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Nurse-patient communication on the south Texas border: Negotiating language and cultural discordance during the COVID-19 pandemic

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Throughout the COVID-19 pandemic, medical professionals have experienced unforeseen and often under-discussed hurdles to meeting the surging demand for patient care. In particular, practitioners in under-resourced areas have faced enormous barriers when attempting to adequately address the swell in demand. Analyzing these tensions through the growing body of literature on patient communication during the COVID-19 pandemic, this article centers the work experiences of registered nurses serving on the frontlines of the South Texas-Mexico border of Laredo, Texas. Using a qualitative method of semi-structured and in-depth interviews with nurses working inside two COVID-19 hospital units, our thematic analysis reveals the work challenges generated by language discordance and cultural differences experienced between travel nurses, patients, and their families. Our findings further exposed the added workload and work strain generated from the language and cultural barriers experienced by local bilingual nurses, tracking how during a global pandemic such barriers place material strain on nurses' workload.

KEYWORDS

language discordance, cultural barriers, translation, nursing workload, U.S. latina/o health communication

Introduction

Throughout the COVID-19 pandemic, medical professionals have experienced unforeseen and often under-discussed hurdles to meet the surging demand for patient care. Work burnout, substantial physician and nurse shortages, and lack of medical supplies are examples of the challenges medical professionals experience (Khot, 2020; American Hospital Association, 2021). In particular, practitioners in under-resourced areas have faced enormous barriers when attempting to provide the swell in demand for patient care. For example, in early 2022, as the COVID-19 infection and hospitalization rates lowered, the South Texas community of Laredo, Texas, faced its fourth surge as community leaders cited the high underinsured rates as problematic since people without health insurance delay or fail to visit a doctor until they are hospitalized. This ultimately leads to a hospital bed shortage (Harper, 2022). Analyzing these issues through

the growing body of literature on nurse-patient communication during the pandemic, this article centers the work experiences of registered nurses serving on the frontlines in the South Texas-Mexico border region of Laredo, Texas. Specifically, we focus on the narratives of nurses working inside two COVID-19 hospital units in a community where a large number of residents are limited English proficient (LEP) or bilingual in both Spanish and English. Compounding these linguistic issues, Laredo, predominantly 95.5% Latina/o (United States Census Bureau, 2022), also faces high rates of poverty and inadequate primary health care provision (Burkhalter et al., 2021).

Equally problematic and unique to the border, language discordance (and related cultural barriers) between monolingual nurses from outside the community and LEP patients, generated multiple problems from impacting patient-centered communication to nursing workloads. Though not a long-standing issue for healthcare workers in the region, language discordance intensified as hospitals became saturated with COVID-19 patients (San Miguel, 2021). The most acute instance of this was experienced in summer 2020, as travel nurses were deployed to Laredo from other regions in the U.S. As patients became sicker and family members were increasingly prohibited from visiting, local bilingual nurses took on the workload of serving as interpreters and cultural brokers between travel nurses, patients, and patients' families.

To fully capture the problems COVID-19 generated for registered nurses working in Laredo, we will focus on the challenges of language and cultural discordance: linguistic and cultural differences between patients and providers that can produce barriers impacting patient care. There has been extensive research on the challenges of linguistically and culturally concordant communication between patients and providers (Tay et al., 2012; Taylor et al., 2013; Hseih, 2016; Hsieh and Kramer, 2021). While some scholars have called for a more holistic approach to mitigating language and cultural barriers (e.g. Schouten et al., 2020) research focusing on the ramifications of language concordance between bilingual nurses and LEP patients (Ali and Johnson, 2016) remains limited. Our study attempts to fill the gap in the health communication and healthcare literature while underscoring the changes in the nursing workload for bilingual nurses. Specifically, we will discuss how the communicative barriers between patients and non-Spanish speaking nurses both impedes quality of care and adds substantial stress to both non-Spanish speaking and bilingual nurses. In this pursuit, we offer a thematic narrative analysis of interviews with local and travel-registered nurses during two local COVID-19 surges in July and December of 2020. The first thematic element consists of work challenges generated by language discordance and cultural differences between nurses, the patients, and the patients' families. Linked to but distinct from the first thematic element, the second consists of how language and cultural barriers among travel nurses and LEP patients shaped the workload of local bilingual nurses during the pandemic. In addressing these elements, we discuss the work strain and demands that emanated, tracking how during a global pandemic such barriers place material strain on nurses' workload, especially regarding quality patient care. Drawing on the themes delineated in our analysis, the article concludes with recommendations for health practitioners and researchers.

Literature review

The COVID-19 pandemic and the south Texas-Mexico border

On March 11, 2020, the World Health Organization declared COVID-19 as a pandemic (David, J. Sencer CDC Museum , 2022). Following suit, five days after Texas Governor Gregg Abbott announced a Declaration of State Disaster, the City of Laredo issued its own Declaration of Local Disaster in an effort to take "measures to reduce the possibility of exposure to COVID-19 and promote the health and safety of Laredo residents" (City of Laredo, 2020a, para. 2). Among the measures taken, the city prohibited "community gatherings" of 50 or more and the Local Health Authority also recommended "individuals who are at the highest risk from COVID-19 to not attend and to avoid community gatherings or events that will have or will likely have 10 or more" people (City of Laredo, 2020b, para. 6). Thirteen days after the city declared a local disaster, the first COVID-19 related death in Laredo was confirmed. This border community experienced multiple COVID-19 surges beginning with the inception of the pandemic in March 2020 and then July and December of that same year. By July 31, 2020, the City announced that 207 individuals were hospitalized and of that number, 74 were in intensive care units in Laredo's two local hospitals, Border Hospital and Fronteras Hospital (City of Laredo, 2020b; the first author created pseudonyms for the two hospitals in Laredo, Texas).

Re(making) the health disparities case on the Texas-Mexico border

Historically, the U.S.-Mexico border experiences significant health care needs in comparison to the rest of the country (Lady et al., 2018). In their policy brief, Lady et al. (2018) detail health care issues contributing to the material disparities encountered on the U.S.-Mexico border. These communities experience higher rates of poverty, lack of infrastructure, workforce and healthcare provider shortages, and language and health literacy obstacles; further difficulties like high numbers of uninsured or underinsured residents contribute to poorer health outcomes (p. 1). Equally important and problematic are the reproductive injustices and gendered violence happening

on the Mexico-U.S. border (Hernández and De Los Santos Upton, 2019, 2020). According to the Texas Department of State Health Services' Office of Border Public Health, the Texas-Mexico border is also disproportionately affected by higher rates of obesity, diabetes, and cervical cancer and caesarian deliveries. The border region has other challenges in developing a sufficient health workforce and access to "primary, preventive, and specialty medical care" (Texas Department of State Health Services, 2021, Demographics section, para. 6). In the Texas border region, about 24.7% of residents live below the poverty level, 38.5% of adults are without health insurance, and 29.7% do not speak English "very well" (Texas Department of State Health Services, 2021, Demographics section, para. 1). These numbers reflect the systemic challenges facing the border and the material implications they generate. Sitting on the South Texas-Mexico border, Laredo, Texas, has been identified as medically underserved for decades and the COVID-19 pandemic exposed the multitude of healthcare shortages and made this community much more vulnerable. For example, according to the Department of State Health Services, Laredo has a capacity of 446 hospital beds for a population of 269,372. This means that of all Texas hospital regions, the border city of Laredo comes last in those efforts (O'Campo, 2021). Building on top of existing disparities, the COVID pandemic further caused an unprecedented crisis for public health within the city. In a span of 4 months, the number of COVID-related deaths multiplied to 127 (City of Laredo, 2020a). As of October 2022, there have been 1,120 fatalities in the county since the pandemic began (Texas Department of State Health Services, 2022). As positive COVID-19 cases first intensified, additional orders and recommendations were announced and in late March 2020, both hospitals announced a "no visitor" policy as a measure to minimize exposure and protect patients and staff (San Miguel, 2020). As this precautionary action was taken by hospital administrations, it simultaneously generated an additional strain as travel nurses experienced language discordance with patients who were LEP and Spanish dominant.

Patient centered communication

The importance of patient-centered communication in patient-provider relationships has been widely studied across disciplines (Street, 2003; Epstein and Street, 2007; Dean et al., 2014) and even though there has been considerable progress, much work remains. Street's (2003) ecological model of communication in medical encounters serves as a helpful entry point to discuss the relevance of patient-centered communication in patient-provider relationships. The ecological model presents five social contexts to examine the communicative interaction between patients and healthcare providers. Although each is significant in presenting a framework in understanding the importance and complexities of patient-provider relationships, the cultural context provides an opening that is germane to our study. Communication is influenced by culture and is significant to language use, ethnicity, geographic location, and religion as well as other characteristics (Dean, 2017). When patients and providers do not share the same cultural understanding, a "clashing of cultures" is instituted and may "produce miscommunication and impact health outcomes." (Dean, 2017, p. 60). The cultural context demonstrates a need to center language and a comprehensive cultural understanding between patients and providers.

The impact of culture and language discordance in nurse-patient communication

Linguistic and cultural differences between patients and doctors can produce barriers impacting the quality of nurse-patient communication. In an effort to improve and promote health equity and the quality of health services to individuals, the Office of Minority Health in the U.S. Department of Health and Human Services established the National CLAS Standards in 2001. The standards introduced culturally and linguistically appropriate care for all individuals who are LEP and/or have other communication needs (Ho and Sharf, 2021, p. 288). For example, under communication and language assistance, the Office of Minority Health (2022) advises organizations to produce an organizational assessment describing the services provided and to specify how organizations can be more effective and efficient as well as provide incentives to staff completing interpreter training. In addition to establishing standards promoting equitable and considerate quality care, the National CLAS Standards provide guidelines encouraging the recruitment and education of a culturally and linguistically diverse workforce (Office of Minority Health, 2022). However, the global pandemic certainly put a strain on health organizations' resources and impacted health workers' daily work experiences. Nurses, in particular, dealt with challenging work conditions like personal protective equipment (PPE) shortages, longer hours at work, exhaustion, stress, and burnout. In the border community of Laredo, nurses at both hospitals dealt with the added strain of language discordance and cultural barriers between non-bilingual travel nurses and patients. Language concordance between providers and patients sits as one of the most important indicators of effective provider-patient communication. Language barriers influence the quality of communication in the following ways: LEP patients receive a lesser degree of information during medical encounters, fewer empathy instances, less rapport, and fewer opportunities in healthcare decision-making (Haskard-Zolnierek et al., 2021, p. 1). In the United States, Spanish-speaking patients are less satisfied with the quality of care

citing underlining shortcomings in listening, explanations, and responsiveness to questions (Morales et al., 1999). Research continues recognizing the value of language concordance between patients and providers and the cost of care when language barriers exist in medical encounters. A study by Haskard-Zolnierek et al. (2021) found that Spanish-speaking physicians whose Spanish was rated as "more highly" were considered "more connected to the patient and welcoming of non-medical talk" (p. 5). This is important since research has found patients experiencing health disparities at all levels of care (Hseih, 2016) when language barriers exist. Consistent with past research of how language concordance can encourage engagement (Detz et al., 2014), this same study revealed "significant associations between patient perceptions on asking questions and being involved in their medical decision-making when physicians were rated as having better Spanish speaking ability" (Haskard-Zolnierek et al., 2021, p. 5). LEP patients' health experiences are impacted by the quality of language concordance between them and doctors, especially when LEP people are less satisfied with their quality of care and tend to visit their doctor and seek preventive services less. Hsieh and Kramer (2021) remind us that rapport between patients and providers should not be ignored since "patients' illness experiences and concerns are socially and culturally situated in their everyday life" (p. 337). It is also necessary to interrogate the traditional interpreter-as-conduit model as the solution to language and cultural barriers seeing that interpreters are not merely transferring information but are working as active agents negotiating tasks, relational goals, and identity in order to collaboratively achieve optimal care (Hsieh and Kramer, 2021). As the majority of registered nurses working in the South Texas-Mexico border community of Laredo are bilingual in English and Spanish, language discordance is historically not as prevalent. However, the pandemic exacerbated this issue as travel nurses arrived to Laredo to care for local COVID-19 patients. As the city faced increasing COVID-19 infection rates in the summer of 2020, travel nurses were brought in to alleviate the workload. Travel nursing, known for registered nurses working short-term intervals at varying health care facilities like hospitals and clinics, increased rapidly during the early surges of COVID-19 (Yang and Mason, 2022). An overwhelming majority of residents are bilingual or speak Spanish in this border community. It is well known as bilingual and much of the local hospital workforce is also bilingual, from the border area, or has managed to acquire sufficient Spanish language skills and a cultural understanding of the border community. Kleinman's (2004) treatment of culture is noteworthy, as he argues the word "culture" is often misconstrued as a fixed entity. Working against this hypostatic definition, he emphasizes that culture is "not a thing; it is a process by which ordinary activities acquire emotional and moral meaning for participants" (p. 952). In a congruent vein, Kleinman (2004) finds that a cultural process allows for an understanding of specific contexts and the "development of interpersonal connections, religious practices, and the cultivation of collective and individual identity" (p. 952). This is central to Latina/o communities, as studies have found that Spanish-speaking patients identify with the cultural constructs of *personalismo (friendliness, politeness)*, *confianza (trust-more often trust in the healthcare system)*, *familismo (value of family unit),* and *simpatía (kindness)* (Sobel and Sawin, 2016; Magaña, 2020). Even though language concordance is central to effective nurse-patient communication, a culture-centered understanding is equally important—particularly in areas like the US-Mexico Border. This form of cultural engagement, we argue, must go beyond what Dutta (2007) has identified as the implicit bias of "cultural sensitivity" approaches: the assumption that culture exists as a reified category with a set of rules that entrants need to learn to navigate. Operating according to this reified version of cultural engagement puts the blame on either the perceived ignorance of the travel nurses or the perceived lack of linguistic and cultural capital on the part of LEP patients and their families. In the process, it forfeits the opportunity to promote a deeper, more effective, and more inclusive approach to nurse-patient communication and care in a culturally heterogeneous environment. Given the health disparities and the impact of the COVID-19 pandemic in border communities like Laredo, Texas, exploring the issue of language and cultural barriers in cross-cultural care is critical. The following section details our approach to answer the following research questions (RQs):

RQ1: What are the challenges of language and cultural discordance between nurses and Spanish-dominant and LEP COVID-19 positive patients in South Texas-Mexico border hospitals?

RQ2: How do language and cultural barriers among travel nurses and patients negatively shape the workload of local bilingual nurses?

Methods

The methodological commitments presented in this research study are grounded in the need to center participants' stories—detailed narrative accounts—in order to capture the bounded stories of nurses working on the South Texas-Mexico border in COVID-19 units during the global pandemic (Mishler, 1991). Qualitative methods carefully consider participants' stories and facilitate a deep understanding of their lived experiences. Moving from quantitative to qualitative methods has been a serious undertaking by health and health communication researchers who are interested in underscoring the "role of cultural identities" in the co-construction of profound—and often conflicting—meanings for the embodied conditions of illness, suffering, and death" (Lindlof and Taylor, 2019, p. 34). This meaning-making process through the use of qualitative

methods also falls in line with the goal of "foregrounding the voices of patients and professionals who constitute the social life of medicine" and to better understand the complexities between and among patients and professionals in healthcare settings (Lindlof and Taylor, 2019, p. 34). To draw upon the multifaceted and complicated nature of nurses' experiences during the peak months of the pandemic, semi-structured and in-depth interviewing provided the most appropriate data collection method. We interviewed 17 registered nurses who currently worked in one of two local hospitals in a South Texas city bordering Mexico; we were specifically interested in those who treated COVID-19 patients. Interviews took place between April and October 2021 which linked to significant COVID-19 surges. Participants' ages ranged from 22 to 61 and were recruited from two social media networks. We posted an IRB-approved flyer to our personal Twitter and Facebook accounts as well as three local Facebook groups created during the COVID-19 pandemic. Once we began interviewing, we also used a snowball sample. Participants informed additional nurses about our study and those interested communicated with the first author *via* email. She arranged for a day and time suited for participants due to their demanding work schedule; they were also sent a follow-up email to ensure participation and submit their IRB approved consent form before each interview. Even though our intention was to recruit local nurses as well as travel nurses, most of the nurses reaching out *via* social media were local. Once we began interviewing, we informed our participants of recruiting travel nurses, yet our best efforts only yielded one participant who was hired as a travel nurse at one of the two local hospitals. At least two additional travel nurses did reach out to the first author, but once they received additional information about the study, both withdrew their interest in participating. All participants were employed in one of the two local hospitals, Border Hospital and Fronteras Hospital, and worked in either the emergency room, intensive care unit, or medical/surgical unit. While all participants were staff nurses, 10 had additional job duties, including charge nurse and floor manager. One participant was a travel nurse hired by the State of Texas. All participants treated COVID-19 positive patients from the inception of the pandemic, with the exception of travel nurses who were hired during local pandemic surges held in the summer of 2020 and December 2020. At the time of our interviews, five nurses had either left their positions at the local hospitals and were hired as travel nurses in and out of Texas, worked in temporary alternative patient sites, or sought other nursing jobs outside of the hospital setting.

Fourteen interviews were conducted and recorded *via* video teleconference platform Zoom. We initially interviewed a total of 20 participants but three retracted their authorization after the interviews were conducted and those interviews were not included in our findings. Three interviews were conducted by telephone and were not recorded. The first author interviewed all but one participant; a former graduate student interviewed one participant *via* Zoom. The interviews ranged from 41 to 114 min and 14 interviews were transcribed. Note-taking was undertaken for the three interviews conducted *via* telephone. Saturation was reached during our last interview and the data collection phase ended. No new codes or themes emerged after the last interview. Considering the time sensitivity of this study, all recorded interviews were transcribed by an audio transcription service. Mindful of our participants' work practices and experiences, we asked each participant to create a pseudonym at the beginning of their interview to protect their identity and fortify confidentiality. Our interview protocol was semi-structured in nature since we were interested in nurses' stories as they shared their work experiences during a strenuous time. This approach to in-depth interviewing enabled nurses to reveal a deep understanding of challenges and experiences as they worked in a demanding and complex environment throughout the pandemic. The following three questions connected to the challenges related to nursing on the Texas-Mexico border, work stress, and resilience: (1) Tell us how the language and culture on the border impacts the way you care for COVID-19 patients, (2) How have you dealt with the stress caused by working as a nurse during the COVID-19 pandemic, and (3) What do you tell yourself during the most difficult days?

Once interviews were transcribed, a thematic narrative analysis was conducted. A thematic narrative analysis makes sense in health communication since it provides an opportunity for patients and healthcare workers to express, recount, and describe their lived experiences, especially when we consider the gravity and work strain this global pandemic has placed on health care workers and citizens around the world. The first author read, coded, and analyzed all data. The data was coded while participants' stories were left intact to understand our participants' unique meanings and experiences. Examples of initial codes were "language miscommunication," "Spanish is a plus in nursing," and "double work." As the first author integrated codes into larger categories, 27 codes emerged from the initial coding and finally two overarching themes emerged through the consolidation of the 27 codes into larger categories. In the following section we present two overarching themes directly linked to communication barriers between patients and non-Spanish speaking nurses. The first theme illustrates the challenges of language and cultural differences between nurses, LEP patients, and their families. The second theme addresses how language and cultural differences among travel nurses and LEP patients negatively shaped the workload and generated work strain for local bilingual nurses. We close our findings by discussing the healthcare challenges in border communities that are often left unnoticed and unseen.

Findings

In line with our research questions, our findings focus on challenges associated with language discordance and cultural

differences between nurses and LEP patients. We were also interested in how language and cultural barriers among travel nurses and LEP patients negatively shaped the workload of local bilingual nurses. Building on these initial research questions, two thematic categories emerged: *experiences of language and cultural discordance on the South Texas-Mexico border and the impacts of these discordant experiences of nurse-patient communication and nurses' workload.*

Experiences of language and cultural discordance on the south Texas-Mexico border

While the COVID-19 pandemic has impacted nurses around the globe in distinct ways (Jackson et al., 2020), our aim was to analyze experiences of nurses working on the border during the peak months of the pandemic. In this pursuit, the first element of our thematic analysis addressed language and cultural discordance between non-bilingual travel nurses and LEP COVID-19 patients and their families. Within this first category, two main sub-themes surfaced: *frustration and communication breakdowns between nurses and LEP patients and a broader feeling of cultural disconnectedness between travel nurses and patients.*

Frustration and conflict between travel nurses and LEP patients

Communication setbacks were widespread, and frustration grew as non-bilingual travel nurses struggled to care for LEP and Spanish dominant patients. Mary, a travel nurse from Kentucky with seven years' experience as a licensed practical/vocational nurse and 18 months as a registered nurse, arrived during some of the most difficult months. She did not speak Spanish and encountered families that "do not like the idea of their family member having a nurse that does not speak Spanish."

> You get the patient that speaks only Spanish and then it's so frustrating for me and for the patient and I've struggled with that. I've even tried to download an app on my phone, and I've struggled with trying to use that app. I tried to use it 1 day and try to communicate with this family member, and I started talking about some kind of Mickey Mouse character or something in the app and he looks at it and he looks at me and he just laughs. I was like, hold on. I've learned *uno momento* but sometimes there's been some staff, [*sic.*] nurses that have gotten frustrated, because they have to stop what they're doing and come translate. But then there's been others like family members themselves that have called and said. . . I'm like, do you have somebody that speaks English? And they will put that person on the phone and that person will kind of translate.

Mary expresses frustration from the difficulties in communicating with her patients and their families and attempts to resolve the language challenges, only to realize the translation application was unsuitable and inadequate. This is supported by the literature on technology-enabled medical interpretation. Ji et al. (2021) argue that although direct translation application software can be useful, patients found it to be unclear at times, clinicians required proper education of the software, and it may be considered unsafe since there is the "potential for errors in translation" (p. 2142). Additionally, translation applications are unable to robustly incorporate the cultural context. Finally, despite significant technological advancements, translation accuracy is not sufficient (Hsieh and Kramer, 2021).

Language discordance and related situational factors generate complex challenges for non-bilingual nurses and Spanish dominant and LEP patients to the point of corroding trust between provider, patient, and family. Mary felt this especially brutally when a family requested to replace her with a nurse fluent in Spanish:

> A family asked me, "Is there any way that you can ask if my mom can have a Spanish-speaking nurse to take care of her tomorrow"? And when I told the charge nurse they got very frustrated, not at me, but at the family, because they know what kind of nurse I am, and they know how good of a nurse I am. And they said that frustrates me because you can have one of the best nurses taking care of your family member that speaks English and not Spanish. But then you would rather, you could take the chance of getting a crappy nurse just so that you could communicate with them, you know, and it makes sense.

Travel nurses like Mary were not alone in expressing their growing frustration of the challenges of language discordance between non-bilingual nurses and LEP patients. Terry, a bilingual ICU charge nurse at Fronteras Hospital, described the language challenges COVID-19 generated as non-bilingual travel nurses communicated with patients' families.

> I feel the family doesn't understand them as much because they [the nurses] don't speak Spanish. You would have us translate for them and it was a bunch of back and forth and a lot of the families would say, can you be their nurse? I feel better because I understand you. I can communicate with you. You can explain things to me. Can you please be their nurse? Can we please have a Spanish speaking nurse? We would hear that all the time when we had those state nurses, and they were good. Some of them were amazing and some not so much, but they tried their best as well to communicate with the family.

Amplifying the growing frustration from non-bilingual speaking nurses like Mary who self-identify as "good nurses", the

literature suggests language discordant clinical encounters can seriously compromise quality of care for patients (Cano-Ibañez et al., 2021). In their study detailing bilingual nurses' perceptions of providing language concordant care to LEP patients, Ali and Johnson (2016) found that language concordance is vital and "improves patients' experience, increases their comfort, makes them feel listened to and enhances their satisfaction with the healthcare service" (p. 422).

Language discordance between non-bilingual travel nurses and Spanish dominant and LEP patients presents an additional layer of challenges: Bilingual nurses being called upon to function as translators. As the number of COVID-19 positive patients increased, non-bilingual nurses arrived to Laredo and bilingual nurses took on additional work. Victoria, a registered bilingual nurse at Fronteras Hospital with 16 months experience, acknowledged the complexities of helping translate for travel nurses.

> A lot of the travel nurses are from other states. And the first thing they don't know is Spanish, so a lot of the Fronteras Hospital nurses end up being translators and it's difficult because as much as we want to help, we can't give information to patient [*sic.*] family members because we are not the primary nurse. And we don't know entirely everything that is going on.

In this case, language discordance between non-bilingual travel nurses and LEP patients presents an additional layer of complexity related to patient privacy and communicating with patients and family members without direct knowledge of patients' care. In one extreme case, language discordance resulted in administrative action taken against a travel nurse. Sasha, a local bilingual nurse working at Border Hospital, recalls a breakdown in communication that persuaded her to report a travel nurse for disciplinary review.

> He [the travel nurse] couldn't speak Spanish. He was asking me, "Hey, I don't know what this patient is saying. Can you help me? The patient was telling him, "You should learn Spanish" but she was joking, kind of playing. I told him "She's just saying you should learn Spanish, but she's joking. She's just teasing you. He said, "How do I say you're in America? You should learn English." And I said, "Don't say that. I'm not going to teach you how to say that". He goes up to another nurse and asks how to say "Learn to speak English. You're an America *[sic]*. You should have to speak English.' This is our community; we're not going to teach you to say that. So, he Googled it and he goes back into the room and he says it in his ugly Spanish. He says it. I said, that's it. I reported him.

Highlighting this extreme example of cultural callousness, Sasha emphasized the challenging environment non-bilingual nurses faced every day and never saw him shortly after the incident.

Cultural disconnectedness between travel nurses and patients

Without risking a normative critique of the cultural positionality of the travel nurses, we can see that the cultural differences between non-bilingual and LEP patients generated additional work and frustration for bilingual nurses. In this vein, Victoria discusses the added burden of having to communicate with multiple members of the patient's family, emphasizing how family members attempt to seek information about their loved one's care. This was especially apparent during the height of the pandemic when visitors were not permitted entrance to hospitals. Like Victoria, Mary had similar experiences. However, coming from a position of a cultural outsider, she recognized an environment that significantly differed from her experience growing up in Kentucky. Specifically, she emphasized the extremely high degree of family involvement, most clearly articulated by the "want to know everything" comment. This also aligns with Victoria's frustration of having to act as cultural intermediary for non-local nurses and family members:

> Mexican culture is very family oriented, and a lot of these staff nurses don't understand how sometimes we get too many members for one patient calling every hour asking for updates. It was frustrating because we can't spend all of our time on our phones giving updates but that's just how we're raised. We just care about each other and we always want to know what's going on.

Victoria's response aligns with *familismo*, the cultural value that centers the family and utilizes it as a source of support and information, important considerations when making medical decisions (Sabogal et al., 1987; Valdivieso-Mora et al., 2016).

As the number of COVID-19 patients rose, so did the nursing workload. Luz, a local bilingual nurse working in Border Hospitals' ICU, describes the time-consuming efforts she undertook as a charge nurse to answer texts from family members at the same time as incoming calls to her floor. As she described the progression of viral severity in individual patients, Luz explains how death became routinized but still emotionally straining: "We cry a lot, we still cry a lot, and patients are in the unit for so long that you get to develop this relationship and rapport with the family members". Luz struggled over feelings of guilt and responsibility arising from the added difficulties posed by the lack of bilingual nurses to guide families through the grieving process. The strain in her voice during the interview clearly reflected the frustration of communicating with patients' families: "I wish. I wish. How can I say this? I wish I would have had more Spanish speaking nurses because you cannot take your time explaining the process to every single family member."

As families were barred from entering, nurses became the only line of communication. This reflects the work of Lucchini et al. (2020) on communication gaps between COVID patients and their families at the height of the pandemic: "When people affected by COVID-19 enter the hospital, they literally disappear from their relatives' lives" (p. 2). In the absence of family member support, our participants described how they were charged with a deepened undertaking of what Luchini and colleagues call "humanistic care" (p. 2). Nurses became the only line of communication and thus the single connection between patients and their families. Bilingual nurses, in particular, were caring for their patients and communicating with their families, translating for travel nurses, LEP patients, and patients' families who only spoke Spanish or were LEP.

Practice-based outcomes and failures of discordant work experiences

Language discordance and related cultural frictions produced significant downstream problems in the acute context of patient care and the broader context of increased workload and responsibilities for bilingual nurses. This leads to our second thematic category: the impacts of these cultural frictions on the practice of nurse-patient communication. Particular attention will be paid to the heightened risk of *misdiagnosis* and the rise of what Jopling and Harness (2022) label "responsibility creep": the steady addition of (often informally mandated) roles and duties.

Language discordance and misdiagnosis

One of the most disquieting examples of the deleterious effects of disregarding culture-centered communication in our interviews was the conflation of linguistic confusion with medical status. Specifically, non-bilingual travel nurses would often mistake Spanish-speaking and LEP patients' lack of linguistic comprehension with medical non-alertness. Rebecca, a charge nurse working in the medical/surgical unit at Fronteras Hospital, expressed her growing frustration of the added labor of translating as non-bilingual nurses continuously confused a strain in language comprehension for medical non-alertness.

> There was one time that they (nurses) would tell me, "the patient's [*sic.*] not oriented," which means that she doesn't know where she is. She doesn't know her name. No, she just doesn't know English. She doesn't know English and she's hard of hearing. She's oriented. She knows where she is. She knows what she's doing. It was so frustrating because you think back to your grandparents, your parents and you don't want them to not be understood and given different treatment because they speak Spanish. It is frustrating to have to be the one to translate, and you're busy, and you're running back and forth. And if you think about it here in Laredo, most of our patients speak Spanish. So, it's not just one or two, or three, it's all of the patients. So, it definitely was frustrating.

Rebecca understood that in Laredo, a large number of the population speaks Spanish. Stephanie, a local bilingual nurse at Fronteras Hospital, shared a similar experience concerning a non-bilingual provider questioning the LEP patient's level of alertness.

> I remember this patient we had. There was a nurse saying she was not alert and oriented and that's something we say: You're alert. You're alert times four: time, day, year and so, yes she is. She is alert. What do you mean? And she said, no she doesn't understand. Well, because she speaks Spanish and she's a little deaf but if you write things down, she understands. They're saying she was a confused patient and no, that's not right. That's scary. We would see that a lot. There were a lot of times I'd be doing something or helping someone else, and I would go to the supply room to get what they need and on my way to the supply room, three people would say, 'can you help me with this, can you help me with that? Yes, hold on, I'll go do that right now.' I'd help another person. And on my five-step journey to the supply room, I would get so many people that needed help. And a lot of times it was because of the translation. And then you have like four patients that speak Spanish, so I'm sure it was hard for them. I understand. I would get frustrated, but I would try to keep my cool and say, I'm on my way. Give me a second.

Patients are usually asked standard questions to test their orientation that fall under four categories: self, place, time, and event. Because LEP patients were unable to communicate with non-bilingual travel nurses, they were mistakenly diagnosed as disoriented or not alert.

These frustrations are reflected in the literature on medical communication with LEP patients, illustrating a deficiency in listening, interpreting, and responding to questions (Morales et al., 1999). Furthermore, and importantly, in these two cases, the value of Spanish language concordant care and culture-centered communication provided Stephanie and Rebecca the understanding to counter travel nurses' initial assessment and afforded them the ability to prevent a misdiagnosis or conflict between nurse and patient.

Workload increase and the labor of translating

As travel nurses arrived during the height of the pandemic, many did not have a cultural understanding of the border community and thus required assistance in communicating with patients and patients' families. Even though several participants

in our study discussed how they routinely helped translate for doctors and a small number of registered nurses before the pandemic, the additional workload dramatically increased once travel nurses arrived, overwhelming the nurses' workload even further.

Jared, a bilingual registered nurse from the border, recognized the language barrier as a "huge factor in our frustration" because it added an increase in workload for local bilingual nurses. He explained the workload at Fronteras Hospital as "almost double work". Furthermore, he struggled to find a resolution to this additional work, finally concluding that there was nothing to be done but help non-bilingual travel nurses communicate with their patients during taxing surges. Alice, a six-year nurse with Border Hospital's intensive care unit (ICU), also detailed the added workload engendered from their translational efforts:

> I was always in there translating for the nurses. I got to know him (the patient) and the family because he and the family only spoke Spanish. I was kind of the intermedian [*sic.*], like me being on the Zoom call for them with the patient and having to talk to them and translate his care... It's not my patient, and sometimes I would spread myself thin; but I mean, I felt like I couldn't say no.

Alice and Jared felt their workload significantly increase as they were called upon to translate. This finding is consistent with Ali and Johnson's (2016) qualitative study detailing bilingual nurses' perceptions regarding language concordant care to LEP patients where bilingual nurses' act of translation resulted in an increased workload and added pressure. The "double work" struggle resonated with most of our bilingual participants. Norma, an emergency room nurse working at Border Hospital, expressed that at times it felt like the non-Spanish speaking nurses were engaging in a game of charades as their attempts to communicate with their patients often failed. Once bilingual nurses like Norma stepped in to help, it alleviated the miscommunication while increasing her workload.

> I have a bit more empathy for them [patients]. They're sick and they can't communicate their needs. And with the state nurses, they're playing this charades game. It doesn't work; they didn't understand the nurse and they would try to say something and looked frustrated, upset and well, I can help; I'm bilingual... but it wasn't fair because it added so much to our day.

Stella, an ICU nurse at Fronteras Hospital with 10 years of experience, supported Norma's assertion of the additional work linked to local nurses' laborious efforts to help facilitate communication between patients and non-Spanish speaking nurses.

> It was very hard for us, because apart from taking care of our patients, talking to our families, we had to translate for other patients, get consent, get this, give them updates. And that wasn't easy, but it was easier in the beginning because there were more of us."

Conversely, exhibiting language concordance also had a positive impact on effective nurse-patient communication that clearly brought a sense of satisfaction. In this vein, Sasha described the relief on a patient's face as she walked into a room speaking Spanish: "They get relieved and then they want to talk and keep you in there. I'm sorry to cut this short, but I have other patients. It was an added burden."

In describing nurses' translation efforts, words like "double work," and "added work" were commonly recorded in our interviews. This reflects trends in workload increase throughout the pandemic. For example, in August 2020, Lucchini et al. (2020) published a call to change the conventional nursing workload in the COVID-19 era. A review of preliminary findings identified new aspects to the nursing workload like getting in/out of PPE, decontamination procedures, and providing "humanistic care in the absence of family" (p. 1-2). Mobile technology provided the necessary connection between patients and their families, and it was also the vehicle between nurses and patients' families. As bilingual nurses communicated language congruent care to non-assigned patients, their workload seemingly increased as well.

As evidenced across the two elements of this thematic category, the inability of travel nurses to communicate with patients produced a number of negative outcomes. These outcomes were directly related to nurse-patient communication, including difficulties with diagnosis and treatment. They were also linked to communication problems with patients' families and caretakers. Outside of the immediate context of patient care, these communicative barriers had further detrimental impacts on the work experience and workloads of both travel nurses and local providers.

Thematic analysis of interviews linked to our first theme reflect central concerns of our first research question linked to challenges caused by language and cultural differences between nurses and LEP patients. Analysis of the second theme revealed how these language and cultural barriers among travel nurses and LEP patients created downstream problems related to issues like misdiagnosis and workload increase for local bilingual nurses. In the following section we discuss our final conclusions and recommendations.

Discussion and conclusion

The purpose of this study was to center the work experiences of registered nurses working in two hospitals on the South Texas-Mexico border of Laredo, Texas during the height of

the COVID-19 pandemic. This border community has grappled with extensive health disparities for decades. The pandemic certainly exposed additional pockets that amplify concern. We aimed to determine the challenges of language and cultural barriers between non-bilingual travel nurses and Spanish dominant and LEP COVID-19 positive patients living on the South-Texas border. Although language and cultural barriers between healthcare workers and patients do not commonly materialize due to a large number of Spanish-speaking local nurses, we found that non-bilingual travel nurses struggled in communicating with their Spanish dominant and LEP patients as well as with the patients' families. Though our aim was to recruit local bilingual nurses as well as travel nurses, this was a challenging feat. Therefore, we recognize that a limitation to our study comes from the disproportionate representation of local nurses: only one participant is a non-bilingual travel nurse, and 16 participants are local nurses. Nonetheless, we believe our analysis captures the larger dynamics of communicative discordance that produce serious problems for all nurses involved–along with patients and their families.

The pandemic created a newfound vulnerability for Laredo. Our findings revealed the gaping challenge of language and cultural discordance between non-bilingual travel nurses and Spanish dominant and LEP patients during this healthcare crisis. Language and cultural differences create material challenges like accessing and processing care (Hsieh and Kramer, 2021). For example, we recorded several instances where the struggle of Spanish dominant and LEP patients to communicate with non-bilingual nurses mistakenly resulted in the assessment of lack of alertness and orientation. These communication disparities impact the communication between providers and patients, especially when they can impact health assessments. As much as language concordant care is critical for patient care, a culture-centered lens is equally indispensable in order to provide a more meaningful and comprehensive approach to nurse-patient communication and care. We found that understanding Latina/o cultural values like *familismo*, *personalismo*, and *confianza* especially, are crucial so that healthcare workers recognize their significance as they engage Spanish dominant and LEP patients, thus centering culture-centered care.

Another challenge produced by language and cultural differences is the increase in nurses' workload as local bilingual nurses became responsible for the interpreting efforts between non-bilingual nurses and their patients. The nursing workload clearly increased for all during the height of the global pandemic, but in this case study other job tasks became indispensable to nurses' daily workload. Those additional tasks placed an added burden on local bilingual nurses. Crucially, studies show how workload variability like interruptions and concurrent demands can cause delays in focused treatment (Jennings, 2008; Swiger et al., 2016). This is vital as our participants indicated how they redirected their attention from their own patients to non-assigned Spanish dominant and LEP patients and their families. Nurses described the task of interpreting as an "added burden" and "double work," falling in line with Jennings' (2008) contribution of the implications of work variability and interruptions to quality patient care.

These findings trouble the historically harmonious bilingual communication process within the Laredo healthcare community. The COVID-19 pandemic has introduced new tensions disrupting nurse-patient communication to a profound degree. The unexpected impact of this exogenous necessitates the promotion of novel strategies and reconsidered best practices for bilingual and intercultural nurse-patient communication. Based on our findings, we offer two recommendations for hospital administrations. First, management must get prepared for the unprepared. This is a varied and copious endeavor that requires an amalgamation of efforts to generate material consequences. Crisis planning is fundamental, but it should be crafted for the particular needs facing communities, especially those who are vulnerable to health disparities. For example, our study found that because of the high hospital admittance rates due to a vast amount of COVID-19 positive patients, an influx of non-bilingual travel nurses was brought into the city to aid the border community; however, this much needed support generated the challenge of managing language discordant care between nurses and patients. Planning efforts should include a comprehensive review of contingency plans enacted in crisis situations and build upon them as new knowledge is ascertained. Crisis planning (and consulting with nurses as the crisis develops) should also be an inclusive effort, and frontline experiences must be valued. Our participants expressed their frustrations of not being heard as the initial number of COVID-19 positive patients rose even though they expressed that most staff and a large number of physicians did not have direct or face to face contact with patients. Nurses were on the front lines of this health crisis and who better to include than those who were directly involved in patient care? Employees want their voices heard during a crisis. An indirect yet significant potential outcome of privileging frontline experiences is the boost in employee morale, especially during a major global health crisis. Second, we recommend that management helps ameliorate the fraught and contentious relationship between nurses and Spanish dominant/LEP patients. It could provide cultural knowledge and awareness of Latina/o close family ties, interpersonal connections, and trust between patients and healthcare workers, especially regarding support, decision making, and information-seeking.

Finally, we make one recommendation for nursing practitioners and researchers and a second for health communication researchers. First, nursing practitioners and researchers should continue challenging the conventional nursing workload. It is imperative to reconfigure how training and workflow are managed so that all areas of work, direct and indirect care, are considered part of the nursing workload.

Second, health communication researchers must engage in research centering marginalized communities and vulnerable groups susceptible to health disparities since these groups are usually mostly impacted by public health crises. Focusing on communities like Laredo also goes along with Soto-Vásquez et al. (2020) recommendation for practitioners to seriously consider the "local cultures and material circumstances" of where they practice (p. 435).

Data availability statement

The datasets presented in this article are not readily available as they require approval from the Institutional Review Board, in order to maintain participant confidentiality. Requests to access the datasets should be directed to ariadnea.gonzalez@tamiu.edu.

Ethics statement

The studies involving human participants were reviewed and approved by Institutional Review Board, Texas A&M International University. The patients/participants provided their written informed consent to participate in this study.

Author contributions

AG conceptualized the research project, collected, analyzed data, contributed to analysis, literature review, and conclusions. SD contributed to analysis and restructured literature review. All authors contributed to the article and approved the submitted version.

Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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