PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	To 'Get By' or 'Get Help'? A Qualitative Study of Physicians' Challenges and Dilemmas When Patients Have Limited English Proficiency
AUTHORS	Parsons, Janet; Baker, Natalie; Smith-Gorvie, Telisha; Hudak, Pamela

VERSION 1 - REVIEW

REVIEWER	Marsha Regenstein George Washington University School of Public Health and Health Services US
REVIEW RETURNED	07-Feb-2014

GENERAL COMMENTS	This paper is very well written and addresses an issue of importance. My principal concern about the paper is that it draws conclusions that are not at all appropriate given the research purpose. The article, I believe, does a good job of describing physicians' experiences of care provision in situations of language disconcordance. The conclusion, however, proposes that physician practices in this area represent a pragmatic response in less than ideal circumstances, rather than a failure. This seems inconsistent with the rationale given about the importance of the topic, which is that these discordant situations are associated with mortality. There's absolutely nothing in the research design or findings to conclude that this is not a failure. This issue was described in an article by Maul, et al in the Joint Commission Journal for Quality and Safety (July 2012) as well as in Regenstein, et al in a JAMA perspectives piece (Jan 9, 2013 -- which also references a report from the Commission to End Health Care Disparities on physician communication with patients with LEP). I also question the use of the term "ideal circumstances" to describe health care interactions that require use of the third party interpreter. I am suggesting a major revisions although, in terms of restructure or rewriting, it is not that major. But it is critical to the paper -- that it not incorrectly extend the findings to fit a conclusion that is completely out of the scope of the study. This had nothing to do with whether physician practices constituted a failure or not and for the authors to use the findings for this conclusion misrepresents the data.

REVIEWER	Laws, Michael Brown University School of Public Health, USA
REVIEW RETURNED	10-Mar-2014

GENERAL COMMENTS	I appreciated the opportunity to review this paper as I have worked on policy regarding medical interpretation in the New England states and done some research of my own on language discordant and interpreted encounters. It is interesting to learn something about how physicians experience the challenges of language discordance and the decision about whether to obtain professional interpretation. The work is presented clearly and the paper is generally well-written and easy to read. I will say, however, that this study is very limited, and perhaps the acknowledgment of limitations is not entirely sufficient. The problem is that, as the paper reports, decisions about interpretation depend strongly on the resources provided within the specific hospital. It presumably depends on hospital polices as well, if there are any, but that is not discussed. This makes the paper a case study of a single institution. There are still insights that can be applied more broadly, but it would have been stronger to have respondents from more than one institution, with differing resources and policies, to support comparison. With that in mind, here are a few specific comments, some very minor, others more substantive. I will finish with my overall reflections. P. 4: I don't think it is correct to say that Canada is "by definition a nation of immigrants representing many linguistic traditions." It is a fact that there are many immigrants in Canada, but that is not the definition of the Canadian nation. P. 5: I think you need an argument for why "understanding physicians' experience is vital." How will this understanding contribute to solving the problems associated with language barriers? P. 7: You say the interview guide was pilot tested but say nothing more about this. How, with whom and how many respondents? Were any changes made as a result? P.10 et seq: The IDs for the excerpts in the appendix appear to be random. They do not help the reader find the corresponding excerpt. It would be better simply to number them consecutively. Also, I see no need for the footnotes. The material in footnotes could be in the text. P. 11: "All language lines are not created equal." Why not? Can you be more specific? Participants say they "can be awkward." Why? How? You mention a "variety of experiences in different settings" but say nothing about this variety. Please don't keep secrets from us! P. 13: You assert that physicians don't like having family members translate. Yet one of your excerpts (90702) has the physician asserting the exact opposite. This must be acknowledged and discussed. P. 14: The decision to "get by" may not be a failure or short-coming of the physician, but it's a failure and shortcoming of something or somebody. See below. My thoughts: I don't know what the law or consensus about this are

	in Toronto, or Canada generally, but in the United States it is widely held that anything other than interpretation by a trained professional, who adheres to a publicly available code of practice and ethics, is unacceptable in any circumstances in which professional interpretation is practical. It is the law in Massachusetts (not enforced or always observed but the law nonetheless) that professional interpretation must be available in emergency departments. Our federal Office of Minority Health has promulgated standards (aspirational in nature, but many states are pursuing ways of achieving them), called the Culturally and Linguistically Appropriate Services (CLAS) standards which include the right to professional interpretation or language concordant providers. There is a good evidentiary base for these policies. Contrary to the opinion of one of your respondents, having family members interpret is unethical and dangerous, for many reasons. Many people believe it should be outlawed. It can actually be considered abusive when children are made to interpret for their parents or other relatives. Family members may substitute their own judgments or wishes for those of the patient. This is always problematic, but perhaps more so in cultures with certain gender role or parental norms. And of course it can incur violations of privacy. As for hospital staff who happen to be bilingual, those with other professional roles, such as nurses or social workers, may actually misrepresent what physicians' say in order to substitute their own judgments (as my own research has found). In any case, they are not trained as interpreters. Your physician respondents find themselves in a difficult position, with which they are clearly uncomfortable, because the hospital does not provide adequate resources for the care of LEP patients. They are forced to assess whether they can get by without these scarce resources, but they have no formal or evidence-based means of making these assessments and the hospital seems to have no stated policy about this. This makes them anxious and insecure, understandably. The major conclusion I would draw from this study is that Ontario needs to pass some legislation and provide some resources to adequately serve the people who live there. The physicians are not responsible for this problem and there is evidently nothing they can do about it except try to muddle through. I am less interested in how they experience the problem than in getting it fixed. (See my comment on your page 5.) At the very least, the hospital should promulgate some clear policies, including a ban on having family members interpret except in the most critical situations; and create some guidance about how to assess when it might be alright to forego the inadequate available resources. Then it should campaign to obtain the resources needed to fix the problem. If hospital management is not already aware of this and working on it, then as I said in my earlier comment, it is a failure or shortcoming on their part. I voted for "minor revision" although I'm not sure how minor a revision it would be to accept my comments and refocus the discussion as I have suggested. In addition I think we would need to have some background on the policies and practices, and interpretation resources at the site; more generally in Ontario; and what relevant legal regime may prevail, if any. Is there a medical

	interpreters' association in Canada? Do they have policy and practice standards? The answer in the U.S. is yes and yes. Again, some reference to any generally accepted standards, or controversy if that's the state of affairs, would be helpful.

VERSION 1 – AUTHOR RESPONSE

Response to Reviewer 1 Marsha Regenstein
As we read it, Dr. Regenstein's major concern was that the conclusions drawn regarding whether physicians' practices in situations of LEP constituted a failure or not were an incorrect extension of the findings, beyond the scope of our study, and that this did the paper a major disservice.

Response: We have modified the conclusions of the manuscript to be more conservative in this regard. Our intent was not to blame physicians but rather to emphasize the challenges the participants described with caring for patients experiencing LEP. The participants in our study emphasized that they wished to provide high quality care and ensure appropriate communication, but at the same time acknowledged that the everyday realities/circumstances of clinical practice made this sometimes difficult to execute. We have revised the Discussion and Abstract sections of the paper accordingly, and have taken out the language related to 'failure/non-failure'. The revised paper is more nuanced and careful in its language and we have aligned our conclusions accordingly. We refer you to the revised Discussion and 'track changes' edits therein. These are woven throughout this section, and we refer you to pages 14 to 19 of the revised manuscript.

In addition, the Conclusions section of the Abstract (page 3 of the revised manuscript) now reads:
"In situations of language discordance, a physician's decision to 'get by' (versus 'get help') rests on a judgment of whether communication can be considered 'good enough' to proceed, and depends on the circumstances of the specific encounter. The tension set up between what is 'ideal' and what is practically possible can be experienced as a dilemma by physicians. The study's findings have implications for practice and policy not only in Canada but in other multilingual settings, and indicate that physicians require greater support."

Dr. Regenstein also suggests that we emphasize the importance of the topic (e.g. that these discordant situations are associated with important outcomes, including mortality). In order to address both reviewers' suggestions for acknowledging the broader context of the study and its practice implications, we have consulted the studies she suggested and incorporated them into the Discussion section.

The conclusions in the paper go well beyond the scope of the study in terms of the failure/non-failure assessment. This was not ever asked on the physicians.

Response: This concern was addressed through the revisions to the Discussion section outlined above.

Response to Reviewer 2 M. Barton Laws, Ph.D.
1. There is limited information on the interview guide. Making it available on-line or in an appendix would be a nice gesture.
Response: We have included a copy of the interview guide as an online appendix.

2. The reviewer went on to note that:
"…this study is very limited, and perhaps the acknowledgment of limitations is not entirely sufficient" and "There are still insights that can be applied more broadly, but it would have been stronger to have respondents from more than one institution, with differing resources and policies, to support

comparison."

Response: The reviewer is correct that the fact that these findings are based on results from a single centre is a limitation, and yes, it might have been a stronger design had there been respondents from more than one institution. We have revised the Discussion to acknowledge this more fully. In qualitative research, the goal is never to generalize to an entire population (in this case, of physicians) but rather to generate concepts that may be transferable across settings. As such, the concepts of 'getting by' and 'getting help' can be construed as broadly applicable, and indeed useful, in considering the experiences of physicians in hospital-based practice. Other investigators have used the notion of 'getting by' in US settings and our paper makes use of them in a new Canadian context.

P. 4: I don't think it is correct to say that Canada is "by definition a nation of immigrants representing many linguistic traditions." It is a fact that there are many immigrants in Canada, but that is not the definition of the Canadian nation.
Response: We have revised these two sentences (paragraph 1, page 4 of revised manuscript) to read as follows:
"Although Canada has two official languages (English and French), it is a nation with many immigrants, representing an array of linguistic traditions. New immigrants may not speak either official language."

P. 5: I think you need an argument for why "understanding physicians' experience is vital." How will this understanding contribute to solving the problems associated with language barriers?

Response: We have added a sentence to make this clearer for readers. The final two sentences of the last full paragraph on page 5 of the revised manuscript now read:
"Understanding physicians' experiences is vital, given that language barriers are known to translate into negative outcomes for patients (including increased mortality). (1, 8, 9) Such studies will yield important contextual information about patient care in situations of language discordance, identifying opportunities for (and barriers to) improvement, and informing practice renewal."

P. 7: You say the interview guide was pilot tested but say nothing more about this. How, with whom and how many respondents? Were any changes made as a result?

Response: We have added the following clarification to the first full paragraph under Data Collection on page 7 (second and third sentences in revised manuscript) and hope this is helpful to readers:
"The interview guide was developed by researchers with practice and methodological expertise, and pilot tested with three participants.(20) Following pilot testing the wording was modified to improve clarity of some questions, but no substantive changes to content were required."

P.10 et seq: The IDs for the excerpts in the appendix appear to be random. They do not help the reader find the corresponding excerpt. It would be better simply to number them consecutively.
Response: The IDs are the unique study IDs assigned to the participants in the study. This is standard practice in reporting the results from qualitative studies, and serves to indicate that the quotes came from different participants in the study. Alphanumeric identifiers such as these also help to preserve anonymity of the participants. We have not made any changes to these identifiers. The thematic headings of each section of the Results correspond to the thematic headings and exemplar quotes in the Table of quotes. We hope this clarification is helpful.

Also, I see no need for the footnotes. The material in footnotes could be in the text.
Response: We have removed both footnotes and incorporated these into the text. See the top paragraph on page 6 and the middle paragraph on page 10 of the revised manuscript (track changes edits).

P. 11: “All language lines are not created equal.” Why not? Can you be more specific? Participants say they “can be awkward.” Why? How? You mention a “variety of experiences in different settings” but say nothing about this variety. Please don’t keep secrets from us!

Response: We have added text on page 12 of the revised manuscript to describe variability in language lines, and what some participants felt is awkward about them. The concluding sentences of the first full paragraph on
page 12 now reads:
“Participants drew on a variety of experiences with language lines in different settings, indicating that all language lines are not created equal. For example, single handsets were seen as less preferable than the two handset option, although even with two handsets, it could be awkward if two people speak at the same time. Speaker phone was another option used.”

P. 13: You assert that physicians don’t like having family members translate. Yet one of your excerpts (90702) has the physician asserting the exact opposite. This must be acknowledged and discussed.
Response: We have clarified this statement. This participant was simply asserting that they saw potential benefits in having family members translate, despite its drawbacks. The individual was not asserting that this was the ideal but rather commenting on the benefits of having additional insights from family members during the clinical encounter. The middle of the first paragraph at the top of page 13 (revised manuscript) now reads:
“For example, participants recognized that using other staff members in the immediate vicinity who spoke the same language was not ideal, yet they would often opt for this approach as most efficient. In a similar vein, most participants indicated that using family members was not a preferred option; however one commented on what they saw as potential benefits to using family members -- that, unlike professional interpreters, families were able to provide additional contextual information as well as the relative’s perspective on the patient condition during interpretation (90702). Despite these pragmatic considerations, most participants acknowledged that there is an optimal or “best” way of providing care in these situations, namely the use of professional interpreters or translation aids.”

P. 14: The decision to “get by” may not be a failure or short-coming of the physician, but it’s a failure and shortcoming of something or somebody. See below.
Response: We have addressed this at length in response to Reviewer 1’s comments as well, and feel that the revised Discussion is more clearly in keeping with the study’s scope. We have attempted to address Reviewer 2’s specific concerns as well both in the further responses offered below as well as in the manuscript revisions (where applicable).

My thoughts: I don’t know what the law or consensus about this are in Toronto, or Canada generally, but in the United States it is widely held that anything other than interpretation by a trained professional, who adheres to a publicly available code of practice and ethics, is unacceptable in any circumstances in which professional interpretation is practical. It is the law in Massachusetts (not enforced or always observed but the law nonetheless) that professional interpretation must be available in emergency departments. Our federal Office of Minority Health has promulgated standards (aspirational in nature, but many states are pursuing ways of achieving them), called the Culturally and Linguistically Appropriate Services (CLAS) standards which include the right to professional interpretation or language concordant providers.
Response: We thank the reviewer for this thoughtful commentary. Indeed, Canada has a series of codes of practice and ethics governing physician behaviour, and it is recognized that it is the physician’s ethical responsibility for ensuring that adequate care is provided and that patients are offered opportunities to receive care in the language of their choice, where practical. The study site has had policies relating to the provision of interpretation services both for patients experiencing language barriers (LEP as well as those with conditions such as hearing loss) since at least 2000.

The hospital's policy is aligned with the Canadian Charter of Rights and Freedoms (federal) as well as the Ontario Human Rights Act (provincial). The policy in place at the time of the study (2009) as well as the current one refers to certain conditions where it is clear that professional interpreters are required (e.g. signing of consent documents, provision of detailed discharge instructions, instructions regarding medications, etc.) which the participants indicated that they felt confident in 'getting help' from professional interpretation services, etc. However participants did refer frequently to a 'grey zone', where they might be coming in to see a patient concerning a change in status, during more routine examinations, and at times when it might be difficult to secure interpretation services (e.g. outside the hours usually worked by professional interpreters, in emergency situations where time is of the essence and no professional interpreter is close at hand). At these instances, they might elect to use a language line, but at others the line might not be readily available and they might have to wait some time before securing translation even with the language line. In cases where the language in question is relatively rare, there can be a waiting period to secure an appropriate translator. In the city of Toronto, many different languages are spoken, which further adds to the complexity of the situation. Also, in cases where delays in securing translation occur, patient acuity and the need to offer care quickly might require the physicians to determine whether they would be doing more harm in waiting. All the physicians in our study expressed a desire to 'do the right thing', but pragmatic considerations (including the immediate availability (and ease-of-use) of adequate resources) might interfere with their ability to execute it to the level of the ideal. As Reviewer 1 rightly points out, assigning 'failure/non-failure' labels to participant accounts is somewhat beyond the scope of the study's purpose and its findings. As such we feel that it is important acknowledge the everyday practice realities that make caring for LEP patients challenging. These participants have made it clear that the day-to-day realities of practice are far more nuanced and complex than simply following a written policy to the letter.

There is a good evidentiary base for these policies. Contrary to the opinion of one of your respondents, having family members interpret is unethical and dangerous, for many reasons. Many people believe it should be outlawed. It can actually be considered abusive when children are made to interpret for their parents or other relatives. Family members may substitute their own judgments or wishes for those of the patient. This is always problematic, but perhaps more so in cultures with certain gender role or parental norms. And of course it can incur violations of privacy. As for hospital staff who happen to be bilingual, those with other professional roles, such as nurses or social workers, may actually misrepresent what physicians' say in order to substitute their own judgments (as my own research has found). In any case, they are not trained as interpreters.

Response: We understand that there are strong documented reasons for not using family members for translation. And participants indicated that this was their least preferred option. Yet, the references offered by Reviewer 1 (as well as that of Diamond et al, 2009; systematic review of Flores, 2005) indicate that such practices are relatively commonplace in US settings as well, despite legislation and standards to the contrary. To our knowledge the provision of professional interpretation in Ontario is not mandated specifically, although it is routinely available in major teaching hospitals in Toronto, as it is in the study institution. It is our understanding that hospitals independently determine whether they will or can provide professional interpretation services or not. It is up to individual institutions and individual practitioners (working in private practice) to provide these. No additional funding is provided to hospitals or individual practitioners to offer these services, and they must pay for these out of their global operating budgets. We also understand that the annual costs associated with in-person professional and technology-mediated translation services are not inconsiderable. This represents a further constraint on putting the ideal of professional interpretation into practice. In a systematic review, Flores (2005) indicates that there are few studies related to costs of interpretation services.

Your physician respondents find themselves in a difficult position, with which they are clearly uncomfortable, because the hospital does not provide adequate resources for the care of LEP

patients. They are forced to assess whether they can get by without these scarce resources, but they have no formal or evidence-based means of making these assessments and the hospital seems to have no stated policy about this. This makes them anxious and insecure, understandably.
Response: We believe we have addressed this in the revised manuscript (Discussion), indicating that the study institution in fact provides more services for LEP patients (and the physicians who care for them) than are likely available in other settings in Ontario. The hospital does have policies and procedures in place to support physicians. Language lines and professional interpretation services were available at the time of the study, however challenges such as acuity of the situation, time constraints, whether the technology was available at the bedside, etc. can all lead to practitioners 'doing what they can' given the circumstances. What we hope the study shows is the complexity of this issue even in the face of adequate resources, largely because of the very nature of clinical practice. Physician-patient communication is complex (and often less-than-ideal) even when both parties share the same language. Our study illuminates how the addition of language barriers into the communicative space adds further layers of complexity.

The remainder of Reviewer 2's comments repeat the concerns addressed above. While he comments that he is less interested in how the problem is experienced by physicians, than in getting it fixed, physician experiences are the focus of this paper. In keeping with Reviewer 1's comments, we do not want to extend our conclusions beyond the scope of the study. To address both Reviewers' concerns, we have expanded the Discussion, indicating further supports that are required, and have outlined improvements that have occurred since the time of the study, and potential solutions that could be the focus of further research.

In closing, we would like to thank both Reviewers and the Editor for their suggestions, and feel that the associated revisions have improved the manuscript considerably.

VERSION 2 – REVIEW

REVIEWER	Laws, Michael Brown University School of Public Health, U.S.A.
REVIEW RETURNED	10-Apr-2014

GENERAL COMMENTS	I appreciate the response and the revisions. My only additional comment is that some of the content of the authors' response to the review could in fact be incorporated in the paper, but has not been. I still feel that the policy and practice context is important. Whether resources and policies are adequate is a judgment. Physicians could certainly benefit from clear policy guidance which they seem to lack.

VERSION 2 – AUTHOR RESPONSE

Reviewer 2's comments M. Barton Laws
Dr. Laws suggested the following:
1. " I checked "no" to 14 [review question: To the best of your knowledge is the paper free from concerns over publication ethics (e.g. plagiarism, redundant publication, undeclared conflicts of interest)?] because it may be that most of the authors are in fact affiliated with the study site. In the response to my review, they extensively defended the policies and practices of the site and the resources it provides for interpretation. If the study site is in fact their employer, this would constitute a conflict of interest which would need to be acknowledged somehow."

Response: We have revised the Competing Interest Statement in both the manuscript and on the

online checklist as follows:
“At the time that the study was conducted, all authors were affiliated with the study institution (JAP, NAB, PLH were employees, and TSG was a residency trainee). At time of publication, JAP and NAB continue to be employed by the study institution, while TSG and PLH are employed elsewhere.” (see page 24, revised manuscript)

2. “I appreciate the response and the revisions. My only additional comment is that some of the content of the authors' response to the review could in fact be incorporated in the paper, but has not been. I still feel that the policy and practice context is important.”

Response: We thank Dr. Laws for his positive assessment of the revisions. To address his further comment, we have incorporated some of the material from the prior response letter into the Discussion to provide additional contextual information for readers. The relevant section of the Discussion (beginning at the bottom of page 15 to the top of page 17, revised manuscript) now reads:

“It should be noted that data collection for this study took place in 2009, when fewer supports were available. At that time, relatively little orientation to interpretation services was offered to medical residents at the study facility, but now instruction regarding available interpretation services is being offered routinely. Training in language barriers and cultural competence is now gaining attention amongst medical educators. Telephone interpretation services continue to evolve and become more user-friendly; however other supports are still needed to make it easier for physicians to ‘get help’ when they need it. The study site has had policies relating to the provision of interpretation services for patients experiencing language barriers since at least the year 2000. These policies are aligned with the Canadian Charter of Rights and Freedoms as well as the Ontario Human Rights Act. The institution’s policy on interpreter services in place at the time of the study (as well as the current one) refers to certain conditions where it is clear that professional interpreters are required (e.g. signing of consent documents, provision of detailed discharge instructions) and in which the participants indicated that they felt confident in ‘getting help’ from professional interpretation services. All the physicians in our study expressed a desire to ‘do the right thing’, but acknowledged that pragmatic considerations (including the availability and ease-of-use of resources) might interfere with their ability to execute it to the level of the ideal. It was these instances that they sometimes found troubling. Busy caseloads and time constraints on clinical practice were and continue to be an issue for most clinicians. For example, it can take some time for an interpreter to be found for telephone interpretation (depending on the specific language required), which again takes time away from caring for other patients. The use of a language line presumes that there is always a telephone readily accessible at the bedside (e.g. handset-based language line), which is not always the case, even in hospital settings. In cases where the language in question is relatively rare, there can be a waiting period to secure an appropriate translator even by telephone. In the city of Toronto, many different languages are spoken, which further adds to the complexity of the situation. When using in-person interpreters, aligning the schedules of physician, professional interpreter, and patient is frequently complex, with some physicians commenting that it can range from several hours to days before these sessions occur. This is confirmed by the findings from other researchers working with both physicians and other health care practitioners. (31, 32) As a result, it is not surprising that in some circumstances, physicians opt for the ‘path of least resistance’ (which may include using another health care professional or a family member to interpret).”

In addition, we have also added a few additional sentences under the Discussion section on limitations to address the issue of costs not having been considered but that they are an important avenue for future research. The end of the first paragraph on page 20 of the revised manuscript has the following sentences added:

"Finally, our study does not address financial considerations. We understand that annual costs

associated with in-person professional and technology-mediated translation services are not inconsiderable. This may represent a further constraint on putting the ideal of professional interpretation into practice. In a systematic review, Flores (2005) indicates that there are few studies related to costs of interpretation services.(35) This should be a topic for further research."