreter availability. For

patients who are too sick to engage in long conversations, providers may prefer to rely on an untrained on-site interpreter over a professional remote interpreter. The condition of the patient, rather than the extra time required to find a professional interpreter, prescribe providers' choice of interpreters.

By viewing time as a limited resource, many researchers have attempted to identify the most time-saving mode of interpreting.[17,44] However, the desire to save time be particularly problematic in bilingual health care. For example, providers often believe that they spend more time with LEP patients than English-speaking patients even though there are no differences in appointment durations when professional on-site interpreters are used.[44,45] The fact that professional interpreters do not extend the appointment duration is intriguing. After all, if all participants communicate the same, the duration of the interpreter-mediated encounter should be longer. Providers in our study argued interpreters' ability to redirect and guide patients in the communicative process is valuable for time management. In contrast, two recent studies found that patients with interpreters speak significantly less than language-concordant patients while providers maintain the same amount of speaking time.[46,47] Combined together, providers' inaccurate assumption about the extended encounters with LEP patients may motivate them to welcome interpreters' active management of patients' discourse in a way that compromises patient empowerment by discouraging patients' information seeking and providing.

Lastly, organizational resources and guidelines need to be consistent with institutional policies and professional norms. Many organizations suggest using remote interpreting services to replace on-site interpreting due to its cost-effectiveness and availability of services.[48] However, emergency medicine providers rarely use telephone interpreting because of "delays in contacting an interpreter in the required language and limited access to phones at the patient bedside".[49] In addition to increased access to professional interpreters through various modalities, health organizations will need to modify the exam room to address the logistics of using a remote interpreter (e.g., good quality speaker phones that are easily accessible and secured settings to respect patient privacy). Interpreter availability is meaningless without logistic and organizational support which includes understanding patient needs. Only 72 % of hospitals routinely record patients' interpreter needs,[42] which can significantly reduce waiting time as an interpreter can be requested ahead of appointments. A study found that bilingual residents spent a mean of 2.3 hours per week interpreting for other colleagues.[50] If organizations recruit bilingual employees with the intention of having them serve as in-clinic interpreters, it is essential to develop organizational policies to address the expectations of their workload. By doing so, other providers would feel more comfortable to request their assistance and, thus, decrease the likelihood of minimizing communication with LEP patients. Furthermore, providing institutional training, certification, and guidelines for bilingual physicians and staff members can promote quality care by maintaining the standards of bilingual health care.[33,51]

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Corresponding Author: *Elaine Hsieh, Ph.D; Department of Communication University of Oklahoma, 610 Elm Ave #101, Norman, OK 73019, USA (e-mail: ehsieh@ou.edu).*

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