ENHANCING COMMUNICATION AND ADVOCACY IN PRIMARY CARE

ENHANCING COMMUNICATION AND ADVOCACY IN PRIMARY CARE: A QUALITATIVE DESCRIPTIVE STUDY ON THE USE OF LANGUAGE INTERPRETATION SERVICES AMONG PHYSICIANS AND RESIDENTS

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LAY ABSTRACT

Language barriers in healthcare can lead to miscommunication, increased errors, and lower quality of care. This study investigates how physicians use language interpretation services (LIS), their challenges, the factors influencing their beliefs and the educational implications. It also explores how physicians advocate for patients who do not speak English.

The study aims to understand the experiences of physicians and residents using LIS in primary care, identify barriers, and offer recommendations for clinical, educational, and policy improvements. The study used interviews with 14 doctors and residents and found that informal LIS are commonly used, due to barriers to its use, such as time constraints and organizational challenges. The study also found that providers were not fully advocating for patients who do not speak English.

The findings highlight the need for better integrating LIS through organizational support and targeted education to improve care for patients with limited English proficiency and enhance health advocacy.

ABSTRACT

Background: Language barriers in healthcare present significant challenges, leading to miscommunication, increased errors, and decreased quality of care. The introduction of a professional language interpretation service (LIS) at McMaster Family Practice (MFP) in Hamilton aims to address these issues. This study explores how physicians use LIS, the challenges they face, their teaching and learning practices, and the role of health advocacy for patients with limited English proficiency (LEP).

Aim: This study aims to understand the experiences of physicians and residents using LIS in primary care, identify barriers to effective use, and provide recommendations for clinical, educational, and policy improvements. Additionally, the study examines how health advocacy can be leveraged to improve care for patients with LEP.

Methods: A qualitative descriptive design was employed, utilizing semi-structured interviews with 14 participants, including staff physicians and residents at MFP. Data was analyzed using directed content analysis to identify key themes and patterns in LIS use and perceptions.

Findings: Participants reported using various LIS, with family members and Google Translate being the most common. They used these services to collect patient information, communicate diagnoses and health information, and engage in health promotion and disease prevention. Significant barriers identified included time constraints, organizational challenges, and others. Many contextual factors influenced providers perception and use of LIS, such as race and power dynamics. Providers demonstrated health advocacy actions at the individual level, but not at the community or systems level. The theme of ‘getting by’ was prevalent in this study, where participants decided to continue a visit without appropriate LIS, even when necessary.

Conclusions: The study highlights the need for better integrating LIS in clinical practice through organizational support and targeted educational interventions. Addressing these barriers can enhance the quality of care for patients with language barriers and support health advocacy efforts within the primary care setting.

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LIST OF ABBREVIATIONS

CanMeds-FM - Canadian Medical Education Directives for Specialists – Family Medicine

ITS Hamilton – Interpretation and Translation Services Hamilton

LEP – Limited English Proficiency

LIS – Language Interpretation Services

MFP – McMaster Family Practice

OSCEs - Objective Structured Clinical Examinations

RCPSC – Royal College of Physicians and Surgeons of Canada

DECLARATION OF ACADEMIC ACHIEVEMENT

This thesis represents a collaborative academic achievement in the field of Health Science Education. Authored by Aisha Shire, RN BScN, at McMaster University, this study fulfills the requirements for the Master of Science in Health Science Education degree. Aisha Shire led the research design, data collection, and analysis and authored the thesis. Dr. Gabrielle Inglis assisted in recruitment and provided feedback throughout the research process. Dr. Lawrence Grierson contributed valuable expertise in research methodology and analysis. Dr. Ruth Chen offered critical insights and feedback, helping to shape the study's direction and outcomes. Dr. Gabrielle Inglis and Dr. Lawrence Grierson provided input on the writing process and co-authored the thesis chapters.

CHAPTER ONE: INTRODUCTION

Language barriers in healthcare pose a significant challenge in delivering safe and high-quality care. Language barriers have many adverse effects, including miscommunication between patients and providers, increased errors, and decreased quality and safety of healthcare provided (Chauhan et al., 2020; Pandey et al., 2021; Laher et al., 2018). This ultimately results in decreased satisfaction of patients in the care they receive. Providers also perceive caring for patients with language barriers as a stressful situation that impacts the quality of care they provide; however, providers continue to underuse interpretation services (Chauhan et al., 2020; Diamond et al., 2009). Despite all the evidence of its detrimental effects on patients, this underutilization of interpretation services has been an ongoing issue (Chauhan et al., 2020).

Literature exists on the impact of language barriers on patient care, as well as the barriers that physicians face when using these services (Bowen, 2015; Diamond et al., 2009; Flores, 2005; Gadon et al., 2007; Hseih, 2014; Karliner et al.,2007; MacFarlane et al., 2020; Parsons et al., 2014). However, the evidence on physicians' perceptions of LIS is lacking and ignores more complex factors that influence perception, such as race and ethnicity. Furthermore, there is a gap in the literature that focuses on health advocacy and social accountability and its relationship to LIS use. No literature focuses on advocating for patients who have LEP, despite the overwhelming literature on health advocacy (Dharamsi et al., 2011; Dobson et al., 2015; Hubinette et al., 2017; Kahlke et al., 2023; LaDonna et al., 2021; Law et al., 2016; Oandasan, 2005). Health advocacy is a way of thinking that promotes access to care, understanding and addressing health inequities, and promoting systemic change (Hubinette et al., 2017). Teaching health advocacy in health professions education is vital to develop competent healthcare professionals who provide optimal patient care. The College of Family Physicians and Surgeons of Canada (RCPSC) created the Canadian Medical Education Directives for Specialists – Family Medicine (CanMEDS-FM) 2017 framework describing the expected roles and responsibilities of all Canadian family physicians, which has guided residency training programs' inclusion of health advocacy as a set of competencies expected of residents upon graduation (Shaw et al., 2017). Individuals with LEP come from a variety of backgrounds, mostly marginalized populations. Language interpretation services and health advocacy are essential to this population. Studies have shown that interpretation services can increase patient understanding of disease, health care access, and follow-up adherence, ultimately improving patient outcomes (Jacobs et al., 2004; Wilson et al., 2005). Research also shows that patients from marginalized populations experience a decline in their health as a result of their language barriers (Ng et al., 2011; Zanchetta & Poureslami, 2006).

In Hamilton, Ontario, McMaster Family Practice (MFP) is the largest teaching site within the McMaster Family Medicine residency program. This clinic has recently introduced a service through Interpretation and Translation Services (ITS) Hamilton in April 2023. ITS Hamilton provides in-person and phone interpretation services to patients at MFP with LEP. Clinicians and learners at MFP have access to these services, as needed, for booked appointments. With the new addition of this service to this academic primary care setting, we are interested in describing the types of LIS providers use, how they use them, the challenges they face, and how they overcome them. We are also interested in describing contextual factors that influence the perception and use of LIS and current teaching and learning practices. Finally, we will consider these findings in the context of competency-based design, exploring how focusing on health advocacy and social accountability among physicians and residents may increase the utilization of LIS.

CHAPTER TWO: BACKGROUND

Canada's Healthcare System

Canada's healthcare system provides universal, free access to almost all healthcare services, excluding optometry, dentistry, and health services provided by other health professionals, such as physiotherapists (Armas et al., 2018). All citizens and permanent residents of Canada do not have to pay out of pocket for doctor's visits and hospital services, with roughly 70% of services being publicly funded (Armas et al., 2018). The remainder is covered by personal insurance and out-of-pocket payments. Healthcare is managed at the provincial level, where provinces and territories administer their plans based on guidelines set by the federal government (Government of Canada, 2022). The Canada Health Act of 1984 sets out criteria and conditions that provinces and territories must follow to receive healthcare funding. The criteria include public administration, comprehensiveness, universality, portability, and accessibility.

Primary Care in Canada

Primary Health Care (PHC) is the foundation of health care services in Canada (Health Quality Ontario). Serving not simply as the bridge to specialty care and testing, high-quality primary care is person-focused rather than disease-focused and comprehensive. It provides continuity of care across the lifespan (ibid). Primary care and family medicine are subsets within primary health care, all overlapping and essential for delivering high-quality PHC (Gupta et al., 2021). Primary care is "first-contact, continuous, comprehensive, and coordinated care provided to populations undifferentiated by gender, disease, or organ system" (Gupta et al., 2021, p.648). Primary care can be delivered by family physicians, general practitioners, nurses, midwives, social workers, and others. Family medicine falls under the umbrella of PHC and is delivered by family physicians (Gupta et al., 2021). It encompasses the features mentioned in the definition of primary care and others, including prevention, family orientation, community orientation, and patient-centeredness (ibid). In this paper, the terms primary care provider (PCP), family physician, and provider will all be used to refer to family physicians.

In Canada, one-third of PCPs practice independently, and the remainder work in small group practices managed by physicians, with only 10% working in larger practices (Hutchison et al., 2013). In recent years, there has been a call for primary care reform, including increasing team-based care and payment reform (Kiran, 2022). Over the last several years, there has been a transition of independent family physicians to team-based care with the introduction of Ontario's family health teams in Ontario (Gupta et al., 2021). However, despite these changes, 4.6 million Canadians do not have a regular PCP; this has only worsened with Canada's COVID-19 pandemic and the shortage of family physicians (Kiran, 2022).

PCPs work long hours, excluding time spent on call; most payment comes from fee-for-service payments. It is essential to understand the workload and conditions of PCPs when looking at factors that may influence their behaviours. Family physicians report high levels of burnout related to the many challenges they face, including time constraints, workload, challenging patients, and management issues: additional challenges include an overwhelming sense of obligation, following policies, feeling undervalued, difficulties keeping up with new information and shortage of physicians (Lee et al., 2008; Lee et al., 2009). Most physicians report feeling stressed and having difficulty balancing their work responsibilities and personal lives (ibid).

With PCPs as vital components of the healthcare system, communication in primary care between physicians and patients is critical. Patients present to their PCP to discuss various health issues, including chronic illnesses, preventative care, minor illnesses, and other matters (Armas et al., 2018). Family medicine is becoming increasingly important as there is a greater focus on upstream, preventative treatments in healthcare after the COVID-19 pandemic (Gupta et al., 2021)

Canadian Population and Language Barriers

Canada is a diverse country with many different cultural and language groups. According to the 2021 Canadian Census, 1.9% of Canadians speak neither English nor French, with the majority being women (Statistics Canada, 2022). Similarly, 1.9% of individuals living in Hamilton speak neither official language.

There has also been an increase in Canadians speaking a language other than English or French at home (4.6 million Canadians or 12.7%). Almost 300,000 immigrants enter Canada yearly, making up 21.9% of the Canadian population (Bajgain et al., 2020). On average, immigrants who arrive in Canada have higher educations and better health than their Canadian counterparts. However, in keeping with what is known as the "healthy immigrant effect", immigrants living in Canada for ten or more years show an alarming decline in health, resulting in worse health status than recent immigrants, including a higher prevalence of mental illness, chronic diseases, and congenital disabilities (Bajgain et al., 2020); Ng et al., 2011). This decline in health status is more common in immigrants with LEP than immigrants with good English proficiency (Ng et al., 2011). Another marginalized subset of the Canadian population is refugees, who have poorer health and higher health needs compared to immigrants (McReary & Newbold, 2010).

Canada's population is aging, and by 2030, it is projected that 23% of the population will be older adults; this has many implications for the healthcare system, as seniors have higher health needs (Armas et al., 2018). This puts more pressure on primary care providers to prevent and manage age-related diseases. Specifically, older immigrants experience more barriers to care and have higher health needs than younger immigrants and Canadian-born older adults (mcreet al., 2019). According to the Canadian census, most Canadians with LEP live with an individual in their household who speaks English. However, over a quarter live alone or without anyone who speaks English or French. Of this population, 56% included older adults. Research also shows that individuals may lose English proficiency and revert to their mother tongue as aging occurs (Gubernskaya & Treas, 2020; Wang et al., 2019). In addition, older immigrants experience more barriers to care and have higher health needs than younger immigrants and Canadian-born older adults (ibid).

Although this data provides essential information on the Canadian population, it is crucial to consider that it does not offer a complete picture of healthcare-related issues. Language proficiency does not translate to an individual's ability to communicate with their healthcare provider and understand health information. As such, it is important to consider that these numbers are likely higher when considering language proficiency in healthcare.

Effect of Language Barriers on Health

Extensive research shows that language barriers pose adverse effects on patient health outcomes. Unfortunately, Canadians with LEP do not receive the same quality of care as English-speaking Canadians (Bowen, 2015). Kaplan et al. (1989) coined three necessary components of improving health outcomes: the amount of information shared, the patient's control in communication, and the provider-patient relationship. All three components are compromised when language barriers are present (Bowen, 2015). These barriers can manifest in many ways, including difficulty understanding medical terms, missed appointments, distrust of care providers, underuse of health resources, lower satisfaction with care, and not feeling connected to the care provided (Bajgain et al., 2020; Laher et al., 2018). Without proper communication between providers and patients, patients may be less likely to adhere to medication and treatment plans, participate less in shared decision-making with their healthcare team, and have lower health literacy (Armas et al., 2018). Specific to the context of family medicine, studies have shown that patients with LEP in Ontario have many social factors that affect their health and a lower health literacy; these individuals require PCPs to explain information in a way they can understand (Armas et al., 2018). However, language barriers and low health literacy are not mutually exclusive and function independently. Individuals with language barriers do not exhibit all the characteristics of those with low health literacy (i.e., low education and learning abilities), and strategies to combat low health literacy cannot be used to address language barriers (Bowen, 2015).

Language barriers also result in patients underutilizing preventative care, such as age-appropriate cancer screening, and tend to increase the number of outpatient visits required for chronic disease management, such as diabetes care (Bowen, 2015; Laher et al., 2018). Language barriers also result in decreased access to mental health services, increased risk of hospitalization, and a higher volume of unnecessary medical testing (Bowen, 2015; Laher et al., 2018). It is unsurprising that patient satisfaction is also lower among patients with LEP (Bajgain et al., 2020; Bowen, 2015; Laher et al., 2018). In addition to the effects on patients, language barriers are associated with more complaints against physicians and an increased risk of medical errors and malpractice claims (Bowen, 2015). In one study, almost half of Canadian

PCPs expressed challenges communicating with patients with LEP and difficulty accessing interpreter services (Bowen, 2015). A study by Gadon et al. (2007) showed that physicians expressed frustration when caring for patients with LEP due to challenges with obtaining health information, communicating the care plan, and obtaining informed consent. These challenges, in addition to time constraints, resulted in some physicians terminating patients with LEP from their practice. This shows the increasing importance of supporting physicians caring for patients with LEP and ensuring they have adequate resources to care for this marginalized population.

Defining Health Advocacy

The 2017 CanMEDS-Family Medicine framework defines health advocacy as "family physicians working in partnership with patients and communities, contributing their expertise and influence to improve health through an understanding of needs, as agents of change, and the mobilization of resources." (Shaw et al., 2017). Health advocacy is one of seven competencies outlined in the CanMEDS framework by the RCPSC and one of the most complex CanMEDS roles. Two key competencies are outlined in the health advocacy competency. Firstly, physicians are expected to respond to individual patient health needs by addressing social determinants of health and barriers to care, engaging in disease prevention, health promotion, and surveillance, and working with patients and families to promote healthy lifestyles. The framework highlights that these activities occur both in and beyond the clinical setting. Secondly, family physicians are expected to advocate for community/population health change at the system level. The CanMEDS framework emphasizes the importance of social accountability and action in health advocacy. Oandasan (2005) echoed this statement by emphasizing how health advocacy is more than thinking something needs to be changed; it is about taking action and calling for that needed change. It is not enough for a few physicians to engage in higher levels of health advocacy; it is a collective effort that all physicians need to engage in. Physicians work with their patients to understand health needs, advocate for others, and initiate the utilization of resources (Law et al., 2016). Health advocacy is a critical skill for physicians in Canada who work in an inequitable system where many marginalized individuals receive poor care. Hubinette et al. (2017) describe activities related to health advocacy, including promoting equal access to care, mobilizing resources, taking action to change the system, and addressing health inequalities. There is a clear distinction between the different levels of health advocacy. There are advocacy actions at the micro or individual level, meso or community level, and macro or system level (Bernard et al., 2019; Mu et al., 2011). Advocacy actions at the micro or individual level include what physicians do daily for individual patients. In contrast, advocacy actions at the meso, or community, level include advocating for the community, such as mobilizing resources to address community health needs (Bernard et al., 2019). Finally, advocacy at the macro or systems level can include calling for policy changes that affect population health (Bernard et al., 2019).

A critical aspect of health advocacy is social accountability, directly related to the CanMEDS-FM framework (Bernard et al., 2019; Buchman et al., 2016; Shaw et al., 2017). Social accountability involves providing equitable care responsive to the needs of patients, communities, and populations (Buchman et al., 2016). By being socially accountable, physicians recognize their commitment to society and understand the full scope of this responsibility, from advocating with marginalized groups, collaborating with stakeholders and policymakers, and supporting research and education addressing health barriers (Buchman et al., 2016). All these actions are directly related to patient health needs and contribute to an equitable healthcare system. Similar to health advocacy, social accountability actions are also at the micro, meso and macro levels. Recognizing that a patient’s language affects their health and intervening with appropriate language interpretation services is an example of a social accountability action at the micro or individual level (Goel et al., 2016). Practising social accountability at the meso, or community, level is vital for family medicine as a community-based discipline; not only do physicians hold power and the ability to leverage resources, but these actions at the community level will also make micro-level care easier (Woollard et al., 2016). Actions at this level can look like developing an outreach program or conducting research investigating community health needs (Woollard et al., 2016). Finally, social accountability at the meso, or systems, level can look like advocating for allocation of funding and policy changes that directly affect social determinants of health or calling for change in medical education to focus on social accountability (Meili et al., 2016). It is evident that these social accountability actions are similar to the health advocacy actions previously mentioned. Most literature on health advocacy or social accountability uses those terms interchangeably (Bernard et al., 2019; Buchman et al., 2016; Goel et al., 2016; Meili et al., 2016; Woollard et al., 2016). The CanMEDS-FM framework uses both terms interchangeably and combines social accountability actions into the health advocate role (Shaw et al., 2017). For this paper, health advocacy and social accountability will be used interchangeably, with health advocacy being the overarching term to describe all actions of advocacy, including social accountability.

Statement of Purpose

This study aims to explore the experience of physicians who use language interpretation in primary care. The study employs a qualitative descriptive design looking to describe how physicians use language interpretation services, the challenges they face, and how they overcome these challenges (Sandelowski, 2000). The results from this study may be used to inform educational reform and drive policy change and initiatives related to language interpretation.

Research Questions

The primary research questions are: (1) what types of LIS do physicians/learners use, and in what ways do they utilize them? What challenges to they face while using these services? (2) What are the effects of prior experiences and background on physicians/learners' perception and use of LIS? (3) What are the teaching and learning practices of physicians/learners who use LIS and (4) How do physicians/learners advocate for patients with LEP and what is the role of health advocacy in LIS use?

CHAPTER THREE: LITERATURE REVIEW

Evidence on Underutilization of Interpretation Services

Despite ample research describing the detrimental effects of language barriers in healthcare, providers consistently underutilize interpretation services. The main barriers to the use of interpretation services were time constraints, disruption of schedule, and lack of availability of interpreters (MacFarlane et al., 2020). However, research shows that even when interpreter services are available, providers in many contexts, including primary care, use these services for fewer than 20% of patients with LEP (Hsieh, 2014). This phenomenon has been referred to as "getting by," where physicians decide to use ad hoc interpretation or proceed with the patient's limited English (Hsieh, 2014). Physicians reported using actions and asking specific questions to check the patient's English proficiency, then deciding whether they could 'get by' or request services (Parsons et al., 2014). Parsons et al. (2014) described this as the "grey zone," where a patient's "level of English proficiency is good enough so that maybe you can feel that you can get by, but their comprehension may, in fact, be poor enough that they can get into trouble." Some strategies physicians used when 'getting by' without translation include speaking slowly and enunciating, using simple words, and asking patients to summarize information shared (Parsons et al., 2014). Physicians described these interactions as 'risky'. They would often rely on objective rather than subjective information, such as over-investigating with imaging or bloodwork or monitoring a patient for longer than they otherwise would. (Parsons et al., 2014). Factors that influenced whether a physician used interpretation or not included patients' presenting complaints, degree of acuity, time constraints, and how user-friendly and accessible the interpretation services were (Parsons et al., 2014). Physicians reported feeling uncomfortable without adequate options, and some physicians expected patients to take responsibility and speak up if communication was poor (Parsons et al., 2014).

Barriers to Interpretation Use

There are many documented barriers to providers using interpretation services, including but not limited to time constraints and lack of availability. One such barrier is physicians' perception of language interpretation; if physicians feel that translation quality is low, they may not use the service in the future (Khoong & Fernandez, 2021). The role of professional interpreters is not agreed upon among physicians. Some physicians reported that they only wanted interpreters to translate verbatim, while others expected interpreters to convey cultural nuances (Rosenburg et al., 2008). Generally, patients will not request an interpreter or will use informal translation (i.e. family members, Google translate) or their own limited English (Khoong & Fernandez, 2021). Due to this dynamic wherein patients do not explicitly request LIS, physicians may underestimate the importance of interpretation services, particularly during brief patient encounters. Furthermore, provider utilization of interpretation services depends upon institutions emphasizing and funding these services (Khoong & Fernandez, 2021). Khoong & Fernandez (2021) also highlight that organizations often fail to consult physicians when implementing services, which can impact the feasibility of use in the clinical environment. Lack of training and knowledge about using interpreters also acts as a barrier to its use (MacFarlane et al., 2020). Finally, physicians also reported that the delay in patient responses while communicating with an interpreter affected their train of thought and ability to gather information in an organized and thorough fashion (Rosenburg et al., 2007).

Evidence for Professional Interpreters

Professional interpreters are the gold standard when it comes to translating for patients who have language barriers. When compared to family members or staff interpreters, professional interpreters improved self-reported patient outcomes (Khoong & Fernandez, 2021). Using professional interpretation also increased the rates of referrals and number of visits for many types of care, including primary and specialty care (Laher et al., 2018). This suggests that by facilitating clearer and more accurate communication, professional interpretation increases patient's access to care by allowing providers to better understand patients' health needs. Patients were also more likely to report mental health concerns when using professional interpreters (Laher et al., 2018). Finally, patients who used interpretation services were more likely to engage in preventative health services, such as mammograms, pap smears, rectal exams, and fecal occult blood tests (Later et al., 2018).

There is also evidence demonstrating that the use of professional interpreters compared to ad hoc translation is associated with less frequent and severe medical errors (Laher et al., 2018). When using professional interpreters, there were also lower rates of interpretation errors when compared to other forms of interpretation (Laher et al., 2018). There is also evidence to suggest a difference between in-person professional interpretation services and remote or virtual professional interpretation services. Hseih (2014) found that remote interpreters are more accessible, cheaper, and just as accurate as in-person interpreters. However, they found that remote interpreters were less personal and lacked cultural competency, and their use generated challenges in terms of technical difficulties and quality concerns (Hsieh, 2014). Studies have shown that visits using in-person interpretation were significantly shorter than visits using remote interpreters (Laher et al., 2018).

Evidence for Other Forms of Interpretation

Despite the evidence showing that professional interpretation is superior to other forms, many physicians continue to use ad-hoc forms of interpretation. The most common form of interpretation is the use of family members as interpreters. This can include the patient’s child (at any age), spouse, friend, or other trusted individual. This raises many issues, including issues around privacy and confidentiality, accuracy of translation, and issues with ethics and informed consent (Gadon et al., 2007). Petronio et al. (2004) described how families who interpret for patients assume an ‘unofficial medical role’ and blur the lines between privacy and confidentiality; even when patients request to use family members as advocates, physicians may accidentally disclose information that the patient wanted to keep private. Patients are more receptive to using family members as translators, making providers more likely to use this form despite its downfalls (Hsieh, 2014). Family interpreters provide more emotional support and advocate on the patient's behalf. However, many studies show that using untrained interpreters increases errors by 10% and has the same rate of errors as using no interpreters (Laher et al., 2018). Additionally, patients were less likely to understand information from their providers about chronic health issues when using family interpreters (Laher et al., 2018). Family members did not possess knowledge of medical terms, and most physicians perceived that information received from family interpreters was less accurate and more biased compared to that received from professional interpreters (Rosenburg et al., 2007). Physicians reported that one benefit of using family interpreters is that they can provide additional information about the patient in addition to interpreting (Parsons et al., 2014; Rosenburg et al., 2008). However, physicians were also less likely to ask sensitive questions to family interpreters, and patients were more likely to disclose private matters to professional interpreters than family members (Rosenburg et al., 2007).

Another form of ad-hoc interpretation is the use of bilingual staff interpreters, which include medical professionals who speak a language other than English and act as interpreters. These interpreters may have the advantage of having clinical knowledge. However, Hsieh (2014) found that their interpretation skills are not formally assessed, and they may be preoccupied with other tasks. Bilingual interpreters may also experience trauma and discomfort from being put in difficult situations (Hsieh, 2014). Patient outcomes can also be compromised if providers overestimate their ability to translate (Hseih, 2014). However, there is some evidence that patients with bilingual providers were the least likely to present to the emergency department and more likely to utilize preventative services compared to other forms of interpretation, including professional interpretation (Laher et al., 2018). Studies have also found that bilingual interpreters had longer visit times when compared to in-person professional interpreters (Laher et al., 2018).

Finally, Google Translate is a common form of translation used by providers. Compared to other similar translation services, Google Translate was found to be the most accurate for the largest number of languages (Randhawa et al., 2013). However, accuracy varies, with Google Translate being more accurate for European languages, such as French, Swedish, and Italian, compared to other languages, such as Hindi or

Vietnamese (Randhawa et al., 2013). This raises concerns when it comes to medical visits, where all patients should have access to the same level and quality of interpretation. There is limited evidence on using apps like Google Translate in clinical settings. As such, providers are discouraged from using these services unless no other alternatives are available. Randhawa et al. (2013) reported that some providers use back translation to assess the accuracy of translated text, which involves pasting translated text back into the translator. This was used to mitigate issues related to the accuracy of translation. There are also issues with privacy and confidentiality when it comes to using Google Translate, where identifying patient information may be breached (Randhawa et al., 2013). Google Translate operates through the Internet, which means that any text entered into the application is transmitted to Google's servers for translation. This poses the risk of information being intercepted or accessed by unauthorized parties. In addition, Google's privacy policy states that user data, including text entered into Google Translate, may be stored. This raises concerns about the possibility of private patient information being stored on Google's servers, as well as the patient's lack of knowledge of this.

Language Interpretation and Health Advocacy

Despite health advocacy being vital to the patient-provider relationship, there is little research on language interpretation and health advocacy. It is virtually impossible for a physician to advocate for a patient with LEP without properly understanding their needs and concerns. There is one study in the UK by Ansari et al. (2009) that looked at bilingual advocates and their role in marginalized populations. These bilingual advocates provided interpretation and advocacy; their role was to provide verbatim translation and give marginalized patients a voice through advocacy. There is ample research looking at provider communication with patients, and numerous studies have examined the teaching and evaluation of health advocacy skills. However, no research exists that specifically explores how physicians can use language interpretation to engage in health advocacy with patients who have LEP. Many of the characteristics outlined by the CanMEDS competency framework for health advocacy, such as health promotion and mobilizing resources for patients, arguably necessitate effective communication between patient and provider (Shaw et al., 2017). Without the use of LIS for patients with LEP, effective communication is not possible. If physicians are underutilizing interpretation services, are they engaging in health advocacy actions when it comes to patients with LEP?

Implications for Education and Research

Health advocacy is the most complex competency outlined by the governing body of physicians and, therefore, the most difficult to teach. There is a lot of literature looking at the educational challenges of teaching and assessing this competency. There is no doubt a hidden curriculum present in medical education that hyper-focuses on biomedical knowledge over knowledge related to advocacy actions (Hubinette et al., 2017). Many educators are asking for clarity from the RCPSC to give a more specific definition of health advocacy with specific and measurable expectations at each level of medical training (Verma et al., 2005). Other CanMEDS roles have clearer distinctions between high and low-level performance in the competency and show staged progression. LaDonna et al. (2020) found that the health advocate role in the CanMEDS framework was up to interpretation on whether a physician's advocacy was sufficient, whereas other roles have clearer, more specific competencies. Teaching activities for health advocacy include seminars, essays, short-answer questions, direct observations, OSCEs with standardized patients, peer and preceptor feedback, and portfolios (McDonald et al., 2019; Scott et al., 2020). However, Hubinette et al. (2017) found these assessment methods to be ineffective as most advocacy actions occurred away from clinical practice and would not be witnessed by preceptors.

One recommendation from the literature is for medical school admissions teams to ensure that future students and faculty come from diverse backgrounds (Dharamsi et al., 2011). Role modelling by preceptors was found to be important in learners' development of this skill by engaging in advocacy and health promotion efforts and recognizing barriers to care (Dharamsi et al., 2011). However, Flynn and Verma (2008) found that this alone was not enough, and a formal curriculum was needed. Flynn & Verma (2008) also proposed that learning health advocacy should be scaffolded, with more complex skills developed later in the program. Several authors have called for reform in medical education pertaining to health advocacy, as most residents view this competency as ‘going above and beyond’ rather than a core competency central to the equitable delivery of care by all physicians (Kahlke et al., 2022).

CHAPTER FOUR: METHODS

Overview of Chapter

This chapter discusses the qualitative research design employed in this study and describes the rationale for its use. Next, this chapter describes other steps in the research process, including sampling and recruitment, study setting, and data collection and analysis. Finally, ethical considerations related to the research process are also discussed.

Research Design

This study uses a qualitative descriptive (QD) design to understand the issue of underutilization of LIS by providers. Qualitative description can be described as a "comprehensive summary of an event in the everyday terms of those events" (Sandelowski, 2000, p. 336). A descriptive design best fits this study design, as researchers aimed to provide an accurate description of how often providers are using LIS, how they use it, and what their experiences are (Colorafi & Evans, 2016). Qualitative descriptive studies are based on naturalistic inquiry, which seeks to uncover the truth without interfering with the natural order of things (ibid). Unlike other qualitative research methods, qualitative descriptive research adheres closely to the data with the hopes of providing an unembellished account of events rather than theory construction. By focusing on descriptive accuracy, qualitative descriptive studies ensure that the voices of physicians and learners are authentically represented, providing valuable insights for enhancing LIS implementation and training programs (Colorafi & Evans, 2016).

Theoretical Framework

The driving force for this study is the recognized need for a focus on health advocacy and social accountability to improve patient health outcomes by improving LIS use. Social accountability is a cornerstone for family physicians and is underlined in all of the competencies in the CanMEDS-FM Framework. The AIDER Framework – Assess, Inquire, Deliver, Educate and Respond – was created by

Sandhu et al. (2013) and offers a comprehensive model for increasing social accountability among physicians and learners. This framework incorporates all the roles outlined in the CanMEDS competency framework. The AIDER framework is a continuous monitoring process that involves marginalized groups and aims to increase social accountability in practice and medical education.

The framework contains five steps, all building on the previous steps and involving community participation throughout. The first step, Assess, involves physicians working with underserved populations to identify barriers they face. The next step, Inquire, involves looking to research, or conducting new research on the topic involving community stakeholders. In the third step, Deliver, physicians start to implement changes to address the issue that is raised, always considering the findings from community discussions. The next step is Educate, where advocacy takes place and physicians educate their colleagues on the communities' experiences as well as the actionable steps taken to address their concerns. In the last step, Respond, physicians get feedback from the community to assess the changes made; here, the changes can be adapted to best suit the community's needs.

This framework was chosen to provide actionable steps for physicians and learners to identify a problem, advocate for underserved populations, and spark change on a systems level. It was also chosen for its focus on community involvement throughout all its steps, which is vital in physicians adopting the health advocate role (Dobson et al., 2015; Oandasan et al., 2004). The RCPSC promotes advocating with patients rather than advocating for patients (McDonald et al., 2019).

Positionality

Reporting the researcher's positionality, as well as addressing any potential biases, is vital for ensuring objectivity in qualitative research (Colorafi & Evans, 2016). Positionality describes how our background, experiences, and worldview affect our relationship with the research process (Holmes, 2020). As a final year master's student with a background in pediatric emergency nursing, my journey and experiences have profoundly shaped my research interests and approach. My study centers on the use of language interpretation services by physicians and residents in primary care. Although my professional experience has been in emergency departments, I am conducting my research at McMaster Family Practice, where I am not employed; this provides a valuable perspective and separation from the study participants. Growing up as a black Muslim woman with parents who were refugees from Somalia, I was often called upon to translate for them from a young age. This role illuminated the challenges non-English speaking patients face in healthcare settings, fostering my passion for addressing language barriers. These early experiences have driven my lifelong commitment to improving communication and reducing disparities in healthcare. Throughout my career in pediatric emergency nursing and as a research nurse, I have witnessed healthcare professionals' underutilization of language interpretation services. The consequences of this underutilization, including medical errors, have only strengthened my resolve to focus on this area of study. My bilingual ability in Somali has frequently positioned me as an informal interpreter, providing firsthand insight into how informal interpretation can affect patient care. I understand that these experiences and my passion for this topic have the potential to cloud my role as the primary researcher. As such, I will ensure that I am constantly engaging in reflexivity and remaining close to the data while also allowing my experiences to add rich depth to the research. This is also why I opted to employ a qualitative descriptive design as a novice researcher, allowing me to stay close to the data while providing interpretation.

Despite my research experience, particularly in quantitative methods, I entered this master's program with limited exposure to qualitative research. Engaging in this study has allowed me to expand my methodological expertise and delve into the subjective experiences of healthcare providers. I hold the ontological view of constructivism, where reality is subjective and constructed through individual experiences and perceptions (Guba & Lincoln, 1994). However, I also align with the ontological view of post-positivism, where I believe that there is some level of objective reality in the world (ibid). This is mostly related to my background as a nurse and how that affects how I view the world. My ontological view of constructivism aligns with my epistemological stance of subjectivism, where I believe that knowledge is shaped by the context and interactions of those involved (ibid). Aligned with constructivism, this study also follows the beliefs of naturalistic inquiry, where researchers must consider the context of the participants' experiences and how that affects meaning (Cutler et al., 2023). This paradigm directly relates to the chosen methodology and informs many aspects of the research design. My assumptions guide my approach to this research, emphasizing the importance of understanding diverse perspectives and the lived experiences of healthcare providers in primary care settings. These views inform my methodology, analysis, and reporting of the data.

Ethics

This study, under project #16811 received approval from the Hamilton Integrated Research Ethics Board (HIREB). Approval was also received from the Family Medicine Program Leadership at McMaster University to involve residents in this research study. Finally, we received approval from the Chair of the Department of Family Medicine at McMaster University. Many considerations were made throughout the study process to ensure that participants were protected. The following paragraphs outline identified risks and how these risks were mitigated.

There was a risk that participants may feel distressed by the questions asked during the interview, particularly questions about race/ethnicity, biases, or power dynamics. This risk was mitigated by informing participants in the consent form and at the beginning of the interview that all questions were completely voluntary and that they could move on to the next question without answering if they felt uncomfortable or end the interview at any time. This message was reiterated before asking any questions that had the potential to make participants uncomfortable. Participants were also informed in the consent form and before the interview that withdrawing from the study did not affect their performance at MFP whatsoever.

There was also a conflict of interest related to the Principal Investigator (PI) being a staff physician at MFP and having supervisory status over some residents. This conflict of interest was mitigated in a few ways. Even though the PI referred some participants, the student researcher was the one completing the consent forms without the PI's presence. The student researcher has no affiliation with MFP or the Department of Family Medicine at McMaster. Participants were informed in writing on the consent form as well as verbally that their consent was completely voluntary and could be revoked at any time. They were also informed that whether they participated or not had no effect on their performance in the program. Participants were given a copy of the consent form to read either virtually or in person. The student researcher ensured that consent remained voluntary and informed from the beginning until the end of the interviews. Participants were also informed that they could contact the researcher at any time and revoke their interview data.

Various measures were taken to ensure participants' privacy and confidentiality. Personal identifiers were collected on the consent forms and the master list. The master list linked participants to a numerical study ID. This study ID was then used on all other study documents, such as demographic forms and interview transcripts. The master list and all these digital files, including audio recordings, were password protected, and Windows Bitlocker was the computer security method used to prevent unauthorized access to identifiable data. No personal identifiers were used during the interview process to protect participants' identities. A trusted, local transcription company was used, and the company drafted a confidentiality agreement signed by both parties.

Sample Size

This study aimed to recruit 18 physicians and residents. 15 participants were recruited, and 1 participant was excluded from the study after not participating in the interview. Multiple attempts were made to reschedule this participant's interview with no success. After 14 interviews, data saturation was reached, and the decision was made to cap the sample size at 14 participants. A breakdown of the participants will be provided in the next chapter.

Sampling Strategies

The qualitative descriptive design supports the use of any purposive sampling strategy, such as maximum variation, homogenous, typical case, or criterion sampling (Colorafi & Evans, 2016). Two types of sampling strategies were used in this study. Firstly, criterion sampling was used to recruit participants who worked at MFP and had experience using LIS in their practice. The rationale for this was to recruit providers who were able to answer the research questions based on their experiences. Participants could have any experience using LIS, but these inclusion criteria were not specific to LIS use at MFP. Next, maximum variation sampling was employed to collect as many different participants as possible. This included participants from various ethnic backgrounds, varying experiences, ages, genders, and languages spoken. This was employed to better answer questions about contextual factors that may influence the perception and use of LIS.

Recruitment Strategies

Recruitment was focused on McMaster Family Practice (MFP) in Hamilton, ON. Recruitment took place between Dec 27, 2023, and Jan 22, 2024. Many different recruitment strategies were employed to maximize participation. Firstly, an email was sent to all physicians and residents at MFP informing them of the research study and how to participate. A few participants were recruited this way. Most participants were approached directly by the research team. Finally, posters were advertised throughout the clinic in common areas, such as staff break rooms and washrooms, as well as on bulletin boards.

Data Generation

Data generation included the collection of demographic data, as well as semi-structured interviews to collect audio and observational data. Qualitative descriptive studies support the use of individual interviews to collect data. Basic demographic data was collected, including age, gender, and race/ethnicity. Education and profession-related demographic data included the highest level of education, current position at MFP, and years of experience at MFP. Languages spoken by participants were another important data point that was collected. Semi-structured interviews were the main source of data for this study. Interviews were 60 minutes long and conducted via Zoom through the researcher’s university account. Participants were given the option of in-person interviews; however, all participants unanimously chose to participate virtually. This offered more flexibility for participants and the research team and was also a cost-effective option. The interview was divided into sections to ensure all research questions were answered thoroughly. The first section focused on LIS in practice and how providers are using LIS. The second section asked questions about the challenges faced when using LIS and how to overcome them. The third section was focused on discovering if any contextual factors influence providers' use and perception of LIS. Finally, the last section focused on teaching and learning practices related to LIS. A copy of the interview guide can be found in Appendix A. Throughout the interview, participants were asked how they used LIS in their practice and how they advocated for their patients who have LEP, communities, and the overall population. For example, participants were asked how they used LIS to address patient's health needs. Participants were also asked questions, such as why they thought it took so long for interpretation services to be implemented at MFP, how these services can be improved, etc. These questions were formulated with the CanMEDS-FM framework in mind to determine if physicians are engaging in advocacy actions related to LIS. All interviews were audio recorded; the researcher also took observational and theoretical notes during the interviews.

Data Management

Many programs were used to collect, organize, analyze, and report the data collected in this study. Microsoft 365 Outlook was used to communicate with participants and send study documents, such as consent forms, for them to review. It was also used to communicate with the principal investigator and send interview reminders to participants, as well as send gift cards. Microsoft Word was used to generate study documents, such as study protocols, consent forms, demographic data collection forms, and others. It was also used to combine the data into a written report. Microsoft Excel was used to create a master list with all participants, as well as to create a chart organizing all demographic data. The master list, containing identifiable data, was password-locked, encrypted, and stored securely on Windows Bitlocker. Zoom was used to conduct virtual interviews and also record audio during interviews. Lastly, NVIVO 14 was used to conduct a literature review and analyze and code data. All of these services were accessed using the student researcher's university email.

Data Saturation

The number of interviews completed was based on when data saturation was achieved. During the interview process, the researcher made notes when new topics were revealed through the participants. At the end of the interviewing process, the researcher noted that common topics were repeated, and no new information was received. The decision was then made to stop the interviewing process and start data analysis. This decision was made with the thought that further interviews would be conducted if there were further areas that needed to be investigated.

After the initial coding, data saturation was re-assessed to confirm that no further interviews were required. Guest et al. (2020) provide a step-by-step approach for assessing data saturation in a new way, specifically for qualitative data using one-on-one interviews. They report how many qualitative studies do not report data saturation extensively and how they decided when they reached saturation. Guest et al. (2020) provided multiple ways to assess saturation, including retrospective assessment after coding has taken place. Base size refers to the total number of information obtained. Run length refers to the number of interviews that are assessed to calculate the number of new information obtained. Finally, the new information threshold is when it is decided that saturation has been reached. Guest et al. (2020) propose <5% of new information and 0% of new information to suggest data saturation. There are various factors in assessing data saturation using this method. In this case, the number of new codes in a run was divided by the number of total codes identified up to that point. This provides a percentage that represents the degree of saturation.

After coding, data saturation was assessed starting at the 8th interview. Prior to this interview, there was a large influx of new information, suggesting further interviews were required to reach saturation. At this point, 51 codes were identified. The run length was 2 interviews from interview 8 through interview 14. The first run yielded 14% of new information, suggesting that saturation was not achieved. However, the second run yielded <5% of new information, suggesting data saturation. The last run further confirmed this, where no new information (0%) was obtained.

Data Analysis

Qualitative descriptive research supports the use of various types of analysis, such as conventional content analysis, directed content analysis, and summative content analysis (Colorafi & Evans, 2016). This study used directed content analysis, which is when an issue/phenomenon is researched, but further description would provide more insight into the topic. Researchers use existing research on the topic to create initial codes. Data is coded into these initial codes, and any data that does not fit into the initial codes is given a new code (Colorafi & Evans, 2016). In this study, initial codes were constructed based on existing research. These initial codes were broken down into sections based on their corresponding research questions. For example, one code was "Current Use of LIS," where any data pertaining to what types of LIS providers used and how they used these services was coded. Sub-codes, such as "Types of LIS Used," were used to better organize the data.

A similar coding method was used for barriers faced when using LIS, strategies to overcome barriers, contextual factors influencing perception and use of LIS, and teaching and learning practices. Transcribed documents with wide right margins were used to sort data into appropriate codes and generate new codes under the main codes and sub-codes. Memos were also used to start to draw connections to different codes and depict the researcher's thought process throughout the coding process. This process was repeated to ensure no codes were missed.

To analyze the concept of health advocacy, codes were created to reflect the key competencies for health advocacy outlined in the CanMEDS-FM 2017 framework. Participants' responses were then organized into these codes to reflect which physicians/residents engaged in health advocacy actions demonstrating one or more of the key competencies. For example, one physician described using LIS to communicate that a patient was overdue for a pap smear and then scheduled that test for the patient. This was coded under incorporating disease prevention, health promotion, and health surveillance.

Then, second-level coding took place, where similar codes were grouped together into themes. In this process, the researcher spent a large amount of time interacting with the data, reflecting on current thoughts and previous memos during the interviews and the initial coding. The final step in the analysis process is the reporting of findings in a narrative format, with a focus on providing in-depth accounts of participants' experiences.

Strategies to Promote Rigour and Trustworthiness

Colorafi and Evans (2016) describe five standards used to assess the rigour and trustworthiness of qualitative descriptive studies: objectivity, dependability, credibility, transferability, and application. Objectivity describes reducing researcher bias. This was addressed by providing a comprehensive description of all study activities so that the study can be easily audited and reproduced. Personal biases were also reported in the paper, and these were taken into account during all steps of the research process. The study data will also be available for others to validate independently.

Dependability is described as consistency throughout the study activities and across participants (Colorafi & Evans, 2016). To foster dependability, I ensured consistency by using semi-structured interviews and standardized data collection forms. The interviews were conducted systematically in the sense that the same main questions were asked in the same order for all participants. Furthermore, the same researcher was used for all interviews to further ensure consistency. Using a coding manual from predefined codes based on the literature ensured that the data collection and analysis process were reliable and repeatable.

Third, credibility can be described as the perception of truth of the study's findings and whether they make sense (Colorafi & Evans, 2016). Credibility was established by providing a thorough description that remained close to the data. This information was also crosschecked by the principal investigator and other members of the supervisory committee to ensure the findings made sense. Findings were linked back to the theoretical framework, which helped reinforce credibility. Furthermore, direct quotations were used with participant numbers and position at MFP. For example, R1 and R2 were used to represent first and second year residents, respectively, with P representing physicians. This was followed by a number sign and the participants ID. This furthers credibility by linking quotations to participants ID, which can then be linked to the full transcribed interviews.

Transferability relates to whether the findings can be applied to other settings (Colorafi & Evans, 2016). The study setting and participants' characteristics were thoroughly described, allowing other similar settings and groups to apply the research findings to themselves. This promoted the broader applicability of the study's conclusions.

Finally, application describes the real-world value of the study's findings (Colorafi & Evans, 2016). This study findings will be available for participants to review. We hope that this study can provide insight to stakeholders at MFP and address the barriers that providers are facing in using LIS. The recommendations provided by participants in this study can be applied in the setting to streamline the use of professional interpreters at MFP and thus improve patient outcomes. We also hope that this stimulates more research on the topic of LIS in healthcare.

CHAPTER FIVE: STUDY FINDINGS

Overview of Chapter

This chapter outlines the study findings using the above-mentioned methods. The results section will report the demographics collection and findings informed by interviews with study participants. The interview findings will be reported using a descriptive method to answer the research questions.

Demographics

This section provides a comprehensive summary of the demographic characteristics of the participants in this qualitative study. The data includes information on age, gender, race/ethnicity, languages spoken, highest level of education, position at the MFP, and years of experience. The participants range in age from 26 to 55 years, with most being in their late twenties to early thirties. This reflects a relatively young group of medical professionals. 3 participants were in the age range of 35-60, with one being a resident and the other 2 physicians. Among the participants, there is a mix of men and women, contributing to a balanced gender representation in the study.

The participants come from diverse racial and ethnic backgrounds. The group includes individuals who identify as Caucasian, Kurdish, Filipino-Caribbean, Chinese, and Sri Lankan, reflecting a wide range of cultural perspectives. The participants reported fluency or conversational ability in multiple languages, showcasing their multilingual capabilities. All participants speak English, with some also speaking French, Hebrew, Russian, Arabic, Kurdish, German, or Tamil.

All participants have completed medical school, indicating a high level of professional education and training. This common educational background ensures that all participants have a solid foundation in medical knowledge and practice. The roles held by participants at MFP vary, including staff physicians and residents in their first and second years of training. The participants have varying lengths of experience in their roles, ranging from less than one year to 11 years. This diversity in experience levels contributes to a rich exchange of insights and practices among the group. The following table is a summary of the demographic data collected in this study:

Demographic variable	**Category**	**Frequency**	**Percent**
Age	Less than 30	6	42.90%
	30-35	6	42.90%
	36-45	1	7.10%
	46-55	1	7.10%
Highest Level of Education	Medical School	14	100.00%
Gender	Male	8	57.10%
	Female	6	42.90%
Ethnicity	Caucasian	9	64.30%
	Kurdish	1	7.10%
	Sri Lankan	2	14.30%
	Chinese	1	7.10%
	Filipino-Caribbean	1	7.10%
Languages Spoken	English	14	100.00%
	French	2	14.30%
	Hebrew	1	7.10%
	Russian	1	7.10%
	Arabic	1	7.10%
	Kurdish	1	7.10%
	German	1	7.10%
	Tamil	2	14.30%
	Spanish	1	7.10%
	Italian	1	7.10%
Position at MFP	Staff Physician	4	28.60%
	1st Year Resident	6	42.90%
	2nd Year Resident	4	28.60%
Years of Experience at MFP	Less than 1 year	6	42.90%
	1 to 2 years	4	35.70%
	3 to 5 years	2	7.10%
	More than 5 years	2	14.30%

Table 1: Summary of Demographic Data

The demographic data reveals a group of young, diverse, and multilingual medical professionals at MFP, all of whom have completed medical school and hold various positions within the institution. This diversity in background and experience enriches the qualitative insights drawn from their experiences and perspectives, providing a comprehensive understanding of the topics explored in this study.

Overview of Major Findings

The major findings in this study include (1) the types and ways in which physicians/learners use LIS, as well as the challenges they experience, (2) the effects of contextual factors on physicians/learners' perception and use of LIS, (3) the teaching and learning practices of physicians/learners who use LIS, and (4) how physicians/learners advocate for patients with LEP.

LIS: Types and Practical Use

The physicians and learners at MFP report using a variety of LIS in their practice, with each provider employing two or more methods across various visits. The types of LIS employed at MFP will be reported in order of most used to least used. All the interviewed physicians and learners reported using family members as translators. This included a patient's spouse, child (both adult and young children), sibling, or trusted friend. Most participants also reported instances of using no translation service at all. In these cases, participants reported using simple English, gestures, drawings, or over-investigating as a means of communication. In cases where a patient did not bring a family member/friend, a large portion of providers reported using Google Translate to communicate with patients. They reported using the conversation function when available, where the patient and provider would speak into the phone, and the translated text would be read aloud. When this option was not available, providers resorted to using the text translation available through the app, where the phone would be passed back and forth, and the patient and provider typed into the app. Participants reported that no other apps/services were used in this setting. A small number of providers reported using ITS Hamilton, the professional translation service offered by MFP. All these visits were in-person, pre-booked translation services at no cost to the patient. A few participants also reported using another healthcare professional working at MFP to serve as a translator for patient visits. Both participants who employed this method of LIS reported using the same individual to translate for patient visits.

The main way physicians/learners described using LIS in their practice was to identify patients' health needs. Participants reported that using LIS allowed them to better understand their patient's health needs; this was the first step in formulating a treatment plan for their patients. By doing this, they felt that this allowed them to understand their patients' priorities and deliver the best quality care. For example, one physician reported using professional translation to collect data on a patient with memory concerns in the form of a full physical and mental assessment, as well as a memory test. Using LIS to engage in disease prevention and health promotion was also a prevalent application of its use. This was mainly used in disease prevention, including chronic disease education, symptom and medication counselling, cancer screening, mental health assessments, and other ways. A common sentiment was that these activities always came up opportunistically, such as using LIS to communicate that a patient was overdue for a pap smear during an acute visit. Some participants also used LIS to engage in health promotion activities, such as smoking cessation and injury prevention, and to promote healthy eating and an active lifestyle. This quote by a physician demonstrates the various ways in which LIS are employed:

> "Yeah, I think – I feel like once I'm in the room with the patient, I use the translation services pretty uniformly; like it helps me to gather data from the patient, helps me to explain my thought process to them and my management, my treatment plans. It helps me to convey when they're in the room, and we realize that they're overdue for a pap or they're due for a tetanus shot or anything kind of disease prevention-wise, it's useful to convey." P#1

Some participants reported using LIS to identify determinants of health. They stated they were able to use this information to better understand their patients and the various factors that affect their health. This included their health literacy, socioeconomic status (housing, food insecurity), and refugee status. Many participants outlined that a language barrier is often a trigger for them to think about other barriers the patient may be experiencing. One physician explained this thought process by saying:

> "…if we don't understand what's going wrong, we can't effectively treat somebody, and oftentimes it means under-treating or diminishing or downplaying symptoms. But also, especially in this population of – for whatever reason, they don't speak English, but they're here, that means that they are likely missing out on other services, which means there is a huge opportunity for interventions. It doesn't matter where it is, whether it's housing, access to food, access to schools, access for a child evaluation because somebody is having developmental delay or language delay and we don't know what's going on. Not being able to understand their social circumstances means that we're really not providing equitable care and appropriate services."
> R1#7

Finally, participants expressed using LIS to connect patients to appropriate resources. One resident recalled using Google Translate to connect a patient to the immigrant women's clinic. They used the application to explain the service and how to access it to the patient. Another physician recalled a time when they used professional translation services to connect a Spanish-speaking patient to a social worker who also spoke Spanish. Other participants gave examples of finding resources in their patients' language that they could take home and read.

Identifying Barriers to LIS Use and Strategies to Overcome Them

There were several challenges faced by providers when using LIS in their practice. These challenges include (1) time constraints, (2) organizational challenges, (3) issues with translation quality, and (4) privacy and confidentiality.

Time Constraints

Time constraint was the main challenge described when using LIS in practice. A common sentiment was that using LIS in practice affected workflow and efficiency, as visits with patients who have LEP took much longer, which is demonstrated in the following quote by a physician:

> “I think there is always a bit of a fear that with that interpretation service, it’s going to take a bit more time. The interaction is going to be a bit more clunky and you might need to ask more questions in order to get the answer you’re looking for, even though that’s probably not necessarily the case. So with it still being a somewhat new thing that I’m incorporating into my practice at least, I think it still takes up a larger chunk of my schedule, even if it’s for something like a stubbed toe, something that there is like maybe four questions to ask and the rest is physical exam and four words to say when they are ushered out the door.” P#1

Most providers reported feeling rushed during these visits, which added a level of stress and affected the care they provided for that patient. This was more evident when patients with LEP were booked in for 15-minute appointments rather than 30-minute appointments. In the cases where these visits were planned for and adequate time was available, participants reported that these appointments were a lot smoother. However, most physicians/residents reported that these appointments are not on their radar and take more time. Some residents reported that their appointments would decrease to 15 minutes as they progressed in their practice.

They expressed that this provided a level of anxiety when thinking of the patients with language barriers that they will need to care for. One resident described a domino effect when they had more than one patient with LEP. Each appointment would take extra time, which would mean a colleague might have to see your last patient.

A marked difference was reported in visit times when using professional vs. ad hoc interpretation. The participants who reported using professional LIS reported those visits being more efficient and smoother. Participants reported that their workflow was greatly affected when using family members, as they would have to repeat the same sentence multiple times or ask family members to translate verbatim. Finally, some participants expressed issues with the nature of using Google Translate and that these visits took longer as information had to be typed out by both the provider and the patient. Any technical difficulties experienced while using the application also added time to the patient's visit. Physicians and residents reported that these time constraints not only affected their efficiency but also affected the quality of care they provided. Many participants felt that they had to scramble to catch up, making them sloppier. To make up for lost time, they also described speaking in short, quick sentences to wrap up the visit.

Organizational Challenges

Many different organizational challenges were identified throughout the interviews. The main barrier identified was the requirement to book a translator well in advance before the patient's appointment. All the providers felt that this was not feasible, as it added extra work to their current load and didn't fit well within their current practices. Many residents expressed that they are not familiar with almost all the patients they see; therefore, they are unable to identify which patients require translation services in advance. This caused a great deal of distress, as residents felt they were not equipped to respond to those situations. Similarly, many respondents expressed that a lot of patients come in for urgent, same-day appointments. In these cases, it is not possible to book translation services for these patients, and providers resort to using ad hoc services.

Similarly, providers are not able to use translation services for instances such as phone calls to patients to discuss test results. In these cases, some providers will book a patient in for an in-person visit with an interpreter or use a family member as a translator. These sentiments are evident in the following quotes by a physician and a resident:

> “Yeah, I mean, it’s good. I think some of the barriers were just kind of coordination – to be able to get this service in a timely way is not always easy. And so you kind of have to – it’s really self-selects for certain visits that are further away. If I need to see someone or talk to someone today about an issue, I can’t just easily get a translator to help with that. But I found it was very helpful.” P#13

> “So for residents, it would be I think a difficult service to use unless let’s say you have – you’ve been at MFP for a while and you’ve already gotten to know a lot of patients and so you know who has a language barrier, who you could pre-book this interpreter for. But otherwise, as you’re still learning the patients – even six months into residency there are still so many patients I don’t know – it would be for residents a bit of a difficult service to use.” R1#2

Some respondents also expressed that the process of booking an interpreter was very labour-intensive, including forms that needed to be filled out. They compared this process to booking a specialist consult for a patient and expressed that it needed to be simplified and streamlined. A final organizational challenge that was mentioned was the cost of booking a professional interpreter. Many of the physicians and residents recognize that there is an added cost when using professional interpreters. They mentioned that this may be an organizational barrier to using other forms of professional interpretation rather than solely using ITS Hamilton.

Interpretation Quality

Issues related to interpretation quality were prevalent barriers expressed by respondents. There was an overall sentiment from providers that no matter what form of translation service they used, they always felt like there was a sliver of doubt in the translation. This was due to the sheer nature of translation services and not knowing the patient's language and associated cultural nuances. Physicians and residents felt that even if the quality of the translation was high, it was nearly impossible to translate emotions and cultural nuances accurately. The following quotes are a few examples of this:

> "It doesn't give me full confidence. I think there might always be – I mean depending on if I use the service more, develop more comfort with it. I think there will always be a sliver of doubt in those interactions that I find just because when it's a language I know and a language I understand you can pick up not only on the words people say but also the nuance and the tone and how someone says it….and in other languages, I can't understand that nuance or can't assume that certain tones mean the same things they might mean in the English language. So I always wonder what's being lost in those more subtle aspects of communication, but definitely, it's useful for kind of doing the information gathering that I do with every patient. Has that information changed my management plan? It always does, right, because I don't have a management plan until I know what the person is saying to me." P#1

This feeling of doubt was exacerbated by any deficiency in the professional interpreter's knowledge. Many instances of interpreters being unable to translate medical terminology or explain a physician's statements resulted in providers not trusting the professional interpretation. One respondent recounted a case where an interpreter was unable to translate what the provider was saying. The patient was confused and the family member had to interject and provide translation. In this case, the provider felt that they went out of their way to use professional translation and the family member ended up being more useful. Many providers expressed that they would say two or three sentences to the patient, and the interpreter would say a few words in their translation; they felt frustrated with the interpreter and felt that they were selecting what to translate rather than translating everything the provider was saying. However, they also felt that they could not express their feelings of doubt directly to the interpreter, as they did not know the language. Additionally, if an interpreter were to act unprofessionally or inject their own opinions into the translation, this added another level of doubt in the translation services. A few providers recounted instances where the professional interpreters were having casual conversations with the patient outside of what the physician was saying, including laughing and telling jokes. Physicians expressed that this made them very uncomfortable, as they were unable to understand what was being said and deterred them from using these professional translation services. Similarly, many physicians and residents reported instances where professional translators injected their own opinions into the translation or offered advice to the patient. In these cases, the participants felt that they were unsure of what was being objectively translated and what was the interpreter offering their insights. This is evident in the following quotes:

> “ I’ve also heard mixed success in terms of which translator you get. I’ve heard some people having translators where like they were offering their interpretation or offering like advice or things like that; not just being like a very objective translator.” R1#8

> “The other feedback that came about from these one-on-one conversations with other providers was that one translator inappropriately was kind of giving their personal opinion about what should take place. And was kind of acting as like a friendly liaison for the patient rather than just providing translation services,

> so kind of giving more of their opinion into the mix rather than just helping with translation." P#12

Lack of trust in the quality of the interpretation provided was a common barrier to using professional translation services. However, this also extended to other forms of translation, including family members and Google Translate. The main challenge that was reported by providers using family members as interpreters was family speaking for the patient or their personal beliefs affecting translation. For example, one resident was concerned about mental health issues with one of their patients. When they tried to bring this up through a family interpreter, the family member was injecting his opinions about mental health, and this affected the uptake of the provider's information. There was a common sentiment of frustration when using family members for translation, with providers having to redirect the patient and consistently remind them to translate verbatim what the patient was saying. Most providers felt that this was not the case with professional interpreters, other than a few occasional instances. According to participants, it was very common for them to answer the provider's questions on the patient's behalf without even translating the question to the patient. Even after being redirected to ask the patient directly, family members would often add extra information that was not provided by the patient. One provider recounted a situation where a pregnant patient was being asked about her symptoms. After redirecting the patient's husband to stop answering on the patient's behalf, he added his explanations of why the patient was having those symptoms and downplayed them. Some providers also mentioned that there were situations where family members' emotions would affect their ability to translate objectively. This physician expressed that the patient's daughter was frustrated with the patient, and this was coming out in her translation of the provider's statements. The physician was worried that the patient would think that she was frustrated with her. However, it was the patient's daughter who was frustrated.

Similarly, concerns were expressed about the quality of the translation when using Google Translate in practice. Many providers expressed that the quality of translation was not consistent, and there were many instances where inaccurate translation was provided. This was identified by the patient’s responses or confusion in the translated text. In these cases, physicians and residents would rephrase their initial statements to generate a different translation or abandon the app altogether and rely on simple English or gestures. According to participants, this was problematic in situations where patients come in for urgent appointments without a family member. There was an extra step of troubleshooting translation or technical difficulties when using Google Translate. Many participants reported trusting the interpretation of family members, and Google Translate less than professional interpretation. However, regardless of the translation services used, there was an expressed level of doubt. This ultimately acts as a barrier to using translation services in practice.

Privacy and Confidentiality

Another prevalent barrier to the use of LIS is issues related to privacy and confidentiality. One of the main barriers is patients not consenting to involve an interpreter despite the physicians/residents’ strong recommendations. Participants expressed frustration around these visits because although they knew there was a significant language barrier requiring translation, they were unable to initiate these services without the patient’s consent. In these cases, providers were forced to use Google Translate or no translation at all. Many providers reported feeling unsettled during these interactions because they were struggling to weigh the patient’s autonomy with their ability to provide high-quality care. In many cases, the patients believed they had enough working English to go through the visit without an interpreter. However, the physicians and residents felt there was a significant enough barrier that they doubted the patients' understanding.

When using family members, participants also expressed that they felt there were many instances where privacy and confidentiality were compromised. Even when patients consented to using family members as translators, the extent of this relationship was not well defined. This left providers in a difficult situation, especially when discussing sensitive topics. One resident described a visit where a patient was using a friend as a translator. The provider was discussing positive test results for a sexually transmitted illness. When these results were relayed through the translator, the patient was visibly upset. The resident felt very distressed during this visit as they explained that although the patient consented to use friend as a translator, the provider was unable to discuss the nature of the visit without a translator due to the patient's LEP. Many participants expressed that they did not feel comfortable discussing sensitive topics while using family members as translators. This included issues that were directly related to the family member translating, such as discussing domestic abuse with the patient's partner present. In these cases, the participants expressed that they would avoid bringing up these topics with their patients altogether, which they admit was a disservice to their patients. They also expressed that when they were put in situations where they were discussing sensitive topics, they did not feel prepared on how to navigate the situation with a translator present. When using Google Translate, many providers also expressed that they were not confident in the privacy and confidentiality standards. This was exacerbated by the fact that they could not control what the patient was inputting into the translator. They also mentioned that many patients agree to use Google Translate without knowing the risks posed to their privacy, so this poses an issue with informed consent.

> "Yeah. I mean like, the first thing I'll say is family members are never ideal, right? It's just there's no privacy, there's no – a lot of times the issues that the patient wants to talk to us about might involve their family members. And there's not an opportunity for them to have that private space. I think that can be problematic. I mean there's – this is not likely what you're getting at, but I will just comment on observations around practical challenges with some cultural interpreters, and specifically family members. Like I have a have a preamble before I work with anyone that's providing language interpretation services that I had ingrained in me when I was a resident – because I was having

> to do – I had the opportunity to work with a lot of different interpreters, and many of them taught me how to do it right." P#14

Participants expressed similar concerns about using professional interpretation services. Some providers have encountered situations where patients become more reserved and unwilling to discuss sensitive topics when professional interpreters are involved in the care circle. Although they felt that their patients were holding back information, providers felt that there was nothing they could do. Some physicians and residents were concerned that patients may fear that they may know the interpreter from the community. This is because ITS Hamilton uses local interpreters, so someone interpreting for a specific language may come from a small, tight-knit community. Similarly, one physician expressed that a lot of patients may not be comfortable with an in-person interpreter and prefer the anonymity of phone interpretation.

Strategies to Overcome Barriers

All participants provided many strategies to mitigate the above barriers they face when using LIS in their practice. These strategies focus on the organizational challenges physicians and residents face, as this is the area where they feel the most need for change. Participants expressed that a simple way to mitigate the time constraints providers face is to book extra time for patients who require LIS. Similarly, one key approach mentioned was to screen all patients, existing and new, and identify all patients who have LEP. Then, the clinic would be able to obtain consent from patients to use LIS and flag their charts, so this information is visible. The next step would be for the receptionists to recognize when a flagged patient is booking an appointment and automatically book the interpreter for the visit. As previously mentioned, providers recommended using this approach to automatically book longer appointments for all these flagged patients. Participants expressed that this would remove the load off physicians and residents who have to identify the need for LIS, consent the patient, fill out the paperwork, and book the LIS. Not only would this ensure that more patients had access to LIS, but it would also mitigate the issues of time and facilitate better workflow for physicians and residents. However, providers did mention that they were concerned that this would increase the workload on the receptionists. All participants expressed that more work was needed to streamline the process of ensuring all patients with LEP receive the highest quality care.

One of the most prevalent recommendations from providers was to have access to multiple forms of reliable, professional interpretation rather than relying solely on ITS Hamilton. Participants mentioned that even if all patients were flagged and interpreters were automatically booked, there was still a large gap in patients who booked urgent appointments and when making phone calls. In these cases, using ITS Hamilton was not feasible due to the lack of notice and the lack of telephone support. In these cases, almost all participants mentioned that a 24/7 phone interpretation service, such as Language Line, would be very beneficial. They mentioned that this service was very easy to access in a timely manner and would solve the issue of interpreter availability for urgent visits. Similarly, providers would be able to coordinate phone interpretation when calling patients to discuss results or other issues. Many residents mentioned that they have used Language Line in their rotations in the hospitals in Hamilton, and they would be more likely to use LIS if this service was available at MFP. Finally, some participants mentioned having video interpretation available for patients who are hearing impaired. Many providers also suggested having all their resources and handouts professionally translated into multiple languages. They mentioned that it would be beneficial for patients with LEP to take home and review. Many participants reported that there is already a folder of commonly used resources and health promotional materials, so this is something that could easily be implemented.

The main barrier for residents using professional interpretation services at MFP was the lack of awareness of these services. Almost all residents did not know the service existed or were unaware of how to access these services. Many of the physicians and residents provided insightful recommendations on how to mitigate these barriers. The main recommendation was to improve the education at MFP; participants suggested having formal training around how to access the service, as well as a refresher on using LIS. Some providers said it would be beneficial to have a teaching session or module that physicians and residents must sign off on. Many participants also recommended having posters with information on the service and a step-by-step guide on how to navigate it; they also mentioned it would be helpful to have this information on the online portal for all providers to access.

LIS Perception and Use: Contextual Factors

The perception and use of LIS were influenced by many different factors, including race/ethnicity, power dynamics, language, and previous experiences.

Race and Power Dynamics

Participants came from a variety of backgrounds, although most participants were Caucasian. The physicians and residents reflected on how their race may influence their perception and use of language interpretation services. Almost all participants expressed that they believed their race has an impact on their attitudes and behaviours related to LIS. However, there was a small number of participants who did not believe their race impacted their beliefs or behaviours. Participants from a Caucasian background recognized their privileged position growing up in English-speaking households and being White. They mentioned that they are not always aware of issues related to language interpretation because language is not something they think about daily. Many physicians and residents noted that they must do extra work to remain cognizant of this privilege and ensure they are not missing opportunities to provide translation services for patients with LEP. On the other hand, participants from non-White backgrounds expressed that they think about this topic a lot because it impacts their personal lives. Personal anecdotes were shared about family members with LEP who received suboptimal care due to the lack of translation services. Some participants even shared experiences of acting as a translator for family members and friends. This made these physicians and residents self-reportedly more passionate about this topic; many expressed thinking about their loved ones when dealing with patients who have LEP.

> "Yeah, absolutely. I think whenever you step into a room with a patient you – there is a power dynamic there where you have more power than they do. You're the one gatekeeping, tests, medications, access to care and I think there are different forces at play. Like for us we're trying to stay on time. We're trying to you know make sure we're checking the boxes and doing the things that the patient needs. Trying to maintain an agenda and then move onto the next patient in the next room. It does take longer to use interpretation services sometimes if you're actually trying to like find out what the patient needs and is trying to say versus like if you just are trying to kind of rush through the appointment quickly it would take a lot longer. I think that the power dynamic puts patients in a really vulnerable place where like patients are not going to advocate for themselves often. Like I've never had a patient ask, "Can you use a translator or can you call a translator?" I've never had them ask that and I don't think that they're going to be quick to advocate for themselves and ask you to use a translator." R1#8

Providers also expressed how power dynamics played a large role in the utilization of LIS. Many reported that there is an inherent power imbalance in the physician-patient relationship and that patients are often in a vulnerable position. A few physicians expressed how this dynamic is heightened as White male physicians caring for patients from marginalized backgrounds. It was widely shared that providers felt that patients are less likely to request translation services and advocate for themselves, request clarification, or raise complaints due to this power imbalance and the fear of being seen as difficult patients. The physicians and residents in this study were very aware of this dynamic and recognized that they played a crucial role in initiating the use of LIS for patients who need it. Due to this power dynamic, many participants reported that it was easy for them to rush through visits in the interest of their time without ensuring their patients fully understood everything. However, they were aware of this inherent bias and continue to work on ensuring patients receive high-quality care. As such, there was a consensus that patients should not be expected to request LIS, and providers have an obligation to recognize this need and implement these services to optimize communication and provide high-quality care. One physician even recommended providing education about the professional translation service offered at MFP for patients in order to empower them to request these services when they feel it is necessary.

Language

Language was another factor influencing providers' perception and use of LIS that was expressed by many participants. One resident was able to converse casually in a second language but was not confident in their ability to translate medical interactions. However, this resident stated they were less likely to use LIS if the patient spoke their native language despite their limited proficiency in their second language. They stated that when it came to their native language, they were able to weigh whether the patient's reason for their visit was complex enough to require professional interpretation. If the patient were coming in for a rather simple complaint, the resident would rely on their limited proficiency in the language to get through the visit. This resident explained their thought process through this quote. The resident's spoken languages are redacted to protect their identity:

> "I speak a tiny bit of [redacted], very, very little. Definitely not enough to practice medicine. But enough to get by where if somebody – if I asked questions in English and they replied in [redacted], I would understand. I wouldn't jump so quick to a translation service, I would kind of rely on my own abilities. Which personally now that I'm saying it out loud, I think is a bad thing [laughs]. I don't think I should be doing that. But I draw a line. Like I know where the line is. If it's something that's kind of very minor issues, very

> minor and they are able to speak a little bit of English to supplement, then I'm not worried about it." R1#11

There was another resident who spoke fluently in their native language; this resident expressed that they did not require LIS for interactions where they spoke the same language as the patient. In these cases, they were able to communicate effectively, and they expressed that their medical knowledge gave them an advantage as an interpreter. They added that they were also able to understand cultural nuances that would otherwise be lost in translation; all this resulted in better trust and rapport and the patient feeling more comfortable. Finally, if there was another staff member who spoke the same language as a patient, some physicians would opt to use that provider as a translator over using LIS. One physician stated that they exclusively use a colleague as a translator for all of their patients who speak Arabic. They expressed that they trusted their colleague more than professional interpreters and felt more comfortable relying on them.

Previous Experiences

The previous experiences of physicians and residents significantly shaped their perception and use of LIS. Many providers cited positive reinforcement regarding the effectiveness of LIS based on their experiences. One physician stated they had a positive experience with setting up the professional interpretation service as well as the interaction with the interpreter and the patient. They emphasized that this positive experience reinforced their willingness to continue to use professional LIS, highlighting its role in achieving healthcare goals effectively. Many participants also expressed that using professional LIS allows them to navigate discussions they otherwise would not be able to; they expressed gratitude for these services, as well as more willingness to use them. Many providers also felt that when using professional translators, their patients were more comfortable and trusting. This, combined with negative experiences of using family members as translators, was an enabling factor in positive perceptions and use of LIS. In addition, residents who worked in more culturally diverse areas or had experiences working with marginalized groups, such as refugees, thought that these experiences made them more aware of how important translation services are, as well as understanding the risks of not using LIS.

However, several physicians and residents had negative experiences using professional LIS, and this greatly affected their perception of these services. One physician heard many negative experiences using the LIS at MFP from other physicians. This included issues with translation quality and professionalism. This physician stated that after hearing these experiences, they did not want to involve a professional interpreter and risk their visits becoming more complex. Similarly, providers who had experienced negative encounters with LIS themselves stated that this affected their perceived usefulness of these services. They also cited that this, combined with their positive success in using family members as translators, meant they were less likely to involve professional interpreters. These participants recognized that professional interpretation was far superior to ad hoc interpretation; however, they felt that using family members worked best for them. In addition, some residents stated that their lack of knowledge on the issue affected how often they involved these services. In these cases, not having previous experiences using LIS regularly meant that they were less likely to use these services. Overall, previous experiences were a significant factor influencing the perception and use of LIS. Positive encounters with these services reinforced positive perceptions and behaviours that facilitated the continued use of LIS. On the opposite spectrum, negative experiences or exposure to other's negative encounters resulted in a negative perception of LIS and a higher likelihood of relying on ad hoc interpretation services. Despite knowing the risks of informal interpretation, many physicians and residents felt this was a better option than dealing with the perceived challenges of LIS.

> “So when you’re hearing a lot of people have a negative outcome from it. I don’t want these complex visits to become more complex because of somebody else’s opinion or somebody non-medical coming in there and giving their opinion about things. That makes me feel very wary about, you know, patient privacy stuff and just about the patient’s comfort level. Like is the patient

> perceiving that I'm making these recommendations, or do they understand it's coming from the translator? Like that makes me feel very uncomfortable about accessing those services." P#12

Teaching and Learning Practices

Almost all participants expressed that education around this topic is lacking significantly. Many physicians and residents felt their medical education did not prepare them to use LIS in their practice. They indicated that they did not have any formal education in medical school and were expected to use these services in their practice. Most residents were positive they received no formal education on this topic, including its importance for patient safety, how to use the services and the risks of not using them. However, some residents vaguely recalled having some education about language barriers in communication and how using family members as interpreters was not ideal. Most residents indicated that all their learning about LIS was highly dependent on their rotations and the populations and LIS they were exposed to. Likewise, most physicians did not recall any formal education prior to their practice. However, some participants felt that their medical education prepared them to use LIS by teaching them to be compassionate and conscientious providers. They shed light on how their medical education taught them to focus on delivering patient-centred care, thus indirectly teaching them to commit to using LIS in their practice. One resident recalled having a simulation in their medical school where a simulated patient with LEP presented with their son, and students had to work through using translation services.

> "I don't know that we had formal teaching during medical school about using interpretation services. We did have lots of training on effective communication with patients. Oh, actually, we might have had a session about language barriers and using – like I recall something vaguely about using – how not to use family members for interpreting. It's like vaguely ringing a bell

> but we did have lots of sessions on what it means to effectively communicate with the patients…" R2#5

Considering the main barrier for residents to using LIS was lack of awareness, it was no surprise that almost all the residents interviewed did not remember receiving education by MFP on this topic. There was a common sentiment of receiving an abundance of information all at once during orientation, making it hard to retain information. A few residents spoke about hearing about the services available briefly in team huddles; however, they mentioned there was nowhere near enough information for them to use the service confidently. Similarly, most physicians also reported that they did not receive formal education about LIS prior to the implementation of ITS Hamilton. One physician recalled being informed that the new service was available and how to request it but noted there was no information on how to properly conduct a translated interview.

Most physicians also shared that they felt they were not formally incorporating teaching around this topic with their learners. Some physicians stated they asked learners how a visit went with a patient using an informal translator, but that was the extent of the discussion. Physicians reported common errors with learners using informal translators, such as speaking too fast, speaking directly to the interpreter, and not providing effective summaries. However, most physicians were incorporating very little teaching around this topic, if at all. In fact, a few physicians shared they instinctually do not give their residents patients with LEP because they don't believe they can handle adding the extra step of using translation. Many physicians expressed a sentiment of feeling like they were still learning how to best use LIS, thus making them feel like they weren't ready to teach learners about it. Most physicians also felt that residents were not prepared to use translation services in their practice. One physician stated that many residents stated that patients with LEP were poor historians when collecting information without using any translation services. This physician expressed that there was a large learning gap where residents blamed a sub-par assessment on a patient's ability to provide information despite the access to professional interpretation services. Almost all residents also reported that they weren't receiving any teaching from their preceptors on this topic outside of on-the-fly debriefing after visits with patients with LEP. They felt that the best way for them to learn about this topic was by exposure and learning as you go. This quote by a resident demonstrates the importance of preceptors incorporating LIS into their teaching practice:

> "… there's no way really for me to prepare [for patients who have LEP] unless a supervisor explicitly tells me so. So, I don't think I'd use it [ITS Hamilton] very much and it's probably why I don't really know about it because I would never use it. I have no idea. I just assume everybody's going to be able to speak English and if not, they'll bring somebody who can. Which I know is not good practice, but so far so good on my end [laughs]." R1#11

This quote demonstrates how institutions and preceptors' lack of education can result in residents not only underutilizing LIS but also not recognizing its importance and the potential consequences of miscommunication.

Recommendations for Learning

Most participants felt there was a significant gap in medical education around this topic, including continuing education. Participants were able to offer tangible recommendations for improving learning around the use of LIS. They recommended formal education in medical schools, including incorporating it into clinical skills. The main teaching method that was recommended was simulations with patient actors, as well as incorporating interpreters into OSCE stations. They noted that formal assessments on this topic needed to be conducted, and they could easily be combined with other skills in formative assessments. They also recommended increasing exposure to different forms of LIS in residency and tracking progress through a competency checklist. A few physicians and residents also suggested self-learning as a method of teaching; they mentioned that residents should identify their own learning gaps and take steps to address those gaps. In terms of LIS, this would mean recognizing that they are struggling with using LIS in their practice and working with their preceptors to create learning opportunities.

> "I don't know if I ever had any formal training on using an interpreter in medical school or in residency… they would say that the patient speaks this language and has difficulty with English, they would say, oh, use an interpreter, and that would be kind of the extent of it. So there is a recognition that interpretation is important, but I didn't receive any information on how to access an interpreter, what policies different clinics or hospital settings have in place ...so I'm always kind of scrambling to figure out, and because our rotations are in so many places… aside from just like booking and accessing interpretation, like we don't, I think there should be kind of some formal teaching on like how to actually effectively work with an interpreter. So like looking at the patient, for example, is something that I heard from some of the doctors that I worked with specifically in refugee and newcomer health settings… so like medical students and residents who didn't do those rotations wouldn't have heard that information." R2#10

This resident's quote demonstrates the need for a standard curriculum that focuses on language barriers in medical education. When clinical rotations are relied on for learning, there is a mismatch between which residents are exposed to what information. This was a common theme among residents in this study. Integrating a standard curriculum would ensure that all physicians receive the same learning experience.

When it comes to teaching at MFP, all participants agreed that there needs to be continuing education around this topic, especially when a new service is being rolled out. They suggested having a half-day topic dedicated to LIS, including teaching about how to effectively use a professional interpreter, the risks of using ad-hoc interpretation, and information about ITS Hamilton and how to access it. They also suggested making information about this service more accessible, such as posting it in the online portal for all physicians and residents. A few physicians and residents also suggested having a module with sign-off required for all physicians and residents. One physician also recommended having a focus group of patients at MFP and getting more insight into how patients feel about the use of translation services. They felt that disseminating this information could discourage physicians and residents from over-relying on ad-hoc interpretation if patients preferred professional interpretation.

A few participants also suggested having more education leaders from diverse backgrounds. They stated how having predominantly white, English-speaking people leading education can result in blind spots when it comes to topics such as language interpretation.

Health Advocacy

The last finding in this study focuses on health advocacy and social accountability. In this study, physicians were asked probing questions to ascertain all the different ways they use LIS in their practice, including how they advocate with patients with LEP. This information was then compared with the competencies of health advocacy.

Advocacy at the individual level

Almost all the physicians and residents demonstrated most of the key competencies under responding to an individual patient's health needs. The main way participants demonstrated this was by engaging in disease prevention, health promotion, and health surveillance. They recognized the importance of these activities in improving patient health outcomes and actively incorporated them into their clinical practice while using LIS. Providers were comfortable using LIS in chronic disease and medication management, preventative screening, nutrition coaching, and other similar activities. Health promotion activities, such as smoking cessation programs, exercise counselling, and vaccination campaigns, were also enhanced using LIS. Providers noted that using professional interpreters helped them deliver these interventions more effectively, ensuring that patients with LEP fully understood the benefits and were more likely to engage in these activities. This comprehensive approach to health promotion is a crucial aspect of health advocacy, emphasizing the provider's role in encouraging healthy behaviours and preventing illness. When participants used the word ‘advocate,’ it was always in relation to these activities in which they felt they were using LIS to advocate for their patients.

However, the study also revealed significant gaps in the participants' ability to address determinants of health and barriers to care at the individual level. It is well known that language barriers are one of the main issues affecting a patient’s access to care. By not using professional LIS, providers are unable to address these barriers. For example, most participants expressed concerns about not being able to address sensitive topics with the patient due to family presence as translators. One participant gave an example of not being able to ask questions about domestic violence with the patient’s husband present translating. This example illustrates how not using professional LIS inhibits physicians from being able to advocate with their patients, even at the individual level, thereby compromising their ability to provide comprehensive care. There were numerous other examples where participants demonstrated a lack of advocacy related to patients with LEP at the individual level. Another physician illustrated an example where they referred the patient to a specialist. After waiting months, the patient did not show up for their appointment and the referral had to be made again. It was at that time that the physician realized the patient was not able to understand the letter outlining the appointment that was sent by the specialist. By not using professional LIS, physicians and residents are failing to address the upstream issues that directly affect their patients’ health. The CanMEDS framework specifies that even at the individual level, physicians are expected to advocate with patients within and beyond the clinical environment (Shaw et al., 2017). However, physicians and residents were only advocating with patients within the clinical environment.

Advocacy beyond the individual level

It became evident that providers were not demonstrating advocacy competencies beyond the individual level. While almost all participants recognized the need for better access to LIS and questioned why these services were not more readily available, they simply accepted this as a significant issue affecting their practice without taking further steps to address it. Participants expressed frustration with the current state of LIS availability but did not actively engage in efforts to improve this issue. Physicians and residents did not acknowledge the social responsibility they have to address these issues on a community level and, even further, a systems level. One participant expressed this by saying:

> “But I think just the fact that people don’t consider solutions more and that they just accept that this is a problem, and it’s our – and now this has become my problem. My patient doesn’t speak my language – now it’s just – it feels crazy to me that it gets brushed aside, and people still, as a result, inadvertently get treated as second-class citizens. They don’t have the same access to the healthcare system that everyone is supposed to have, and that is biased, top-to-bottom.” P#14

This quotation perfectly describes this phenomenon, where physicians and residents lack many aspects of social accountability and health advocacy, which are key competencies of family physicians. Similarly, many physicians were able to recognize and address a patient’s social determinants of health. However, no participants described any efforts to address these issues on a community level and, in turn, improve their patients’ health.

Many participants also brought up opportunities for advocacy at a systems level. For example, a few residents suggested that people from diverse backgrounds need to be given powerful positions in healthcare, education, and policy. They explained how individuals from diverse backgrounds will have more insight into issues that directly affect marginalized groups. Another physician brainstormed ways to change funding and billing, such as providing a stipend amount of money for physicians to use only for translation services. These findings show that the issue is not that physicians and residents were not thinking about the systems-level issues that affect their patients. Most participants were cognizant of the structural and institutionalized inequalities that affect marginalized populations. Furthermore, they were able to brainstorm ways to change these inequalities at the macro level. However, it’s the next step of putting those thoughts into action that signifies the true essence of health advocacy.

CHAPTER SIX: DISCUSSION

Overview of Chapter

This chapter discusses the key findings of this study and themes that evolved from the data. We will discuss its implications for education, research, clinical practice, and policy. These findings will be discussed in relation to what is currently known in the literature. Finally, this chapter concludes by discussing the strengths and limitations of this study as well as areas for future research.

Key Findings

This study shed light on many key findings regarding the use of LIS in family medicine. The major findings reveal that physicians and learners utilize a variety of LIS, primarily relying on informal methods such as family members, Google Translate, and bilingual providers. It also sheds light on the fact that there are many instances where providers use no translation at all and rely on other methods to communicate with patients who have LEP. In addition, participant interviews revealed the various ways in which physicians and residents utilize LIS, such as understanding patients' health needs as well as engaging in disease prevention and health promotion. A second finding is that there are several barriers that hinder the use of LIS, including time constraints, organizational issues, and concerns about translation accuracy. Participants were able to provide insightful strategies to overcome these, including flagging patients with LEP and automatically booking a translator, as well as booking extra time for these patients. Next, the interviews revealed various contextual factors that influenced providers' perceptions and utilization of LIS. Race, power dynamics, language, and previous experiences all affected how participants viewed LIS and how likely they were to use the services. Our findings uncovered the teaching and learning practices of physicians and residents related to LIS. Almost all participants reported that they did not receive formal medical education on language interpretation use in practice. They also did not receive any education prior to the implementation of ITS Hamilton at MFP. Furthermore, teaching and learning practices around this topic were not commonplace in practice at MFP, whether it was between preceptors and learners or self-learning practices. Participants unanimously agreed that education and training in this area need to be improved and recommended various activities to improve this. Finally, providers were only advocating with their patients at the individual level; the full scope of advocacy at this level was inhibited when providers did not use professional LIS and relied on informal translation. Furthermore, providers were not advocating with patients at the community or systems levels and did not recognize their social accountability to drive change in this area.

Getting By

The theme of 'getting by' was prominent in this study. 'Getting by' refers to the physicians and residents choosing not to use professional interpreters and opting to use ad hoc interpretation, such as family members, Google Translate, and bilingual staff interpreters. In some cases, providers will also use no interpretation at all and use slow speech or few-word sentences, gestures, pictures, or other non-verbal communication methods. In these scenarios, providers relied solely on these non-verbal communication methods and the patient's LEP. This was a common occurrence among participants and highlights the pragmatic yet risky strategies that physicians and residents often resort to when faced with barriers to accessing LIS in primary care. This concept of getting by is evident in the literature, citing consistent underutilization of professional interpreters in practice (Diamond et al., 2009; Hseih, 2014; MacFarlane et al., 2020; Parsons et al., 2014). Parsons et al. (2014) examined physicians in Toronto's decision-making process for deciding whether to 'get by' without translation service or 'get help.' This phenomenon is well understood, and unsurprisingly, some participants even used the words 'get by' to describe their decision to move forward without appropriate LIS. This is evident in the following quotes:

> "…I sort of just like get by with the English that they have. I know there are options to use you know more formal interpretation services at MFP…I have used like the more formal like language line and such in other settings, at hospital settings mainly, but yeah, not something that I've needed yet at MFP."
>
> R1#4

> "I think my main thing is that it would just be nice if it was more streamlined so that every time we could have formal translation…and so I think that's maybe part – maybe that's something I didn't touch on was there are times where I will think to myself like do we need to bring in a formal translator or do we think we can get by if the family and the patient are OK with translating."
>
> P#9

Rationale for 'Getting by'

Participants frequently cited time constraints and the lack of a streamlined process for arranging LIS as primary reasons for getting by. The lack of translator availability for urgent visits combined with time constraints and the administrative burden of booking interpreters led providers to make quick, albeit suboptimal, decisions about communication methods. Participants reported being more likely to 'get by' rather than reschedule with an interpreter if the patient presented with a straightforward complaint. In these cases, they were more likely to rely on family members or the patient's LEP. However, there were still examples where patients presented with serious complaints, and LIS were not used. One resident recounted an example where a patient with LEP did not understand the resident's questions during a health history. The resident decided to move on to the physical exam, where they found the patient had critically elevated blood pressure. The resident and staff physician then decided to send the patient to the hospital. In this situation, despite the urgency and fast-changing situation, both the resident and physician relied on physical findings and did not use LIS. In contrast, participants were more likely to use professional LIS for patients presenting with mental health concerns, as they found family members affected the patient's ability to speak freely by tainting the visit with their opinions and biases. This may be due to the subjective nature of the presenting complaint and the inability to rely on objective data. Almost all physicians and residents reported at least one example of relying on a patient's LEP where no translation was available, including family members. In these cases, they were almost always over-investigating and relying on objective data rather than subjective data.

This nuanced decision-making process mirrors findings from Parsons et al. (2014), who examined how physicians in Toronto decide whether to "get by" or "get help" with translation services.

Risks and Consequences of 'Getting By'

Despite the perceived short-term efficiency of 'getting by,' providers were cognizant of the significant risks it carries. Several physicians and residents shared anecdotes illustrating the pitfalls of not using professional LIS. They cited examples where they felt communication was incomplete and inaccurate; however, they felt like they had no other option but to rely on patients' limited working English. Even when using Google Translate, family members, or non-verbal communication methods, participants felt like they had to over-investigate to compensate for their lack of confidence in the subjective data. These sentiments were not expressed when using professional interpreters, despite providers expressing a small sliver of doubt in these encounters. One participant reported relying on physical assessment, which sometimes means downplaying the patient's concerns or over-investigating. They recognized that downplaying carries the risk of missing important information and, therefore, missing a more urgent, critical health issue. Participants also expressed that their previous experiences with professional interpreters positively affected their perceived importance of using these services. They noted that they realized that patients were more satisfied when professional interpreters were used, and communication was more seamless. Knowing this, they acknowledged that their lack of interpreter use has great impacts on patient care and patient satisfaction. This aligns with the literature indicating that professional interpretation improves patient satisfaction and reduces medical errors (Karliner et al., 2007). Conversely, participants reported that relying on ad hoc methods often compromised patient privacy and confidentiality, particularly when discussing sensitive health issues, which is consistent with findings from Flores et al. (2003).

Provider discomfort and ethical concerns

The theme of provider discomfort and ethical concerns was a significant issue in this study. It highlights the moral dilemmas and emotional strain that healthcare providers experience when ‘getting by’ without translation services. Participants described feeling uneasy and ethically compromised when they had to rely on ad hoc methods; one participant described a sinking feeling any time they had to continue through an encounter without the appropriate LIS. A feeling of cognitive dissonance was omnipresent in participants' experiences, where their actions were not aligning with their values as a physician or resident and their commitment to providing equitable and high-quality care. Healthcare providers view themselves as advocates for their patients' health and are responsible for ensuring that patients understand their medical conditions and treatment options. When providers are unable to fulfill this role due to language barriers, their professional identity and self-efficacy are challenged. This internal conflict can lead to frustration and moral distress, as providers feel they are not meeting their professional obligations.

One physician gave an example of a patient who came with a family member and required a gynecological assessment. The family member had to step out, and the physician had no choice but to complete the assessment without translation. This physician felt discomfort not being able to explain each step of the assessment to the patient, a practice they normally do with all their patients during sensitive assessments. Similarly, there were many other examples of participants reporting a sense of discomfort that they weren’t addressing sensitive topics with the patient due to the limitations of using family members as translators. They felt that they were doing their patients a disservice by not addressing all aspects of their health, something they normally do with English-speaking patients. Such scenarios are not uncommon in the literature. Diamond et al. (2009) and Hsieh (2014) report that providers often feel caught between their duty to deliver high-quality care and the practical limitations they face. This tension leads to significant emotional strain, as providers are aware that inadequate communication can compromise patient care and autonomy. Some physicians reported feeling ‘stuck’ when patients who clearly have LEP don’t consent to using LIS. Providers report feeling an intense feeling of discomfort because the patient is clearly not understanding the health information and not following health recommendations. However, they are not able to involve an interpreter without the patient's consent. Finally, many physicians and residents expressed a sense of frustration and discomfort at the fact that having adequate LIS was something they have to fight for. They expressed how it was saddening that these services weren't ingrained in every aspect of health care, considering a large portion of Canadians don't speak English. There was a sense of discomfort realizing that they were perpetuating inequalities in healthcare by not consistently using LIS due to the barriers and limitations they faced.

Efforts to Mitigate 'Getting By'

Participants in this study suggested several actionable strategies to reduce reliance on ad hoc interpretation. The study also points to the need for more organizational support and training for physicians caring for patients with LEP. Providers highlighted the need for streamlining processes, time allocation, training, and awareness. Simplifying the process of booking interpreters and integrating LIS into electronic health record systems could reduce barriers to use. This would ensure that interpreters are available when needed without placing additional administrative burdens on healthcare providers. Having various forms of interpretation also solves the issue of having to pre-book professional interpreters. For example, having 24/7 phone interpretation available allows providers to use these services for urgent visits, as well as providing results over the phone. This recommendation aligns with findings from Karliner et al. (2007), who suggested that integrating interpreter services into routine clinical workflows can facilitate their use. By simplifying access to LIS and incorporating them into everyday clinical practice, healthcare organizations can create an environment that supports the consistent use of professional interpreters. The study findings also shed light on the importance of involving multiple stakeholders when implementing new services in practice. The lack of utilization of ITS Hamilton among physicians and residents and the presence of so many barriers suggests that physicians and residents were not consulted before implementing this service. However, the solution is not as simple as increasing the use of LIS. Even when physicians and residents were prepared to use professional LIS, there were instances where the patient did not consent to use these services, thus forcing providers to continue the visit without LIS even when they perceived its necessity. When increasing the use of LIS, a multifaceted approach is required, targeting organizational support, provider and patient education, and policy development.

This study also highlights the importance of training and awareness in increasing the utilization of interpretation services. Most participants reported feeling unprepared by their medical education to use LIS in practice. Many physicians felt they still needed to learn how to use the services before they could incorporate it into their teaching practice with residents. Similarly, residents felt unprepared, which added to their discomfort during interactions with patients who have LEP. More importantly, a surprising yet concerning finding of this study was that not a single resident interviewed used the professional interpretation service available to them. Many residents expressed a concerning attitude towards LIS, such as expressing it would be “pretty frustrating to bring in an interpreter for 10 minutes of conversation where we might not get very far” R1#7” or that “things are easier and faster when you don’t understand what somebody is saying. R1#7” This points to an underlying issue: the lack of perceived importance of LIS, which can only be improved with education and by increasing social accountability among physicians and residents. Incorporating more training at an organizational level and, more importantly, formal education in the medical education curriculum is vital for equipping providers with the necessary knowledge and skills to use LIS. Providing formal training on the significance and use of LIS can shift attitudes and improve utilization rates. Similarly, by addressing the barriers to using LIS, healthcare providers can better advocate for their patients' health needs, ensuring equitable access to quality care. This involves recognizing the impact of language barriers on patient outcomes and taking proactive steps to overcome these barriers through effective communication strategies.

The theme of "getting by" without professional interpretation services highlights significant challenges in primary care. Despite recognizing the importance of professional LIS, physicians and residents often rely on ad hoc interpreters due to time constraints and organizational challenges. This approach, while pragmatic, carries substantial risks, including incomplete communication, misdiagnoses, compromised patient privacy, and ethical dilemmas. Addressing these barriers through systemic changes can support the consistent use of professional interpreters, improving patient safety, satisfaction, and overall care quality. By enhancing LIS utilization, healthcare providers can uphold their professional and ethical standards, advocate effectively for their patients, ensure equitable access to healthcare for all, and feel more fulfilled and satisfied with the care they provide.

Distance from Patient

Another theme that evolved from the data was a sense of distance from the patient. This perceived distance stemmed from the inherent distance created when involving a third party to act as a translator between the provider and the patient. Even when providers are employing strategies to promote rapport when using LIS, such as talking directly to the patient, there is still a sense of distance when information is filtered through a translator. Whether this translator is a professional translator, bilingual staff member, family member, or even a phone, providers felt distanced from patients who have LEP. This feeling was compounded by doubts in translation quality, complex power dynamics, and challenges in non-verbal communication. This distance encompasses the physical distance of having a translator present, as well as the emotional and hierarchical distances involved.

Inherent doubts in translation

Despite the recognized importance of professional LIS, many participants expressed ongoing skepticism about the completeness and accuracy of interpreted communication. This skepticism often stems from previous experiences where translations were incomplete or altered. For example, respondents noted instances where family members, acting as ad hoc interpreters, filtered or modified the patient's responses, leading to potential miscommunications. Even with professional interpreters, there remains a concern that nuances and medical terminologies might not be fully conveyed. This inherent doubt can lead to a persistent feeling of uncertainty, causing providers to question whether the patient truly understands the medical advice and whether the patient's concerns and symptoms are being accurately conveyed.

This skepticism is supported by the literature, where Hsieh (2014) found that providers often doubted the accuracy of translations, leading to compromised patient care. Many studies highlight issues with translation accuracy with professional and ad hoc interpretation, citing lower accuracy with ad hoc translation (Nápoles et al., 2015). Most of these errors include omission, answering for the patient or substituting words/sentences; these mirror the concerns of physicians and residents in this study (Nápoles et al., 2015). Providers' lack of confidence in the reliability of LIS can impact their perceived ability to communicate effectively with patients. When physicians and residents doubt the accuracy of translations, it undermines their confidence in the overall interaction, contributing to a sense of professional inadequacy and emotional distance from the patient. Even when using a trained interpreter demonstrating strong skills, many providers report that there will always be a sliver of doubt in the translation. Some participants gave examples of patients giving long answers to a question that was seemingly summarized by the professional translator. Not knowing what information, if any, was filtered out or changed seemed to contribute to this feeling of doubt. This is supported by bilingual physicians and residents reporting feeling more connected to their patients when they are speaking in their native language. Many physicians and residents reported that when they spoke the same language as their patients, their patients were happier, more comfortable, open, and overall appreciative. This supports the idea that using an interpreter inherently causes a level of distance between the patient and provider; this distance is worsened when communication is compromised by inaccurate interpretation.

Impact of Power Dynamics

Power dynamics are inherent in the physician-patient relationship; however, this dynamic is further complicated by language barriers. Physicians hold significant authority in medical settings, which can create a power imbalance for patients, especially when there is a significant language barrier. Patients hold less authority, are in an unfamiliar setting, and have significantly less medical knowledge than their physicians. Patients are also less likely to ask for clarification or admit that they did not understand the information that was presented to them. This dynamic results in patients feeling disempowered and makes them less likely to request interpretation services, even when it is required. This further widens the gap between patients and their healthcare providers. This is consistent with findings from Diamond et al. (2009), who reported that language barriers exacerbate existing power imbalances, making effective communication and relationship-building more difficult. In this study, resident physicians normalized the underuse of LIS and perpetuated inequalities in the healthcare system, which caused them moral distress. Similar findings were present among participants who were interviewed. Most participants felt that this power imbalance affected their perception and use of interpretation services; they reported feeling less likely to use professional LIS since the patient didn't request it. One respondent explained the presence of this power dynamic by saying,

> "The power dynamic that exists between physician and patient is heightened when the patient doesn't speak English. It creates an added level of distance and a feeling like 'Oh, I'm an outsider.'" R2#10

This quote highlights how the power imbalances present in healthcare are exacerbated when language barriers are present. This furthers the distance between the provider and patient and has many consequences.

Emotional Distance

Another factor contributing to the feeling of distance from the patient is the inability to understand non-verbal cues and emotions through translation. One concern that providers cited in their interviews was how LIS can disrupt communication, especially when trying to understand non-verbal cues, which are very important in knowing the whole patient. The interruptions and delays inherent in using interpretation services can hinder the natural flow of conversation, making it harder to build rapport and trust with patients. Similarly, participants reported frustration with not being able to understand cultural nuances that are lost in translation. This can lead to a sense of emotional distance, where the provider feels disconnected from the patient’s experiences and concerns. Interpreters may come from a different culture than the patient or not be equipped to convey cultural nuances. Furthermore, some physicians and residents state they prefer that their interpreters translate strictly verbatim, bringing up the debate regarding the interpreter's role.

The added pressures related to using LIS, combined with time constraints, can make providers overwhelmed; this creates an environment where physicians and residents prioritize the patient’s physical needs over their emotional needs. Participants in the study were more goal-oriented when discussing their sense of success related to patients with LEP. They felt an interaction was successful based on whether they achieved their agenda as a physician. They also used this line of thinking to justify their use of informal interpretation, stating that it allowed them to meet their goals. Hseih (2014) found similar findings where providers' relationships with interpreters were directly related to their ability to help them achieve particular objectives. One physician in this study noted that he gauged the success of an encounter based on whether the patient accepted his diagnosis or not.

There is also an emotional toll on providers using translation services in their practice. With family physicians already functioning at such a high capacity, the added cognitive load and effort it takes to arrange and use interpreters can lead to burnout. Providers have to spend more time and work harder to ensure that their communication is clear and accurate, and that the patient understands the information they’re conveying. When providers are burnt out, it may affect the ways they interact with their patients unknowingly, leading to further emotional distance. This sentiment is also present in the literature, where studies have found that physicians often report frustration when caring for patients who have LEP through translation services (Gadon et al., 2007). There is also an emotional toll on bilingual staff providers who provide interpretation services. One physician reported regularly using a bilingual staff member over professional LIS. By doing this, more workload and burden are placed on this provider, as they are providing extra services in addition to their regular, expected work. The negative emotions that may arise from arranging and using LIS can negatively affect providers' perceptions and use of these services.

The theme of "distance from patient" underscores the complex interplay of communication barriers, power dynamics, non-verbal communication, cultural nuances, and the emotional toll on healthcare providers. While LIS is essential for overcoming language barriers, they can inadvertently create emotional and relational gaps between providers and patients. Addressing these issues requires a multifaceted approach that includes improving the training and availability of professional LIS, enhancing cultural competency among healthcare providers, and developing strategies to mitigate the inherent power imbalances in physician-patient interactions. By doing so, healthcare providers can foster more meaningful and effective patient interactions, ultimately improving care outcomes and patient satisfaction.

Lost Voice

The theme of 'lost voice' was a very interesting theme in this study. This theme refers to when patients or physicians feel unable to communicate effectively or where their concerns and perspectives are not adequately heard or addressed. This phenomenon can have significant implications for patient care and health outcomes, as well as physician stress and burnout. There were many examples where both patients and physicians experienced a lost voice, particularly in settings where language barriers and inadequate communication support systems were prevalent.

Lost voice of the patient

Patients with LEP often experience a lost voice in healthcare settings, especially when appropriate LIS are not used. When language barriers prevent effective communication, these patients struggle to convey their concerns to their healthcare providers. In these cases, there is an extreme loss of the patient's voice, where patients and providers resort to using simple English, gestures, drawings, and other forms of non-verbal communication. Participants in the study explained that for 'straight-forward,' simple visits, they were far less likely to use appropriate LIS. Even when ad hoc interpretation is used, there is still a loss of the patient's voice. In extreme cases, many participants encountered scenarios where the family member would completely speak for the patient without even relaying what the physician or resident was asking. Again, like situations where no interpretation is used, the patients in these situations are unable to communicate with their providers and are effectively voiceless. In less extreme cases, participants recounted numerous scenarios where the patient's family members filter what the provider or patient is saying or inject their own opinion. In these situations, there is a partial loss of the patient's voice, where they can communicate, but their words are being altered.

Participants gave many examples of this dynamic, where patients were unable to clarify misunderstandings due to others speaking on their behalf. One participant gave an example of a patient who presented with breathing complaints. The resident explained that the patient had a recent cardiac diagnosis, so they were focusing on cardiac symptoms. The patient's son said that they were checking the patient's vital signs at home, and everything was normal. The son expressed concerns regarding the patient's anxiety and questioned whether this may be related to that. The resident explained that this changed the plan of care, and they started to investigate that avenue rather than the cardiac symptoms. In this example, the patient is voiceless and is unable to clear up any misunderstandings or communicate their concerns. Although this is not always the case, family members speaking for patients can change the patient's plan of care and may result in misdiagnoses or missing serious symptoms. The literature supports this, with Karliner et al. (2007) suggesting that patients with LEP often feel less empowered in clinical settings, which can adversely affect their engagement and outcomes. This power dynamic can create an atmosphere of compliance rather than collaboration, where the patient's voice is diminished.

Unfortunately, this issue is not unique to just ad hoc interpretation. A few participants had repeated experiences where professional interpreters were injecting their opinions into their translation, giving personal advice, or inferring the meaning behind the patient's words. This practice can undermine the very purpose of using a professional interpreter and still subject the patient to a significant loss of voice, potentially leading to feelings of disempowerment and compromised care. This can also undermine the provider's trust in the integrity of interpretation services, which was a repeated concern among participants. Many physicians stated they choose not to use ITS Hamilton because they have heard negative experiences of interpreters speaking for the patient or being unprofessional. This brings up the question about the role of the interpreter, which some participants alluded to. There was no consensus among participants who spoke about this topic; some thought that the role of the interpreter was to strictly translate verbatim, and others believed there was a place for the interpreter to provide extra information, such as cultural nuances. Ansari et al. (2009) explored the concept of bilingual advocacy, where interpreters provided translation services alongside advocacy services. These bilingual advocates can provide insights into cultural, religious, or social backgrounds and can advocate for the patient by giving them a voice.

Loss of provider voice

There is also a loss of provider voice when using LIS. Physicians and residents may find themselves feeling voiceless and disempowered when they cannot communicate directly with their patients due to language barriers. The inherent process of using an interpreter contributes to a feeling of diminished voice, where the provider's words are filtered through an interpreter. Using a professional interpreter can help mitigate this when the provider's words are translated verbatim to the patient. However, when using ad hoc interpreters or when professional interpreters do not translate strictly verbatim, effective communication is compromised. This further contributes to a feeling of voicelessness and can undermine the provider's ability to provide competent care. One physician recounted a scenario where a patient's daughter was upset with the patient. While translating the physician's words, the daughter was expressing frustration and anger towards the patient. The physician recounted feeling uneasy and worried that the patient may believe that the physician was upset with the patient rather than the daughter. Not being able to clarify misunderstandings or doubts can further the feeling of disempowerment. Situations like these can sabotage the physician-patient relationship, highlighting how clear communication is vital between both parties.

Another aspect of the loss of provider voice relates to health advocacy and speaking up. In this study, physicians and residents expressed numerous concerns with the current process of involving LIS in their practice. They expressed concerns about insufficient time, administrative burdens, and lack of resources related to the use of LIS. This directly hindered their ability and willingness to use these services and ultimately affected the care they provided. Providers expressed feelings of frustration when using ad hoc interpretation, knowing that it is not the standard of care. Providers often felt that they had limited options and support when it came to improving communication with LEP patients. However, there seemed to be a sentiment of voicelessness, where physicians and residents did not feel empowered to voice their concerns. This lack of empowerment can stem from various factors, including hierarchical dynamics within healthcare institutions, fear of repercussions, and a sense of futility in effecting change. Providers may feel that their role does not include advocacy for systemic change, or they may perceive that their work environment does not support or value such advocacy.

The theme of 'lost voice' highlights critical communication challenges faced by both patients and providers when language barriers are present. Patients with LEP often struggle to convey their concerns effectively, leading to compromised care and a sense of disempowerment. Providers, on the other hand, experience their own form of voicelessness as they navigate the complexities of using language interpretation services. These communication barriers can exacerbate existing power dynamics, increase provider stress and burnout, and ultimately affect patient outcomes. Addressing these issues requires a multifaceted approach that includes enhancing the availability and quality of interpretation services, fostering a supportive environment for both patients and providers, and promoting effective communication strategies to bridge the gap created by language barriers.

Health Advocacy

Family physicians are pillars in the healthcare system and play an integral role in improving the health and well-being of their patients, communities, and the broader populations they serve. Family physicians hold a position of authority and privilege; the CanMEDS-FM 2017 framework outlines the social accountability of family physicians to engage in advocacy at all levels: individual, community, and systems levels. The framework emphasizes that family physicians are accountable to society and must contribute to efforts to improve health outcomes by advocating for their patients and communities. This role includes addressing the social determinants of health, promoting healthy public policy, and ensuring equitable access to healthcare services. Patients with LEP face significant barriers to accessing quality healthcare, leading to adverse health outcomes (Bowen, 2015; Laher et al., 2018). Consistent use of professional LIS is essential for ensuring that patients with LEP receive the same quality of care as English-speaking patients. However, the underutilization of LIS remains a pervasive issue despite the abundance of literature seeking to improve its use. Addressing concerns related to social accountability and health advocacy should be at the forefront of improving LIS use and patient outcomes. Physicians and residents need to be socially accountable advocates who recognize the importance of LIS and advocate for its use on an individual, community and system level.

Barriers to engaging in health advocacy

It is evident in the literature that family physicians are only engaging in micro (individual) levels of advocacy actions and fail to recognize their responsibility to engage in meso (community) and macro (system) levels of advocacy (Bernard et al., 2019). The main barriers to family physicians engaging in health advocacy in the literature are the same barriers expressed by participants in using LIS. Bernard et al. (2019) found that family physicians felt they did not have enough time to engage in higher levels of advocacy, felt burnt out and expressed a lack of education on how to engage in higher levels of advocacy. The health advocate role is the most complex competency in the CanMEDS framework and does not have specific, measurable goals (Flynn & Verma, 2008). If residents and even physicians aren’t equipped with proper education on how to engage in the role of a health advocate, it is unrealistic to expect them to engage deeply in this role. This also relates to LIS, as many residents did not have the knowledge of professional LIS that were available to them – this directly impacted their ability to use these services and, therefore, communicate effectively and advocate for their patients. Kahlke et al. (2022) found that residents' knowledge of what resources were available to them directly impacted their ability to advocate for their patients. However, as vehicles of change, physicians and residents hold great power and responsibility to drive positive change that improves population health. If providers do not view themselves as health advocates and understand the full scope of this role, it will impact their motivation to engage in health advocacy behaviours. Physicians and residents must see themselves as responsible for not only addressing individual patient needs but also advocating for systemic changes that improve health outcomes for all patients. Furthermore, a supportive culture is vital to ensuring physicians and residents feel empowered to engage in advocacy efforts. If physicians are in a supportive environment and have appropriate resources, they are more likely to engage in health advocacy, even at higher levels (Bernard et al., 2019).

Improving Health Advocacy

Improving health advocacy and social accountability among physicians and residents would positively impact their ability to provide culturally appropriate care, including using LIS in practice. In the literature, organizational support and education are the main ways to improve health advocacy and social accountability. Physicians who express interest in engaging in higher levels of advocacy require organizational support and targeted skills development to help them reach these goals (Dobson et al., 2015). Organizational support ensures that physicians and residents are working in an environment that values health advocacy, makes time for health advocacy efforts and supports physicians and residents who wish to engage in advocacy activities. The main barriers physicians face when engaging in higher levels of health advocacy are time constraints and burnout (Bernard et al., 2019). Organizations can help mitigate these barriers by ensuring that physicians have dedicated, paid time to engage in health advocacy efforts. This can look like nominating a physician to join various community organizations to work together with the community and advocate on their behalf (Hubinette et al., 2017). Similarly, organizations can offer paid time for physicians to engage in research directly related to the health needs of the communities they serve. Not only would these efforts foster an environment that stresses the importance of these activities, but they also support physicians in mobilizing their insights into effective and useful advocacy efforts (Law et al., 2016).

Another important way to improve health advocacy and social accountability is through education, both through medical curriculum and continuing education for practicing physicians. Health advocacy is one of the most difficult competencies to teach and assess in the Canadian medical curriculum, resulting in it being undervalued and often ignored in education (Endres et al., 2022; Hubinette et al., 2017; Poulton & Rose, 2015). This lack of clarity and focus deters residents from developing skills of health advocacy, which transfer into their practice as physicians (Endres et al., 2022). Even when health advocacy is taught in medical education, it focuses on advocacy at the individual level and ignores teaching residents how to engage in higher levels of advocacy (Bernard et al., 2017). This mirrors the results in this study, where residents and physicians were more comfortable engaging in lower levels of advocacy. There are various ways to incorporate health advocacy and social accountability into medical education. Some literature has found short, classroom-based teaching sessions to be effective for residents and their busy schedules (Scott et al., 2020). Another instructional activity involves interactive sessions where residents can work directly with community organizations that match their interests and brainstorm ways to advocate on individual, community and systems levels (Belkowitz et al., 2014; Scott et al., 2020). It is highlighted in the literature that community engagement is key when integrating health advocacy and social accountability in the medical curriculum (Belkowitz et al., 2014; Boroumand et al., 2020; Scott et al., 2020). Finally, there is also some evidence for resident-led curriculums where residents can design a curriculum that meets their needs and relates to their interests (McDonald et al., 2019). However, education should not stop after medical school; it is equally important to educate practicing physicians on health advocacy and social accountability through various teaching activities (Fleet et al., 2008). Similarly, education in both medical school and continuing education should include what it means to be socially accountable as a physician (Leinster, 2011). Health advocacy is a vital competency for physicians and residents; it is often undervalued and challenging to teach and assess (Poulton & Rose, 2015). Learners also view higher levels of advocacy as ‘going above and beyond’ rather than an expectation pointing to the larger issue of lack of social accountability (Hubinette et al., 2021). Improving health advocacy requires simple, quick, but effective teaching strategies that can be woven into the medical curriculum without adding more time or burden to residents’ busy schedules.

AIDER Framework

The AIDER framework is a tool that can be used to increase social accountability among physicians and residents (Sandhu et al., 2013). This framework can be directly applied in this context to guide physicians and residents through the process of engaging in higher levels of advocacy. In the first step, assess, providers can work together with their patients and community members to understand the issues they face with language barriers. Here, physicians and residents identify the social determinants of health that affect their patients and communities. Next, physicians inquire through developing research on this topic. This context can include conducting a qualitative study exploring the experiences of patients with LEP at MFP. In the next step, deliver, physicians work with community members to ensure that their findings are accurate. Then, they use these findings to implement change, such as increasing LIS at MFP by implementing a new policy and standard process. These findings can also be disseminated to the public, other institutions or policymakers to drive change. These actions include advocating for individual patients as well as the community. Next, physicians work to educate other physicians as well as patients. By educating patients, physicians are empowering them and improving their health, as well as community health. In this example, patients would be educated on the LIS available at MFP and the processes for using them; this will ensure that patients are more likely to request the services rather than relying on the physician to initiate its use. The last step is respond, where physicians get feedback from the community on the effectiveness of the change; this feedback can be used to adapt as needed to ensure patients' and community needs are being met.

Overall, this framework is a valuable tool for physicians and residents to improve social accountability and work toward community-focused care, which is vital for family physicians (Oandasan et al., 2004). It is a feasible and simple guide for physicians and residents who want to improve their social accountability and advocate for their patients on a broader scale. In this example, the framework was used to demonstrate how physicians can work with their communities and advocate on an individual and community level. However, this framework can be used to encourage physicians and residents to engage in advocacy activities at systems levels.

Health advocacy is a critical component of the CanMEDS-FM framework, emphasizing the role of family physicians as advocates for their patient's health at individual, community, and system levels. The study highlights significant challenges in this area, particularly in addressing language barriers and utilizing LIS effectively. While providers demonstrated competencies in disease prevention, health promotion, and health surveillance, they often fell short in addressing the broader determinants of health and engaging in higher levels of advocacy. Addressing these challenges requires a multifaceted approach, including better education and training for physicians and residents, increased awareness of available resources, and a stronger emphasis on the importance of advocacy roles. By understanding and embracing their role as health advocates, family physicians can help ensure that all patients receive equitable and high-quality care, ultimately improving health outcomes and promoting health equity.

IMPLICATIONS, STRENGTHS, LIMITATIONS AND CONCLUSION

Implications for Clinical Practice

The findings of this study have many implications that pertain to clinical practice, particularly in family medicine. The findings from this study can be used to understand the experiences of physicians and learners in using LIS in their practice. By knowing this information, these barriers can be addressed to improve the use of LIS in practice. The use of LIS in healthcare is critical for ensuring adequate care for all, as well as reducing stress among physicians.

Improving LIS Use

The main findings of this study indicate that physicians and residents underutilize professional LIS and rely on ad hoc interpreters or use no translation at all. This is a prominent issue in healthcare across specialties, as evidenced by the literature. The goal of this study is to provide insights into the reasons behind this underutilization with the hopes of increasing the regular use of professional LIS. Physicians and residents face a multitude of barriers preventing them from using these services effectively. This ultimately impacts patient safety and provider satisfaction. Not only would increased use of professional LIS improve patient care and health outcomes, but it will also help to decrease burnout in providers. The study findings also point to the importance of organizational support in promoting the use of these services and empowering physicians and residents to be health advocates.

Patient safety and care quality. Utilizing professional interpreters ensures that patients can effectively communicate with their providers. This allows patients to express their health concerns, fully understand their diagnoses and treatment plans, and reduces the risk of medical errors by improving clinical outcomes. Additionally, the use of LIS will improve patient satisfaction and quality of care. This study found that using ad hoc interpretation methods increased investigative procedures due to a lack of confidence in the subjective information obtained. It also found that there is a risk of missing important information that may lead to misdiagnoses. By regularly using professional LIS, providers can ensure that patients are receiving streamlined, directed, high-quality care.

Provider stress. The reliance on ad hoc interpretation not only affects patient care but also contributes to provider stress and satisfaction. Providers often feel a sense of discomfort and moral distress when forced to resort to using ad hoc interpretation due to organizational challenges. Knowing that they are not providing high-quality and equitable care results in an ethical dilemma. Similarly, having to order more investigations for patients and spending more time due to untrained interpreters contributes to a feeling of burnout and lack of time. Using professional LIS can help physicians and residents provide more efficient and focused care, which can increase their job satisfaction and decrease their stress.

Organizational support. The main barriers to the use of LIS in this setting were time constraints and organizational challenges. The study findings reinforce how crucial organization support is in effective practice, specifically the utilization of LIS. All participants in this study found the process of arranging professional interpreters to be time-consuming and difficult. With providers already dealing with busy schedules, these challenges inevitably discourage providers from using these services. Organizational support should focus on working with physicians to identify areas for improvement to help them work efficiently while using these services. Standardized protocols should be put in place to integrate these services into providers' current workflow. For example, many participants suggested flagging charts of patients with LEP and allocating staff members to consent these patients and automatically book interpreters. Moreover, organizations should regularly monitor and evaluate the use of LIS to promote continuous quality improvement and accountability. To address these organizational challenges, strong leadership is paramount in fostering a culture that values and prioritizes effective communication with patients.

Implications for Education

The findings from this study highlight the lack of education related to the use of language interpretation services. Most participants felt unprepared by their medical education and did not receive education from their organization prior to the implementation of this new service. There is an evident need for educational reform on this matter to better equip physicians to overcome language barriers effectively. Participants in this study were able to give valuable recommendations to improve education.

Integrating LIS into Medical Curriculum

Effective communication is a fundamental skill for healthcare professionals, and addressing language barriers should be a key component of medical education. Curriculum development should focus on dedicated, formal education related to addressing language barriers in practice. The current medical curriculum lacks formal training on cultural competency and the use of LIS, as cited by participants. Research has shown that cultural competency training is crucial for improving patient-provider communication and health outcomes (Betancourt et al., 2005; Flores, 2005). Integrating these components into the curriculum requires a structured approach that includes interactive instructional activities, robust assessment methods, and appropriate evaluation techniques.

Instructional Activities. The first step is building the theoretical foundations by understanding the impacts of language barriers on patient care and health outcomes. This includes the risks and consequences associated with not using appropriate translation services. This should also include cultural competency training to understand cultural differences in patients that may affect patient care. This can include, but is not limited to, cultural beliefs and practices related to health, strategies for culturally sensitive care, and how to deal with cultural barriers in clinical care. The instructional activities that can help achieve these learning outcomes can include interactive workshops involving group discussions and concept mapping. Group discussions using unfolding case scenarios are a great way to solidify the foundational knowledge. This type of learning can incorporate multiple sources of information into one scenario, reducing the content load. This type of learning can help novice residents engage with the information in a low-fidelity setting; this reduces intrinsic load and builds confidence (Van Merriënboer & Sweller, 2010). It also promotes experiential learning as residents are actively engaging with the scenario to apply it in future situations (Kolb, 1984). Concept maps are also a great way to educate residents on this topic. It helps to decrease the cognitive load by taking a large body of information and breaking it down into meaningful groups, or “chunking” (Van Merriënboer & Sweller, 2010). These concept maps can help residents visualize the relationships between cultural beliefs, health practices, and health outcomes, providing a comprehensive understanding of how cultural competency can improve patient care (Smith et al., 2007). The group discussions can cover the topics previously mentioned, as well as how to utilize LIS and create an appropriate plan for patients (Atschuler & Kachur, 2001). These interactive workshops can also involve role-playing exercises to practice using interpreters in various clinical scenarios in a low-fidelity, controlled setting. There is literature demonstrating examples of similar workshops, including discussions and role-playing for cultural competence and LIS teaching; in these workshops, residents returned positive feedback on their learning (Akins, 2009; Atschuler & Kachur, 2001; Bansal et al., 2015; Hobgood et al., 2008; Smith et al., 2007).

Simulations using standardized patients are also a great tool for residents to practice using LIS in a low-fidelity setting. Participants suggested integrating this topic into other simulations. For example, a simulation practicing stabilizing a patient in respiratory distress can involve a standardized patient who doesn’t speak English. In this simulation, residents would have to work with an interpreter to communicate with the patient. Using this template, communicating through language barriers can be integrated into any simulation. By mimicking situations that residents are likely to encounter in their practice, simulations facilitate a positive transfer of learning to practice (Perkins & Salomon, 1992). Buenconsejo-Lum & Maskarinec (2004) found that using standardized patients to teach this topic resulted in residents’ increased cultural competency and communication skills. More information is needed to know whether this is already being implemented in the medical curriculum; however, no participants reported learning about LIS through any simulations in their education. This is a feasible, simple way to implement learning about this topic into already existing simulations. These simulations can be tailored to include cultural nuances and utilizing LIS in practice, which residents are likely to experience in their practice (Chow et al., 2014; Juarez et al., 2006; Lie et al., 2010;).

Assessment. Effective assessment methods are important to evaluate residents' competency in cultural awareness and the use of LIS. Many residents recommended including a station on this topic in Objective Structured Clinical Examinations (OSCEs). These OSCE stations can be designed to assess residents' competency in interacting with patients who come from various cultural backgrounds and who have LEP. Atshuler and Kachur (2001) gave well-rounded examples of OSCE stations, such as obtaining consent or performing a pelvic exam on a Muslim patient, which residents found very helpful. The use of LIS can easily be included in these stations by including patients who don't speak English and allowing residents to navigate the system to mobilize the appropriate LIS. Written reflections can also be used to assess residents' learning, including writing about positionality, biases, experiences working with culturally diverse patients, and the use of LIS. These essays can provide valuable insights into the residents' learning processes and highlight learning gaps that can be addressed (Hobgood et al., 2008). Reflections are also vital for addressing personal beliefs or biases related to cultural competency and the use of LIS (Smith et al., 2007). Finally, direct observations during patient interactions can be used as an effective tool to assess residents' competency in this area. These observations can take place during patient interactions and can be used in any rotation. Structured observation tools can be used to ensure consistency and comprehensiveness in the evaluation process across all preceptors (Smith et al., 2007). Many studies have shown that direct observation can be a valuable and objective tool in assessing competency in this area (Buenconsejo-Lum & Maskarinec, 2004; Hobgood et al., 2008; Juarez et al., 2006; Shapiro et al., 2002; Smith et al., 2007).

Evaluation. To determine the overall effectiveness of the curriculum and identify areas for improvement, effective evaluation methods are required. Direct observation and feedback from preceptors can be used as an evaluation tool to measure the effectiveness of the instructional activities. If residents are scoring low on standardized checklists, this can point to a deficiency in the curriculum and changes would need to be made. Similarly, surveys can be collected from residents who have completed the curriculum. These surveys can get feedback on the instructional activities as well as identify areas for improvement. Similarly, feedback can also be collected directly from patients to help identify the level of patient satisfaction, as well as areas for improvement. Finally, metrics such as patient outcomes and error rates can provide objective data on the impact of cultural competency and LIS on patient health (Lie et al., 2010).

Integrating cultural competency and LIS training into the medical curriculum is essential for preparing residents to provide high-quality care to a diverse population. This can ensure that residents develop the necessary knowledge and skills to navigate cultural differences and language barriers effectively. Considering that even senior physicians identified using LIS in practice as a personal learning gap, it is evident that medical education around this topic is severely lacking.

Integrating LIS into Continuing Education

Beyond integrating education on language interpretation in medical education, there is also a need to integrate these topics into continuing education. Continuous professional development is necessary to keep providers updated on best practices and new innovative LIS. This education should be focused on specific contexts, such as MFP. Almost all participants did not recall receiving education on LIS use before the implementation of ITS Hamilton. This would have been the perfect opportunity to provide a refresher for physicians and residents to ensure they understand the importance of using LIS, as well as the potential consequences of not using appropriate services. This education can also focus on the specific service of ITS Hamilton, how to access it, and troubleshooting issues with using this service.

Many participants said they would find a short workshop helpful in providing concise, important information on how to use the services. This can be easily integrated into the already existing educational sessions offered at MFP for physicians and residents. Literature shows that the implementation of Quality Improvement (QI) workshops educating providers on the importance of interpreter use can significantly increase its utilization (Lion et al., 2015). Another helpful instructional activity mentioned was the integration of e-learning modules. This provides the advantage of allowing providers to complete the module on their own time and fit it within their busy schedules. Clinical leaders at MFP can have providers sign off on completing the workshops and modules before the implementation of the service to ensure that all physicians and residents are equipped with the knowledge and skills to navigate language barriers in practice.

In addition to providing appropriate education, quality improvement initiatives are vital in ensuring the continuous, appropriate use of services. For example, results from this study can be used to address concerns in the process of involving interpreters.

Implications for Policy

Policy changes play an important role in addressing the systemic issues that affect the delivery of equitable healthcare, particularly for marginalized patients. Structural racism and implicit biases within the healthcare system perpetuate inequalities in healthcare delivery. Implementing policies that mandate the use of LIS and promote cultural competencies can help mitigate these inequities and ensure all patients receive the same standard of care. Effective policy changes can create a healthcare environment that is more inclusive, equitable, and responsive to the needs of diverse patient populations.

Mandating LIS Use

In the United States, the Civil Rights Act of 1964 mandates the use of LIS in healthcare settings that receive federal funding (DeCola, 2011). However, there is no formal document mandating the use of LIS in the Canadian healthcare system. Section 14 of the Canadian Charter of Rights and Freedoms mandates the use of interpreters for individuals involved in the justice system. Patients consenting to life-changing surgeries, dealing with chronic diseases, or even those simply existing in the healthcare system deserve unobstructed access to LIS. Research like this and other work can be used to address concerns regarding the gross underutilization of interpreters by healthcare providers. This is an urgent issue that must be addressed, considering the detrimental effects it can have on patients. An effective policy will mandate the use of LIS in all provincially funded healthcare settings, similar to the Civil Rights Act in the USA. Similarly, provincial governments can include appropriate LIS services as a requirement to receive healthcare funding. This will ensure that all healthcare settings consistently provide LIS to all patients who need them. Another important area for policy is to include specific questions in the Canadian Census regarding Canadians' level of LEP when interacting with the healthcare system. This information can provide insights into the number of Canadians affected by language barriers in healthcare; this information can also be used to advocate for funding and resources in this area.

Fundings and Resources

Mandating the use of LIS is not going to solve all the issues. Healthcare settings may not have the funding or resources to incorporate LIS into their practice. Policy changes can focus on increasing funding to support the implementation and maintenance of LIS programs. Similarly, existing resources should be allocated to ensure that appropriate services are available when needed. For example, implementing LanguageLine services at MFP can provide more resources to physicians caring for patients with LEP. This will allow physicians to seamlessly communicate with patients who present with urgent concerns and communicate with patients over the phone. Physicians and residents in this study did not feel that they had adequate resources to provide high-quality care. Similarly, many physicians cited funding as a limiting factor in their ability to get access to more resources. Although funding may be scarce in healthcare settings, allocating funding to ensure equitable access to care should be a top priority, especially in Canada, where there is a diverse population of patients from various backgrounds.

Guidelines and Protocols

To ensure seamless delivery and use of LIS, guidelines and protocols should be developed to support professionals using these services. These guidelines can be created for various disciplines, such as physicians, nurses, midwives, etc. These guidelines and protocols should include when and how to use professional interpreters. They should also cover various clinical contexts, such as emergency care, family medicine, and specialty services. Specific institutions should also develop guidelines on what resources are available and exactly how to access these resources. This included in-person vs. remote interpretation, necessary forms for booking interpreters, etc. The development of these protocols should include updates on the current literature, as well as quality assurance programs, to ensure appropriate compliance with guidelines and protocols. One of the main barriers to the use of LIS in this study was knowing what resources were available and how to access them. A comprehensive guideline can consolidate all the necessary information into one document, including links to appropriate forms. Institutions can even summarize these guidelines and protocols into one quick sheet and upload it electronically, where providers can easily access this information.

Implications for Research

This study provides helpful insights into the challenges providers face when caring for patients with LEP. It also outlines how contextual factors play a role in providers' perception and use of LIS. Although there is a lot of research on this topic, not many studies have identified contextual factors influencing the use of LIS. There is also no research looking at health advocacy related to patients with LEP and the use of LIS. Although this study provided an introduction to this topic, dedicated research on this topic would be important in ensuring advocating for patients with LEP is integrated into all discussions of health advocacy. This study focused on barriers providers faced when using LIS in their practice, as well as how they overcame these challenges. More research can focus on facilitators to providers’ perception and use of LIS; this information can help understand what factors can increase utilization of these services.

Current literature and participants in this study touch on the role of the interpreter. However, more research is needed on this topic. Many physicians in this study expressed concerns about professionalism when interpreters engaged in friendly conversation with the patients. To accept the regular use of interpreters, more research is required to investigate the impact of different roles interpreters may take on and how this may affect patient care and satisfaction. Context-specific research would be beneficial for evaluating the impact of services on patient care. This can include qualitative research investigating patient’s experiences at MFP dealing with language barriers. Not only would this provide insight into the concerns of patients, but it can also motivate providers to continuously use professional LIS if their patients prefer it over family members. There is also a lack of Canadian-specific research on curriculum development around using LIS. More research is needed to evaluate the effectiveness of various curricula in teaching this topic.

Finally, this study shed light on the risks of over-investigating when LIS are not used. An interesting area of research can investigate the cost-effectiveness of using LIS by comparing the number of times patients present to a healthcare provider and the number of tests/procedures they undergo. If research shows that using LIS can decrease how often patients re-present for the same issue and how many tests they require, this can also further motivate providers to continue using these services.

Strengths and Limitations

While this study provided valuable insights into the use of LIS in family medicine and its associated challenges, a few limitations must be acknowledged. The main limitation of this study is its transferability. Although the participants were from diverse backgrounds, the study's findings are influenced by the specific context in which the research was conducted, including the healthcare system, institutional policies, and available resources. These context-specific factors may limit the applicability of the results to other settings with different healthcare structures and resources. However, a detailed description of the study context was provided to allow transfer to similar contexts. Similarly, this study focuses on the experiences of family physicians and residents, indicating the results may be different in other disciplines or specialties. However, the study provides important information on the experiences and challenges of physicians and residents using LIS in their practice. Similar experiences were evident in the literature across different specialties in medicine.

The study had an appropriate sample size that allowed for rich data that directly answered all of the research questions. However, only the principal investigator reviewed the coding to ensure that accurate codes were chosen to represent the data. Additionally, most participants being early trainees may also affect the results.

Another limitation is the researcher's experiences and background. There is a risk that my prior experiences dealing with language barriers in healthcare, as well as my passion for this topic, may have influenced the interpretation of the data. However, employing a qualitative descriptive design and staying closer to the data helped to mitigate this risk of bias. Other measures were also taken to mitigate this risk, such as reflexive journaling, notes, audit trails, and providing a positionality statement in the written report. The researcher was also an outsider who did not have a relationship with any of the participants, which added more strength to the study. Similarly, the researcher's prior experiences and knowledge on this topic allowed for more richness and depth to the data.

The involvement of health advocacy in this study may also present another limitation. There were no specific questions asked in the interview regarding health advocacy. However, using the CanMEDS framework, the researcher was able to ask questions to probe about key competencies outlined in this framework. This allowed the researcher to identify which competencies were met by providers when caring for patients with LEP. Not including specific questions regarding health advocacy was a decision by the research team to mitigate the risk of social desirability bias. Furthermore, health advocacy was not a main research question in this study. The inclusion of this topic in this study was meant to provide an introduction to this topic, where further research can build on it.

Overall, this study has many strengths and few limitations. It was able to provide new insights into an area of research that is very important for ensuring equitable patient care.

Reflections

As I reflect on the study results, I feel that these findings deeply reflect the underlying institutional racism that exists in our healthcare systems. This results in issues affecting marginalized populations not focused on or viewed as urgent matters. As a Somali-Canadian whose parents came to this country as refugees, I found myself in the role of an interpreter for my father while he navigated the healthcare system with multiple health issues. I recall being a preteen and having to translate my father’s diagnosis of end-stage renal disease – a daunting task for a young person, but one I shouldered out of necessity. This study findings have shown me that unfortunately, almost 20 years later, not much has changed. Similarly, as a registered nurse working in pediatric emergency, I have witnessed firsthand how LIS are utilized and the effects this has on patient care. I also assumed the role of a bilingual interpreter for Somali-speaking patients; this often conflicted with my duties as a nurse, taking me away from my own patients.

The underutilization of professional LIS in this study did not surprise me; this is something I witnessed in my professional and personal life. Similarly, the challenges faced by participants did not come as a surprise to me with my experience working in a busy emergency department. However, one thing that did surprise me was the nonchalant way that some participants spoke about their choices not to use interpreters, particularly the residents in the study. The blasé comments, laughter, and making light of such a serious issue made it difficult to keep my composure during interviews. I struggled to keep a straight face knowing that their actions affect their patients in ways they may never understand. I resonated with the many non-White participants who expressed passion on this topic and reflected on their own experiences acting as interpreters for their families.

Despite my personal experiences and biases, I made a commitment to partake this research with an open mind and to truly understand the experiences of healthcare professionals as they use these services in their practice. I was able to do this while still allowing my personal experiences to add richness to the data. I understand that by engaging in this research, I am not only shedding light on an under-researched area, but also advocating for patients who may feel voiceless and disempowered. Similarly, I hope that this research can empower physicians and residents to recognize their social accountability and commit to tackling this issue once and for all.

Conclusion

This qualitative descriptive study aimed to explore the experiences of family medicine physicians and residents who use LIS in their practice. Through accounts of their experiences, the study aimed to understand how they use these services, what challenges they face and how they overcome them, and if contextual factors influence their perception and use of LIS. We were also interested in exploring their teaching and learning practices related to LIS, as well as how they engage in health advocacy for patients with LEP. Results from this study mirror previous literature suggesting that physicians and residents underutilize professional LIS and, in some cases, use no translation at all, including ad hoc translation. Physicians and residents in this study utilize a broad range of LIS, such as family members, Google Translate, and bilingual providers. When they tried to integrate these services into their practice, they faced significant barriers, such as time constraints, organizational challenges, translation quality issues, and privacy and confidentiality concerns. This study also highlights contextual factors that influence participants' perception and use of LIS, such as race, power dynamics, and previous experiences. Participants in this study also revealed that their medical and institutional education did not prepare them to use LIS, and topics related to language barriers were not actively integrated into their teaching and learning practices. Providers in this study also demonstrated a lack of health advocacy actions with patients who have LEP on the community and systems levels. Although all participants recognized the underutilization of LIS was a prevalent issue that has detrimental effects, no physician or resident expressed their social accountability to drive change in this area.

Physicians' and residents' accounts of their experiences underscore the necessity for effective LIS use to overcome language barriers, improve communication, and enhance patient care. Addressing barriers to LIS use requires strategic interventions, such as scheduling longer appointments, flagging patients with LEP and automatically booking interpreter services, employing multiple forms of LIS, and enhancing education and training. This study touched on the topic of advocating for patients with LEP and revealed that physicians and residents only exhibited some competencies in the CanMEDS framework for advocating at the individual level. By promoting health advocacy through effective LIS use and lobbying for better services, healthcare providers can address health disparities and delivery equitable and socially responsible care for all patients.

REFERENCES

Akins, R. (2009). Teaching cultural sensitivity to pediatric residents. *Academic Leadership: The Online Journal*, *7*(2), 14.

Altshuler, L., & Kachur, E. (2001). A culture OSCE: Teaching residents to bridge different worlds. *Academic Medicine*, 76(5), 512-516.

Armas, A., Meyer, S. B., Corbett, K. K., & Pearce, A. R. (2018). Face-to-face communication between patients and family physicians in Canada: A scoping review. *Patient Education and Counseling*, *101*(5), 789-803.

Bajgain, B. B., Bajgain, K. T., Badal, S., Aghajafari, F., Jackson, J., & Santana, M. J. (2020). Patient-reported experiences in accessing primary healthcare among immigrant population in Canada: a rapid literature review. *International Journal of Environmental Research and Public Health*, *17*(23), 8724.

Bansal, A., Swann, J., & Smithson, W. H. (2014). Using professional interpreters in undergraduate medical consultation skills teaching. Advances in Medical Education and Practice, 5(default), 439–450. https://doi.org/10.2147/AMEP.S71332

Belkowitz, J., Sanders, L. M., Zhang, C., Agarwal, G., Lichtstein, D., Mechaber, A. J., & Chung, E. K. (2014). Teaching health advocacy to medical students: a comparison study. Journal of public health management and practice, 20(6), E10-E19.

Bernard, C., Soklaridis, S., Paton, M., Fung, K., Fefergrad, M., Andermann, L., ... & Whitehead, C. R. (2019). Family physicians and health advocacy: Is it really a difficult fit?. *Canadian Family Physician*, *65*(7), 491-496.

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O. (2005). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*, 118(4), 293-302.

Boroumand, S., Stein, M. J., Jay, M., Shen, J. W., Hirsh, M., & Dharamsi, S. (2020). Addressing the health advocate role in medical education. BMC medical education, 20, 1-5.

Bowen, S. (2015). The impact of language barriers on patient safety and quality of care. *Société Santé en français*, 603-623.

Buchman, S., Woollard, R., Meili, R., & Goel, R. (2016). Practising social accountability: From theory to action. Canadian Family Physician, 62(1), 15-18.

Buenconsejo-Lum, L. E., & Maskarinec, G. G. (2004). Using standardized patients to enhance cross-cultural sensitivity. *Asia Pacific Family Medicine*, *3*, 23-27.

Chauhan, A., Walton, M., Manias, E., Walpola, R. L., Seale, H., Latanik, M., ... & Harrison, R. (2020). The safety of health care for ethnic minority patients: a systematic review. *International journal for equity in health*, *19*, 1-25.

Chow, C., Teo, E. J., & Low, L. L. (2014). Integrating cultural awareness into busy residency training: What could work. *BMC Medical Education*, 14, 125.

Colorafi, K. J., & Evans, B. (2016). Qualitative Descriptive Methods in Health Science Research. *HERD*, *9*(4), 16–25.

Cutler, N. A., Halcomb, E., & Sim, J. (2023). Using naturalistic inquiry to inform qualitative description. Nurse researcher, 31(3).

DeCola, A. (2011). Making language access to health care meaningful: The need for a federal health care interpreters' statute. *JL & Health*, *24*, 151.

Dharamsi, S., Ho, A., Spadafora, S. M., & Woollard, R. (2011). The physician as health advocate: translating the quest for social responsibility into medical education and practice. *Academic Medicine*, *86*(9), 1108-1113.

Diamond, L., Schenker, Y., Curry, L., Bradley, E. H., & Fernandez, A. (2009). Getting by: underuse of interpreters by resident physicians. Journal of General Internal Medicine, 24(2), 256-262.

Dobson, S., Voyer, S., Hubinette, M., & Regehr, G. (2015). From the clinic to the community: the activities and abilities of effective health advocates. Academic Medicine, 90(2), 214-220.

Endres, K., Burm, S., Weiman, D., Karol, D., Dudek, N., Cowley, L., & LaDonna, K. (2022). Navigating the uncertainty of health advocacy teaching and evaluation from the trainee's perspective. Medical Teacher, 44(1), 79-86.

El Ansari, W., Newbigging, K., Roth, C., & Malik, F. (2009). The role of advocacy and interpretation services in the delivery of quality healthcare to diverse minority communities in London, United Kingdom. *Health & social care in the community*, *17*(6), 636-646.

Fleet, L. J., Kirby, F., Cutler, S., Dunikowski, L., Nasmith, L., & Shaughnessy, R. (2008). Continuing professional development and social accountability: a review of the literature. Journal of Interprofessional Care, 22(sup1), 15-29.

Flores, G., Abreu, M., Barone, C. P., Bachur, R., & Lin, H. (2012). Errors of medical interpretation and their potential clinical consequences: a comparison of professional versus ad hoc versus no interpreters. Annals of Emergency Medicine, 60(5), 545-553.

Flores, G. (2005). The impact of medical interpreter services on the quality of health care: A systematic review. *Medical Care Research and Review*, 62(3), 255-299.

Flynn, L., & Verma, S. (2008). Fundamental components of a curriculum for residents in health advocacy. *Medical teacher*, *30*(7), e178-e183.

Gadon, M., Balch, G. I., & Jacobs, E. A. (2007). Caring for patients with limited English proficiency: the perspectives of small group practitioners. *Journal of General Internal Medicine*, *22*, 341-346.

Goel, R., Buchman, S., Meili, R., & Woollard, R. (2016). Social accountability at the micro level: One patient at a time. Canadian Family Physician, 62(4), 287.

Guest, G., Namey, E., & Chen, M. (2020). A simple method to assess and report thematic saturation in qualitative research. *PloS one*, *15*(5), e0232076.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. Handbook of qualitative research, 2(163-194), 105.

Gubernskaya, Z., & Treas, J. (2020). Pathways to Linguistic Isolation Among Older U.S. Immigrants:

Assessing the Role of Living Arrangements and English Proficiency. *The journals of gerontology. Series B, Psychological sciences and social sciences*, *75*(2), 351–356.

Gupta, A., Gray, C. S., Landes, M., Sridharan, S., & Bhattacharyya, O. (2021). Family medicine: An evolving field around the world. *Canadian Family Physician*, *67*(9), 647.

Hobgood, C., Sawning, S., Bowen, J. L., Savage, K., & Lester, C. (2008). Teaching culturally appropriate care: A review of educational models and methods. *Academic Emergency Medicine*, 15(3), 239-246.

Holmes, A. G. D. (2020). Researcher Positionality--A Consideration of Its Influence and Place in Qualitative Research--A New Researcher Guide. Shanlax International Journal of Education, 8(4), 1-10.

Hsieh, E. (2014). Not just "getting by": factors influencing providers' choice of interpreters. Journal of General Internal Medicine, 29(3), 451-457.

Hubinette, M., Dobson, S., Scott, I., & Sherbino, J. (2017). Health advocacy. *Medical teacher*, *39*(2), 128-135.

Hubinette, M. M., Scott, I., van der Goes, T., & Kahlke, R. (2021). Learner conceptions of health advocacy:‘Going above & beyond’or ‘kind of an expectation’. Medical Education, 55(8), 933-941.

Hutchison, B., Abelson, J., & Lavis, J. (2001). Primary care in Canada: so much innovation, so little change. *Health Affairs*, *20*(3), 116-131.

Jacobs, E. A., Shepard, D. S., Suaya, J. A., & Stone, E. L. (2006). Overcoming language barriers in health care: costs and benefits of interpreter services. American Journal of Public Health, 94(5), 866-869.

Juarez, J. A., Marvel, K., Brezinski, K. L., Glazner, C., Towbin, M. M., & Lawton, S. (2006). Bridging the gap: A curriculum to teach residents cultural humility. *FAMILY MEDICINE-KANSAS CITY-*, *38*(2), 97.

Kahlke, R., Scott, I., van Der Goes, T., & Hubinette, M. M. (2023). Health advocacy among medical learners: Unpacking contextual barriers and affordances. *Medical Education*, *57*(7), 658-667.

Karliner, L. S., Jacobs, E. A., Chen, A. H., & Mutha, S. (2007). Do professional interpreters improve clinical care for patients with limited English proficiency systematic review of the literature? Health Services

Research, 42(2), 727-754.

Khoong, E. C., & Fernandez, A. (2021). Addressing gaps in interpreter use: time for implementation science informed multi-level interventions. *Journal of general internal medicine*, *36*(11), 3532-3536.

Kiran, T. (2022). Keeping the front door open: ensuring access to primary care for all in Canada. *CMAJ*, *194*(48), E1655-E1656.

Kolb, D.A. (1984). Experiential learning: experience as the source of learning and development. Englewood Cliffs, New Jersey: Prentice-Hall.

LaDonna, K. A., Watling, C. J., Cristancho, S. M., & Burm, S. (2021). Exploring patients' and physicians' perspectives about competent health advocacy. *Medical Education*, *55*(4), 486-495.

Laher, N. (2018). *Access to language interpretation services and its impact on clinical and patient outcomes: a scoping review*. Wellesley Institute.

Law, M., Leung, P., Veinot, P., Miller, D., & Mylopoulos, M. (2016). A qualitative study of the experiences and factors that led physicians to be lifelong health advocates. *Academic Medicine*, *91*(10), 1392-1397.

Lee, F. J., Stewart, M., & Brown, J. B. (2008). Stress, burnout, and strategies for reducing them: what's the situation among Canadian family physicians?. *Canadian family physician*, *54*(2), 234-235.

Lee, F. J., Brown, J. B., & Stewart, M. (2009). Exploring family physician stress: helpful strategies. *Canadian Family Physician*, *55*(3), 288-289.

Leinster, S. (2011). Evaluation and assessment of social accountability in medical schools. Medical teacher, 33(8), 673-676.

Lie, D. A., Lee-Rey, E., Gomez, A., Bereknyei, S., & Braddock, C. H. (2010). Does cultural competency training of health professionals improve patient outcomes? A systematic review and proposed algorithm for future research. *Journal of General Internal Medicine*, 26(3), 317-325.

Lion, K. C., Ebel, B. E., Rafton, S., Zhou, C., Hencz, P., & Mangione-Smith, R. (2015). Evaluation of a quality improvement intervention to increase use of telephonic interpretation. Pediatrics (Evanston), 135(3), e709–e716.

MacFarlane, A., Glynn, L. G., Mosinkie, P. I., & Murphy, A. W. (2008). Responses to language barriers in consultations with refugees and asylum seekers: a telephone survey of Irish general practitioners. BMC Family Practice, 9(1), 68.

MacFarlane, A., Huschke, S., Pottie, K., Hauck, F. R., Griswold, K., & Harris, M. F. (2020). Barriers to the use of trained interpreters in consultations with refugees in four resettlement countries: a qualitative analysis using normalisation process theory. *BMC Family Practice*, *21*, 1-8.

McDonald, M., Lavelle, C., Wen, M., Sherbino, J., & Hulme, J. (2019). The state of health advocacy training in postgraduate medical education: a scoping review. *Medical education*, *53*(12), 1209-1220.

McKeary, M., & Newbold, B. (2010). Barriers to care: The challenges for Canadian refugees and their health care providers. *Journal of Refugee Studies*, *23*(4), 523-545.

Meili, R., Buchman, S., Goel, R., & Woollard, R. (2016). Social accountability at the macro level: Framing the big picture. Canadian Family Physician, 62(10), 785-788.

Mu, L., Shroff, F., & Dharamsi, S. (2011). Inspiring health advocacy in family medicine: a qualitative study. *Education for Health*, *24*(1), 534.

Nápoles, A. M., Santoyo-Olsson, J., Karliner, L. S., Gregorich, S. E., & Pérez-Stable, E. J. (2015). Inaccurate Language Interpretation and Its Clinical Significance in the Medical Encounters of Spanish-speaking Latinos. Medical Care, 53(11), 940–947. https://www.jstor.org/stable/26418071

Ng, E., Pottie, K., & Spitzer, D. (2011). Official language proficiency and self-reported health among immigrants to Canada. *Health Reports*, *22*(4).

Oandasan, I., Malik, R., Waters, I., & Lambert-Lanning, A. (2004). Being community-responsive physicians. Doing the right thing. Canadian Family Physician, 50(7), 1004-1010.

Oandasan, I. F. (2005). Health advocacy: Bringing clarity to educators through the voices of physician health advocates. *Academic Medicine*, *80*(10), S38-S41.

Perkins, D. N., & Salomon, G. (1992). Transfer of learning. International encyclopedia of education, 2, 6452-6457.

Petronio, S., Sargent, J., Andea, L., Reganis, P., & Cichocki, D. (2004). Family and friends as healthcare advocates: Dilemmas of confidentiality and privacy. *Journal of Social and Personal Relationships*, *21*(1), 33-52.

Poulton, A., & Rose, H. (2015). The importance of health advocacy in Canadian postgraduate medical education: current attitudes and issues. Canadian medical education journal, 6(2), e54–e60.

Randhawa, G., Ferreyra, M., Ahmed, R., Ezzat, O., & Pottie, K. (2013). Using machine translation in clinical practice. *Canadian Family Physician*, *59*(4), 382-383.

Rosenberg, E., Leanza, Y., & Seller, R. (2007). Doctor–patient communication in primary care with an interpreter: physician perceptions of professional and family interpreters. *Patient education and counseling*, *67*(3), 286-292.

Rosenberg, E., Seller, R., & Leanza, Y. (2008). Through interpreters' eyes: comparing roles of professional and family interpreters. *Patient education and counseling*, *70*(1), 87-93.

Sandelowski M (2000). Whatever happened to qualitative description? Research in Nursing & Health, 23, 334–340.

Scott, M. D., McQueen, S., & Richardson, L. (2020). Teaching health advocacy: a systematic review of educational interventions for postgraduate medical trainees. *Academic Medicine*, *95*(4), 644-656.

Shapiro, J., Hollingshead, J., & Morrison, E. H. (2002). Primary care resident, faculty, and patient views of barriers to cultural competence, and the skills needed to overcome them. *Medical education*, *36*(8), 749-759.

Shaw E, Oandasan I, Fowler N, eds. CanMEDS-FM 2017: A competency framework for family physicians across the continuum. Mississauga, ON: The College of Family Physicians of Canada; 2017

Smith, W. R., Betancourt, J. R., Wynia, M. K., Bussey-Jones, J., Stone, V. E., Phillips, C. O., ... & Bowles, J. (2007). Recommendations for teaching about racial and ethnic disparities in health and health care. *Annals of Internal Medicine*, 147(9), 654-665.

Statistics Canada. (2022). Mother tongue by first official language spoken and knowledge of official languages: Canada, provinces and territories, census divisions and census subdivisions. https://doi.org/10.25318/9810017001-eng

Oandasan, I., Malik, R., Waters, I., & Lambert-Lanning, A. (2004). Being community-responsive physicians. Doing the right thing. Canadian Family Physician, 50(7), 1004-1010.

Pandey, M., Maina, R. G., Amoyaw, J., Li, Y., Kamrul, R., Michaels, C. R., & Maroof, R. (2021). Impacts of English language proficiency on healthcare access, use, and outcomes among immigrants: a qualitative study. *BMC Health Services Research*, *21*, 1-13.

Parsons, J. A., Baker, N. A., Smith-Gorvie, T., & Hudak, P. L. (2014). To ‘get by’ or ‘get help’? A qualitative study of physicians’ challenges and dilemmas when patients have limited English proficiency. BMJ Open, 4(6), e004613.

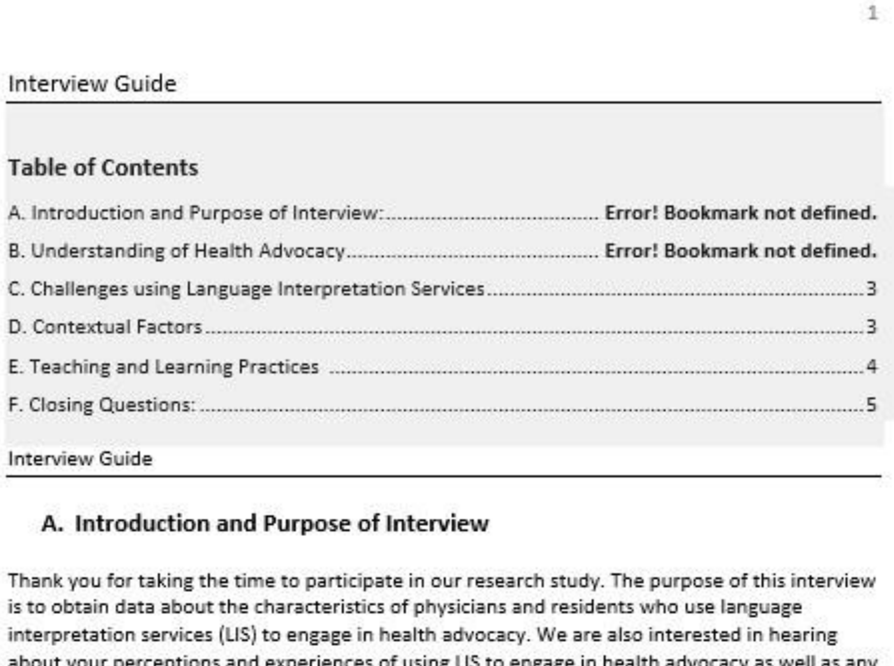
Van Merriënboer, J. J., & Sweller, J. (2010). Cognitive load theory in health professional education: design principles and strategies. Medical education, 44(1), 85-93.

Verma, S., Flynn, L., & Seguin, R. (2005). Faculty's and residents’ perceptions of teaching and evaluating the role of health advocate: a study at one Canadian university. *Academic Medicine*, *80*(1), 103-108.

Wang, L., Guruge, S., & Montana, G. (2019). Older immigrants' access to primary health care in Canada: A scoping review. *Canadian Journal on Aging/La Revue canadienne du vieillissement*, *38*(2), 193-209.

Woollard, R., Buchman, S., Meili, R., Strasser, R., Alexander, I., & Goel, R. (2016). Social accountability at the meso level: Into the community. Canadian Family Physician, 62(7), 538-540.

Zanchetta, M. S., & Poureslami, I. M. (2006). Health literacy within the reality of immigrants' culture and language. *Canadian journal of public health*, *97*(Suppl 2), S28-S33.



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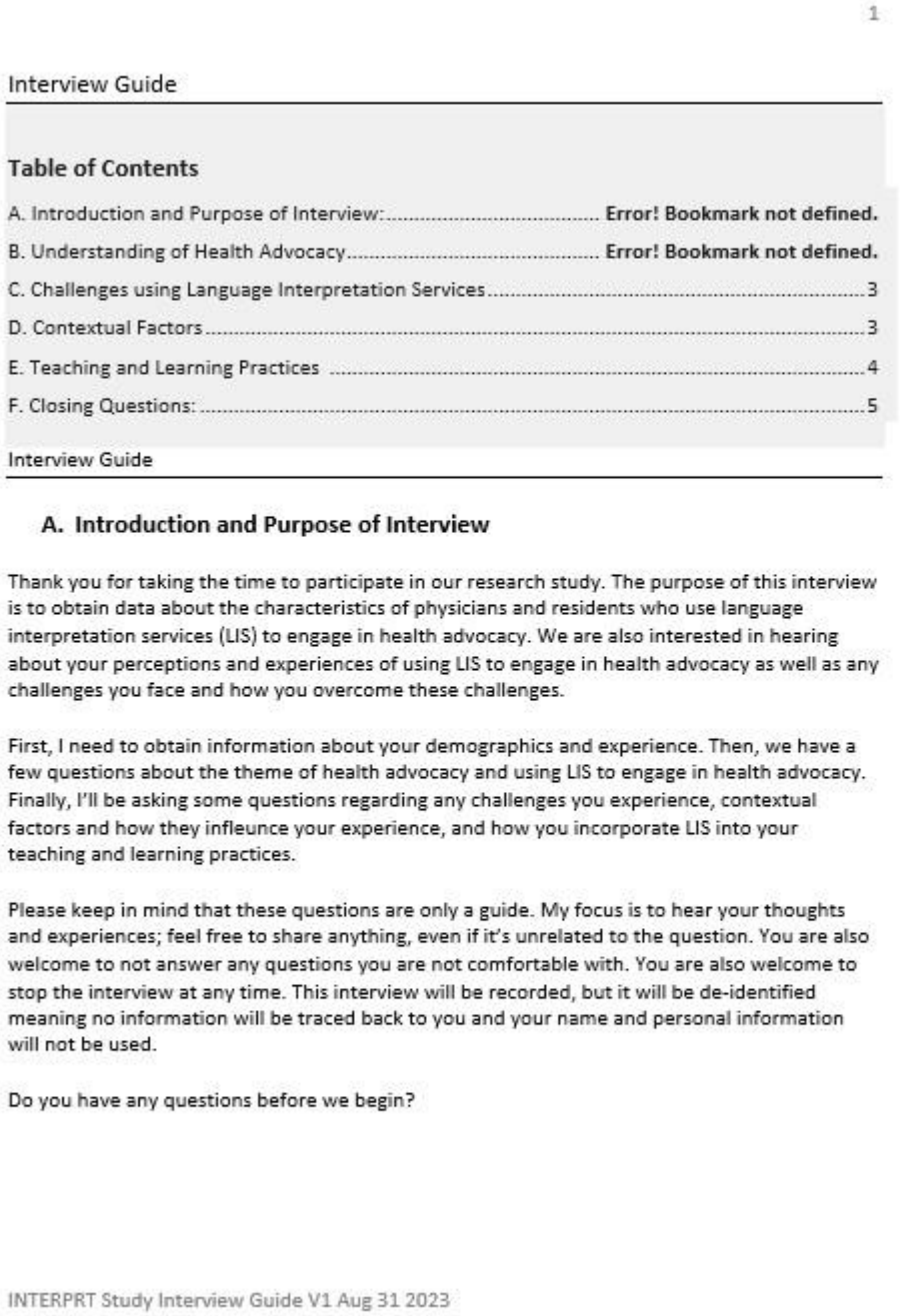
A. Introduction and Purpose of Interview

Thank you for taking the time to participate in our research study. The purpose of this interview is to obtain data about the characteristics of physicians and residents who use language interpretation services (LIS) to engage in health advocacy. We are also interested in hearing about your perceptions and experiences of using LIS to engage in health advocacy as well as any

APPENDIX

Appendix A: Interview Guide



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Interview Guide

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Interview Guide

A. Introduction and Purpose of Interview

Thank you for taking the time to participate in our research study. The purpose of this interview is to obtain data about the characteristics of physicians and residents who use language interpretation services (LIS) to engage in health advocacy. We are also interested in hearing about your perceptions and experiences of using LIS to engage in health advocacy as well as any challenges you face and how you overcome these challenges.

First, I need to obtain information about your demographics and experience. Then, we have a few questions about the theme of health advocacy and using LIS to engage in health advocacy. Finally, I'll be asking some questions regarding any challenges you experience, contextual factors and how they infleunce your experience, and how you incorporate LIS into your teaching and learning practices.

Please keep in mind that these questions are only a guide. My focus is to hear your thoughts and experiences; feel free to share anything, even if it's unrelated to the question. You are also welcome to not answer any questions you are not comfortable with. You are also welcome to stop the interview at any time. This interview will be recorded, but it will be de-identified meaning no information will be traced back to you and your name and personal information will not be used.

Do you have any questions before we begin?

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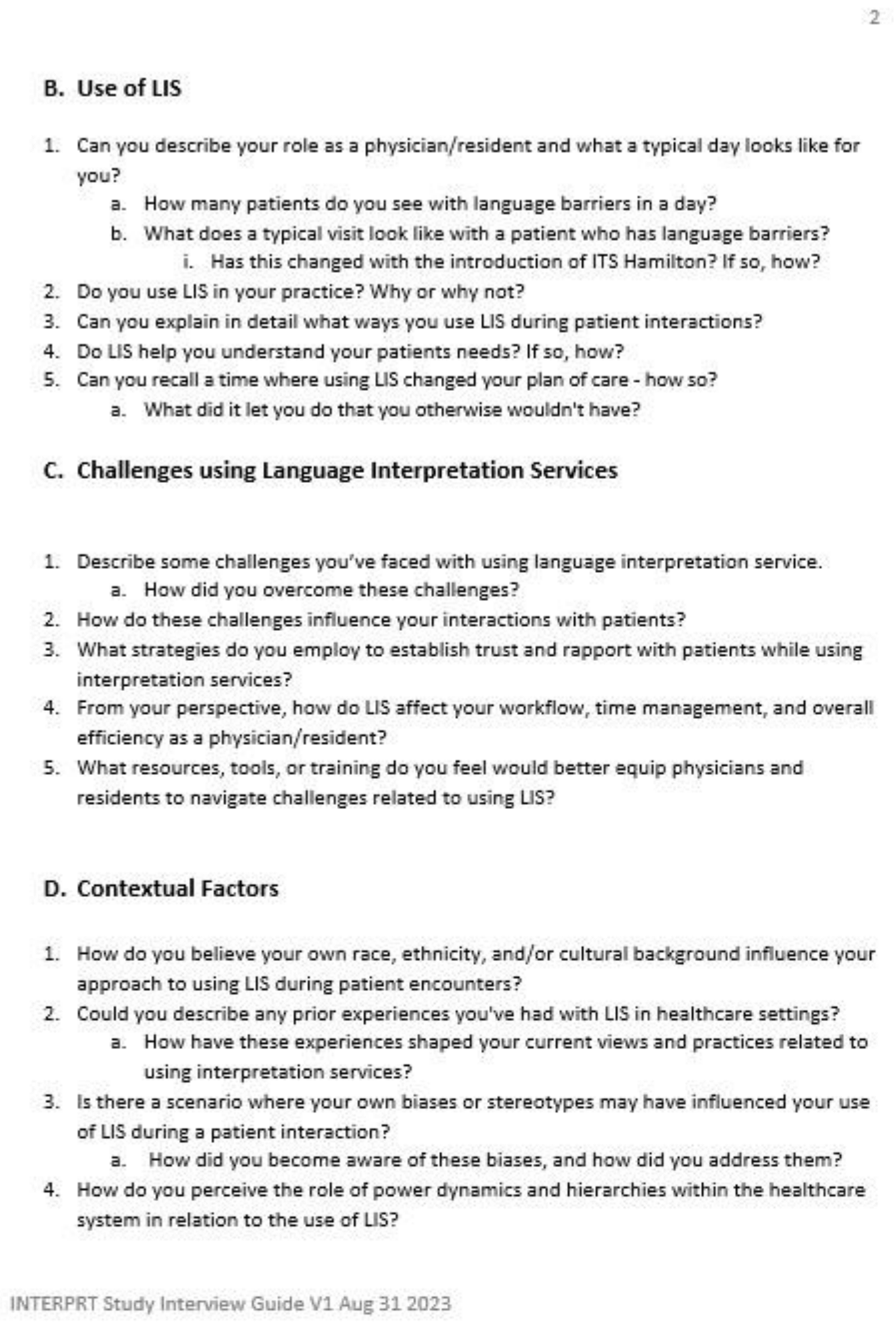

B. Use of LIS

1. Can you describe your role as a physician/resident and what a typical day looks like for you?
   a. How many patients do you see with language barriers in a day?
   b. What does a typical visit look like with a patient who has language barriers?
      i. Has this changed with the introduction of ITS Hamilton? If so, how?
2. Do you use LIS in your practice? Why or why not?
3. Can you explain in detail what ways you use LIS during patient interactions?
4. Do LIS help you understand your patients needs? If so, how?
5. Can you recall a time where using LIS changed your plan of care - how so?
   a. What did it let you do that you otherwise wouldn't have?

C. Challenges using Language Interpretation Services

1. Describe some challenges you've faced with using language interpretation service.
   a. How did you overcome these challenges?
2. How do these challenges influence your interactions with patients?
3. What strategies do you employ to establish trust and rapport with patients while using interpretation services?
4. From your perspective, how do LIS affect your workflow, time management, and overall efficiency as a physician/resident?
5. What resources, tools, or training do you feel would better equip physicians and residents to navigate challenges related to using LIS?

D. Contextual Factors

1. How do you believe your own race, ethnicity, and/or cultural background influence your approach to using LIS during patient encounters?
2. Could you describe any prior experiences you've had with LIS in healthcare settings?
   a. How have these experiences shaped your current views and practices related to using interpretation services?
3. Is there a scenario where your own biases or stereotypes may have influenced your use of LIS during a patient interaction?
   a. How did you become aware of these biases, and how did you address them?
4. How do you perceive the role of power dynamics and hierarchies within the healthcare system in relation to the use of LIS?

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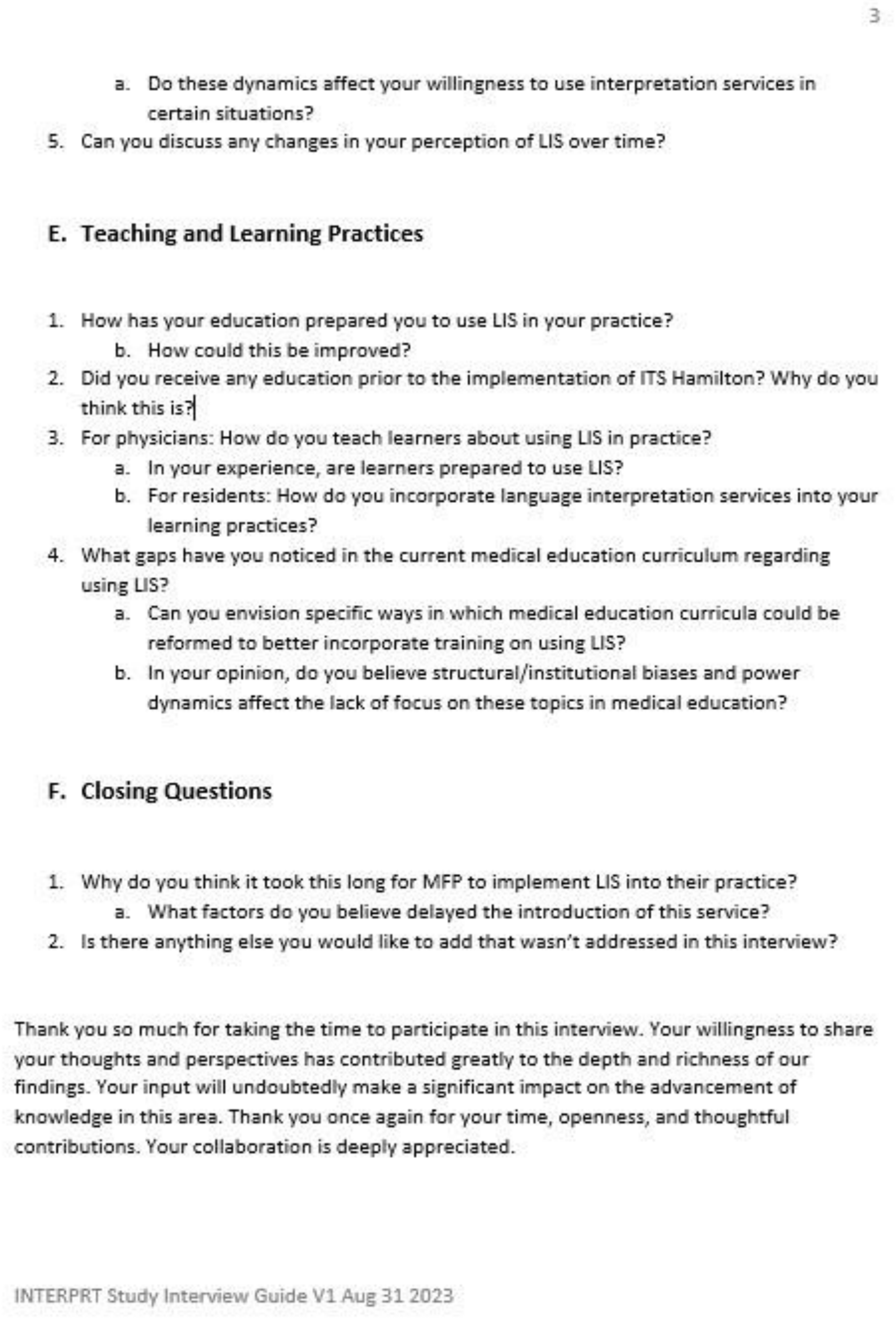

   a. Do these dynamics affect your willingness to use interpretation services in certain situations?

5. Can you discuss any changes in your perception of LIS over time?

E. Teaching and Learning Practices

1. How has your education prepared you to use LIS in your practice?
   b. How could this be improved?
2. Did you receive any education prior to the implementation of ITS Hamilton? Why do you think this is?
3. For physicians: How do you teach learners about using LIS in practice?
   a. In your experience, are learners prepared to use LIS?
   b. For residents: How do you incorporate language interpretation services into your learning practices?
4. What gaps have you noticed in the current medical education curriculum regarding using LIS?
   a. Can you envision specific ways in which medical education curricula could be reformed to better incorporate training on using LIS?
   b. In your opinion, do you believe structural/institutional biases and power dynamics affect the lack of focus on these topics in medical education?

F. Closing Questions

1. Why do you think it took this long for MFP to implement LIS into their practice?
   a. What factors do you believe delayed the introduction of this service?
2. Is there anything else you would like to add that wasn't addressed in this interview?

Thank you so much for taking the time to participate in this interview. Your willingness to share your thoughts and perspectives has contributed greatly to the depth and richness of our findings. Your input will undoubtedly make a significant impact on the advancement of knowledge in this area. Thank you once again for your time, openness, and thoughtful contributions. Your collaboration is deeply appreciated.