

Connecting Across a Communication Chasm: Exploring Experiences of Palliative Patient-Health Care Provider Language Discordant Care

K. Kehoe MacLeod, S.H. Lee, T. Tabatabaei, M.-È. Tittley, M. Gibb, C. Backman, L. Shoppoff, S. Karunanathan.

Background

Population-level health administrative data show lower rates of hospital harms, length of stay, and death for patients who speak the same language as their care provider. This is called language concordant care.

Health disparities exist among older adults belonging to different linguistic groups. Language barriers in health care generally negatively affect access, quality, and safety of palliative care services.

Yet, little evidence exists about the complex interactions among patients and health care providers who do not speak the same language and how language barriers impact the provision of palliative or end-of-life care.

Aim

To take a novel, in-depth look at the experiences of care providers involved in language discordant care interactions with older adults from linguistic minority groups at the end-of-life.

Methods

- 3 interconnected studies
- Semi-structured interviews using the same interview guide
 - Family doctors (n=16)
 - Nurses (n=12)
 - Primary care team (n=12)
- All had experience providing language discordant care to older adults
- Ontario, Canada
- Data collected: July 2023-March 2024
- Reflexive thematic analysis
- Intersectionality framework



Results

Characteristic	Study 1			Study 2			Study 3			Total
	Doctors	Nurses	Care Team	Doctors	Nurses	Care Team	Doctors	Nurses	Care Team	
Age, yr										
≤ 30	0	6	1	7	Geographic location					
31-40	8	3	2	13	Urban	8	10	12	30	
> 40	8	3	9	20	Rural	3	1	0	4	
Gender										
Female	8	12	9	29	Remote	5	1	0	6	
Male	8	0	3	11	Multilingualism					
Ethnic background										
European	7	7	7	21	Yes	11	11	11	33	
East Asian	6	0	0	6	No	5	1	1	7	
Other	3	5	5	13	Primary practice setting					
Primary practice setting										
					Hospital	7	4	0	11	
					Community clinic	6	7	12	25	
					Other	3	1	0	4	

Figure 1: Participant demographic characteristics

Providing care across language barriers requires more resources, which are often not available.

Increased time for appointments is needed to account for translation and repetition of information to ensure understanding.

I'm aware we're going to be repeating things several times, and there's some more that's going to go into it to ensure understanding, I'll book an extra 15 minutes. What happens then for the rest of my day is, it throws off...[working across language barriers] does negatively affect other patients' access to care while balancing that with having to provide good access to these individual patients. (TP03)

Care providers do more care coordination for their linguistic minority patients.

Amoxicillin is a big word if English isn't your first language and it's not your first alphabet. So then I'm going to call the pharmacy because the pharmacist speaks English. (MP01)

I'll set things up a lot more for them. Instead of giving somebody a requisition, I would send a message to our front desk to book their follow-up appointments, to arrange their tests for them, have where we're sending a test call us with the appointment details, so then we can call the patient versus [them calling] directly. (TP03)

Care providers encounter barriers to accessing interpretation services.

The biggest barrier would be cost. The cost of running the clinic is a lot. I pay overhead. So, the model I'm in is I pay a percentage to the clinic owner. The cost of what you might refer to as luxuries, like professional translation, is not something that I think [the owner] would be prepared to spend money on. (AP14)

Care providers felt that providing care across language barriers increased risk for both patients and providers.

There are risks of misunderstanding and miscommunication. It can also increase the time required to try and convey understanding and explanations. Again, runs the risk for both provider and patient, as well. So, for the patient, they, again, may misunderstand in terms of follow up, or tests, or health recommendations. It may also be for the provider then, as well, that if there's a bad patient outcome and also around dissatisfaction. (TP02)



Communicating across language barriers also creates barriers for the provision of person-centered care.

We are expecting patients to make decisions, with very limited information, and it's because of the language discordance. As you know, they are perfectly capable of making this decision. But because I am limited in the language, I'm not able to give them the necessary information. (MP08)

Those consultations become a lot more doctor-centered. And I'm just not able to have that in-depth pros, cons, risk, benefit discussion. So sometimes I just don't do it. I kind of will say - "you need this medication for your heart" - and accept that it's the best way forward. (AP14)

Discussion

- Care providers as individuals have adopted many creative strategies to cope with lack of resources in dealing with language discordant care, including using Google translate and white boards, taking photos of medications, and learning new languages themselves. But many see language matching between patient and provider as the ideal.
- Care providers highly value working for organizations that fund and prioritize access to interpreters. This helps to reduce provider burden too but is not the norm.
- There is a call for action by care providers for better training on how to work across language and cultural barriers to provide high quality, culturally sensitive palliative care.

Conclusions and Future Directions

Finding ways to provide care to patients and families in a language that they can easily understand truly matters in end-of-life care. Bridging the communication chasm can increase equitable access, quality, and safety of palliative care for patients from linguistic and ethno-cultural minority groups.

We have a project underway looking at care provider-recipient language discordance from the perspective of older adults and caregivers receiving home care.

Krystal Kehoe MacLeod PhD
kmacleod@bruyere.org

