Perspectives of oncology nurses and oncologists regarding barriers to working with patients from a minority background: systemic issues and working with interpreters

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Abstract

This study aimed to ascertain the systemic barriers encountered by oncology health professionals (HPs) working with patients from ethnic minorities to guide the development of a communication skills training program. Twelve medical and five radiation oncologists and 21 oncology nurses were invited to participate in this qualitative study. Participants were interviewed individually or in a focus group about their experiences working with people from minority backgrounds. All interviews were transcribed verbatim and analysed thematically. HPs encountered language and communication barriers in their interactions with patients and their families, which were perceived to impact negatively on the quality and amount of information and support provided. There was a shortage of, and poor processes for engaging, interpreters, and some HPs were concerned about the accuracy of interpretation. HPs expressed a need for training in cultural awareness and communication skills with a preference for face-to-face delivery. A lack of funding, a culture of “learning on the job”, and time constraints were systemic barriers to training. Oncologists and oncology nurses encounter complex challenges in clinical interactions with minority patients and their families, including difficulties working with interpreters. Formal training programs targeted to the development of culturally competent communication skills are required.

Key Words: oncology, health professionals, minority patients, communication skills, cultural competence

Running title: Oncologists’ and nurses’ views on minority patients

Introduction

Worldwide rates of migration have increased (United Nations Department of Economic and Social Affairs, 2013). Health professionals (HPs), therefore, are increasingly likely to encounter patients from ethnic minority groups, including those from culturally and linguistically diverse backgrounds (Schouten and Meeuwesen, 2006), whose beliefs and practices regarding health and illness may differ markedly. For example, in 2011 in Australia, one in four residents were born overseas (26%), 19% of Australians spoke a language other than English at home, and 2% of the population did not speak English at all (Australian Bureau of Statistics, 2012). The United States Census Bureau has projected that by 2044, more than half of all Americans will belong to a minority group (any group other than non-Hispanic White); and by 2060, nearly one in five of the nation's total population will be foreign born (Colby and Ortman, 2014).

Cultural and linguistic diversity poses challenges for HPs; these will be magnified in cancer care, where communication of complex and often distressing information is required (Fallowfield et al., 2002, Butow and Baile, 2012). Communication is a core clinical skill (Fallowfield et al., 2002); it affects cancer patients' outcomes including satisfaction, psychological morbidity and understanding (Schofield et al., 2001). Of concern is that previous research has demonstrated significant differences in the quality, length and content of consultations between oncologists and cancer patients as a function of ethnicity (Butow et al., 2011a, Siminoff et al., 2006). In an early communication skills training study, 43% of oncologists reported that the patients with whom they experience the most difficulties communicating are those from minority backgrounds (Fallowfield et al., 1998).

One of the main difficulties reported by nurses and physicians when working with minority patients is dealing with limited access to interpreter services (Richardson et al., 2006). Interpreter services are heavily relied upon to overcome the language barrier of working with minority patients, and in particular are required during important stages such as consent and initial assessment. Interpreters, cancer patients and their families describe mismatches of expectations about the interpreter's role, with some patients expecting more than translation from their interpreter, for instance emotional support, advice and advocacy (Butow et al., 2011b, Butow et al., 2012, Rose et al., 2010).

Cultural competence consists of knowledge of cultural differences and cross-cultural similarities in how cancer patients face their illness and a set of clinical skills, both of which can be taught. Developing cultural competence relates not only to individual HPs but also to organisations and systems. At the level of the organisation, there must be acknowledgement of the importance of

culture, and services need to be adapted to meet the unique needs of minority patients (Surbone, 2008). Previous studies have demonstrated low rates of usage of professional interpreter services (Karliner et al., 2011) and have suggested systemic barriers to accessing interpreters (Leng et al., 2012, Kale and Syed, 2010). In addition, most oncology nurses and oncologists have not received training in how to communicate in a culturally competent manner. This is primarily because there is a lack of formally evaluated training programs.

To inform the development of an evidence-based training program for oncology HPs in how to best communicate with patients from minority backgrounds, it is critical to explore professionals' training preferences to inform the development of the format and content of a training program. To the best of our knowledge, no data are currently available to help guide intervention development in this area. Therefore this study fills a gap in the literature by providing a qualitative description of training needs in relation cultural competence in the oncology setting. Prior to the development of such programs, it is also important to ascertain what specific challenges cancer HPs encounter individually and at the organisational level when working with minority patients. Accordingly, the aim of this qualitative study was to explore organisational and systemic challenges encountered by HPs who work with minority cancer patients and caregivers. The individual challenges encountered by HPs in working with minority patients and caregivers are reported elsewhere (Watts et al., 2017).

Methods

Participants

Oncology nurses and medical and radiation oncologists who were working clinically with cancer patients at three Australian teaching hospitals were invited to participate by e-mail between May and October 2013 through relevant professional organisations. Written informed consent was obtained from all individual participants included in the study.

Data Collection

Individuals participated in a semi-structured interview conducted by EZ by telephone or face-to-face, or a focus group. Data were collected through focus groups and individual interviews to exploit the advantages of both data collection methods. Specifically, the group setting may lead to synergistic effects, including the creation of ideas that might not have arisen in individual interviews (Stewart, 1990). Focus groups also allow for observation of nonverbal responses (Stewart, 1990). By contrast,

individual interviews allow participants who are unable to attend focus groups (e.g. those living in rural areas) to be involved.

An interview schedule was used to guide the interviews and focus groups. Two slightly different interview schedules were employed depending on the method of data collection; for example, the interview guide for the focus groups included questions to elicit contrasting views (Stewart, 1990). Questions explored participants' definitions of the minority patient population; perceived impact of patients' minority backgrounds on clinical interactions; perceptions of the impact of the language barrier; experiences working with interpreters; and training needs and preferences. Data on sociodemographic and professional characteristics were also collected. All interviews were audio-taped and transcribed verbatim. Recruitment was continued until informational redundancy was reached (Patton, 2002).

Data Analysis

All interviews and focus groups were analyzed using a combination of the methods of grounded theory (Glaser and Strauss, 1967) and the techniques described by Miles and Huberman (2014) to develop an agreed set of codes and categories. The grounded theory constant-comparative method (Glaser and Strauss, 1967) was used, which involves coding units of meaning (i.e. specific response) and comparing and contrasting these to identify recurring themes and discrete categories. However, in contrast to grounded theory, whose explicit goal is to develop theory, the methodology was also informed by a more deductive approach informed by Miles and Huberman (2014), i.e. the interview schedule was used to develop the coding structure, in addition to allowing themes to directly and inductively emerge from the data. The emphasis of the approach of Miles and Huberman is to produce credible and replicable results in qualitative terms. It makes explicit the different strategies a researcher might use to guard against analytical bias and to increase the validity of findings, e.g. involvements of multiple analysts. Table 1 shows the phases of the qualitative analysis. In brief, one author (MT) coded the transcripts using the qualitative data analysis software QSR NVivo9. Two transcripts were selected early in the coding process and were coded by authors EZ and AP to compare the coding schemes and to ensure inter-coding agreement, and then MT continued to code the remaining transcripts.

[Insert Table 1 about here]

Results

Participant characteristics

Thirty-eight HPs were recruited. Twenty participants were interviewed individually, either by telephone (n=19) or face-to-face (n=1) and 18 participated in one of five focus groups. Interviews ranged from 20 to 60 minutes; focus groups ranged from 30 to 90 minutes. The full description of the sociodemographic and professional background of participants was published recently (Watts et al., 2017). The cohort was comprised of 12 medical oncologists, 5 radiation oncologists and 21 oncology nurses.

Twenty-five (66%) and 13 (34%) of participants were female and male respectively. Thirteen (34%) participants were born overseas, while 25 (66%) were born in Australia. Five participants (13%) indicated that English was not their first language, and four (11%) spoke a language other than English at home. Participant quotes are denoted by an ID number, professional background (N=nurse, O=oncologist), level of work experience (J=junior status – less than 5 years' experience, S=senior status – 5 years or more experience), and whether they spoke a language other than English (E=English only, A=another language). No differences in themes and subthemes were noted between focus group and individual interviews, and hence findings are described without reference to the method of data collection.

Key themes

The key themes identified included: defining the minority patient population and the impact of minority status on the clinical interaction; the language barrier; working with interpreters; and training needs and preferences. Selected quotations from HPs which illustrate these themes are presented in Tables 2 to 5.

(1) Defining the minority patient population and the impact of ethnicity on the clinical interaction

Selected quotes illustrating these concepts are presented in Table 2. Health professionals consistently defined the term 'minority' as referring to patients whose first language was not English (n=22), those who had been born overseas (n=9), or had a different cultural background (n=10). A small number of participants also included in their definition of 'minority' indigenous Australians (n=5), patients from religious groups (e.g. Jewish, Muslim) (n=6) and minority groups such as gay people (n=1). A number of HPs also acknowledged that there was change in the cultural context, with multiculturalism increasing in the community and in the workforce, and a greater cultural awareness in the migrant population.

Ten oncologists and five nurses remarked that minority consultations required more time due to the need for speech to be interpreted, and for clarification and exploration. Nine participants reported they spent more time with patients using strategies to increase rapport and communication,

such as asking questions about their patients' backgrounds. Consultations were also reported to take longer when an interpreter was present to interpret the conversation, and because it generally took longer to explain information to a patient who was not proficient in English. Additional time was also taken up encouraging follow-up contact.

[Insert Table 2 about here]

(2) The language barrier

Almost all participants described the language barrier as the most significant challenge working with minority patients (see Table 3).

[Insert Table 3 about here]

The majority felt that it imposed limitations on the amount and quality of information they were able to convey, and the depth to which they were able to explore topics. HPs also reported that the minimal availability of written resources in different languages in their health care setting was a significant disadvantage to minorities. Several participants explicitly mentioned the need for written hand-outs whilst others suggested online resources with translated information in the patient's language. Eight HPs suggested that many patients, even non-minority patients, may find it difficult to absorb information surrounding their diagnosis and treatment options. Without adequate take-home printed material to reinforce the information conveyed, minority patients were further disadvantaged. HPs also questioned whether the resources that were available were appropriate for the different cultural groups. This resulted in HPs feeling that minority patients were often not getting their information needs met in the same way as non-minority patients.

(3) Working with interpreters

Working with interpreters was a significant area of discussion for most participants, including oncology nurses, for whom the challenges focused upon lack of access to interpreter services on the ward when they were required (see Table 4). Five nurses reported that minority consultations required more time for interpretation, clarification and exploration. Additional time was needed to establish rapport and to encourage follow-up contact, and in the case of nurses, managing appointment changes and symptoms. Resoundingly (n=30), HPs reported a shortage of interpreter services.

[Insert Table 4 about here]

Adding to this challenge, HPs at several sites reported that there were either no or inadequate processes to identify a minority patient prior to their appointment and to allow interpreter services to be arranged before the consultation. The majority expressed appreciation for the services offered by interpreters, and a number of participants felt that the presence of an interpreter had a positive impact on the consultation. However, some participants felt that the presence of an interpreter changed the interaction with the patient. Oncologists reported needing to simplify information when the interpreter was involved. Ten HPs expressed concern regarding the accuracy of interpretation; whether all the information was being translated and also whether more subtle aspects of communication were being captured. They also reported instances when they felt the interpreter had decided to withhold information.

It could be difficult to find an interpreter for the correct dialect, given the increases in immigration from regional overseas areas. In smaller communities, threats to privacy could also arise. Most participants reported having used the telephone interpreter service, but the majority felt it was inadequate for more detailed or sensitive discussions due to the inability to exchange nonverbal cues. All HPs reported having had to resort to using a family member to interpret the consultation when a professional interpreter was unavailable. However, a number of HPs expressed concern regarding the accuracy of the information being conveyed, whether it was understood by the family member, and the risk of information being withheld from the patient.

(4) Training needs and preferences

The majority of participants indicated that they had very little or no formal training in cultural competence and/or in dealing with minority patients (n=35, 92%) (see Table 5). Barriers to formalised training included: HPs may think they do not need training, lack of funding, and the view that any single culture was too diverse for cultural training to be beneficial. In addition, 16 participants believed that cultural competence was a skill that had to be learned 'on the job' (n=11 oncology nurses, n=1 radiation oncologist, n=4 medical oncologists). Several participants mentioned time constraints as a barrier and felt they would not have time to attend in-person training or allocate time at work to doing an online training program.

[Insert Table 5 about here]

Of the 12 participants who indicated their preferred mode of delivery for training, six preferred face-to-face training, two online delivery, and four a preference for face-to-face delivery supplemented by online delivery. None of the oncologists suggested online training only, while two nurses did. Also, nurses' preferences were equally split between face-to-face training (n=3), or a

combination of face-to-face and online (n=3), whereas oncologists mostly preferred face-to-face (three out of four). Some participants suggested that training be targeted to those beginning training in the field, when teaching would have more relevance, or to junior HPs, who were perhaps more likely to adopt new approaches rather than change existing ones.

The types of additional training required included communication and dealing with the language barrier (n=14), which included skills such as being able to assess a patient's understanding of the information communicated, learning to individualise or tailor conversations, and successfully communicating about diagnosis, prognosis and treatment plans. More than half of the participants suggested cultural awareness training, including training on cultural sensitivity and asking appropriate questions about cultural background; general education around common religions and cultures; and consultation with community groups about how to adapt treatment to appreciate cultural differences. Two other areas for improvement in oncology care were to put systems in place to alert HPs to patients with a minority background, and a need for training in how to provide individualised care (n=5).

Participants (n=18) suggested that some information about specific cultural groups and their services would improve their work with minority populations, with the preferred format being an online resource such as a webpage. In addition, training on how to work with interpreters appropriately was discussed by approximately half of the participants. The type of training desired by participants for using interpreter services included: learning how to access interpreters, learning to look at the patient whilst speaking rather than at the interpreter, and using role-play education to demonstrate successful use of interpreter services.

Discussion

There have been many calls for the development of evidence-based training programs for doctors in intercultural communication (Paternotte et al., 2015, Cyril et al., 2016), and such training programs have been shown to increase cultural awareness (Dabney et al., 2015) and cultural competence (Doorenbos et al., 2016). In accordance with the UK Medical Research Council's conceptual framework for the development of a complex intervention (www.mrc.ac.uk/complexinterventionsguidance), the main aim of this study was to explore HPs' training needs and preferences relating to formal education programs for developing cultural competence prior to developing and pilot-testing such a program. Based on the findings reported here, we have recently completed the development and pilot-testing of an online training program, the results of which will be reported separately. Another aim of this study was to ascertain the systemic

and organisational challenges experienced by oncology HPs working with patients from minority backgrounds, including difficulties associated with working with interpreters.

Underscoring previous research (Alpern et al., 2016), the primary challenge encountered by HPs working with minority patients was the language barrier, which was perceived to contribute to minority groups having significant unmet information needs. This was exacerbated by limited access to culturally appropriate written resources in the patients' own language. There was also a shortage of interpreters, and when engaged, oncologists were concerned about the accuracy of interpretation, including whether all the information was interpreted and whether more subtle aspects of the patient-clinician interaction were captured. These findings are not unique to the cancer setting, and have also been reported in other settings, including paediatric medicine are have

Minority patients have unmet information and support needs that arise from language barriers and the lack of access in the health care setting to culturally appropriate written information in patients' own language. Patients from minority backgrounds have reported dissatisfaction with the amount, reliability, and/or intelligibility of the information available (Leng et al., 2012), feelings of frustration and alienation when they fail to understand information, and their need for access to verbal and written information in their own language (Kwok and White, 2011, Butow et al., 2011b). Previous research has demonstrated that many health professionals do not handle language and communication barriers well (Butow and Baile, 2012). For example, several studies have analysed audio-taped consultations between doctors and their patients as a function of ethnicity. Compared to patients from the majority culture, oncologists engaged in significantly less relationship building with non-white patients (Siminoff et al., 2006) and, when an interpreter was present, doctors spent less time speaking about cancer-related issues and less time summarising and informing immigrants (Butow et al., 2011a); and were engaged in less hope-giving (Butow et al., 2013). While individual factors such as personal biases and stereotypes are certainly involved, these disturbing disparities likely also arise from systematic factors including poor access to evidence-based training in culturally competent communication for oncology settings.

In the current study, HPs were concerned about the shortage of interpreters, about the accuracy of interpretation, and the impact of an interpreter on the consultation, whilst also recognising the benefits of a professional interpreter. Cancer patients and caregivers from minority backgrounds have reported similar issues with interpreters including: not being aware of the availability of interpreting services (Leng et al., 2012), having a different interpreter at each hospital consultation, poor interpretation, and being provided with interpreters who speak the wrong language (Butow et al., 2011b). In the absence of a professional interpreter, minority patients (Leng et al., 2012) and HPs often use family members to interpret (Karliner et al., 2011, Kale and Syed, 2010). This is of concern given that trained interpreters are up to 70% less likely to make errors in the translation of clinical

terminology than untrained interpreters (Gany et al., 2010). Previous studies have highlighted that professional interpreter services are under-utilised in public health services (Kale and Syed, 2010) and by surgeons and oncologists in cancer settings (Karliner et al., 2011). An important barrier to usage of professional medical interpreters is systemic, namely lack of easy access to these services (Karliner et al., 2011). In the current study, HPs expressed the need for process change, where they could be informed in advance and prepare for a minority patient. This was also highlighted in previous studies, which suggested the need for system-level changes such that standardized procedures are implemented so that a professional interpreter can be arranged at short notice (Kale and Syed, 2010). Organisational processes should also ensure that minority patients are aware of, and are given the option of, having a trained interpreter present at their consultations (Leng et al., 2012).

Interestingly, 10 oncologists and 5 oncology nurses in this study reported that consultations with minority patients took longer because of the need for interpretation and clarification. Yet audio-taped consultations of oncologists speaking to immigrants with an interpreter showed that doctors spoke proportionally more to Anglo-Australian patients than to immigrants (Butow et al., 2011a). Interpreters working with minority clients have reported that oncology HPs often fail to: check on interpreters'/patients' language or dialect compatibility, use lay language and short sentences, and speak in the first person (Butow et al., 2011b, Butow et al., 2012). In the current study, it appears that oncology HPs were concerned about interactional deficits with minority patients due to cultural and language barriers, and that they would benefit from specific training targeted to developing culturally competent communication skills, including how to work effectively with interpreters, rather than generic skills training (Butow and Baile, 2012). Previous research has identified ways in which oncology HPs could work more effectively with interpreters (Saleh et al., 2009, Lubrano di Ciccone et al., 2010).

Strikingly, no participant reflected on the difference between consecutive and simultaneous translation by interpreters. This could result from limitations in their experience or lack of availability of interpreters trained in the simultaneous method. Simultaneous interpreting is "a near word-for-word running translation performed almost immediately after the original speech – nearly simultaneously" (Gany et al., 2007 p. 319). In consecutive interpreting, the interpreting occurs after the speaker has finished speaking (Hornberger et al., 1996). Medical interpreting can also be "proximate" (where the interpreter is physically present in the room) or "remote" where the interpreter is outside the room and connected to the interaction by telecommunication (Gany et al., 2007). We did not ask participants what mode of interpreting was generally available. However, medical interpreting is usually proximate consecutive (PCMI) or over-the-telephone consecutive (remote consecutive medical interpreting [RCMI]) (Gany et al., 2007). HPs in the current study reported some limitations of telephone-based RCMI. When HPs describe the patient in the third person to the interpreter, rather

than making first person statements directly to the patient, the clinician-patient relationship has slipped to allow the clinician-interpreter and interpreter-patient relationships to be privileged [24, 26], hence the care paradigm is fundamentally altered. Many of these problems predominate with the consecutive model of language translation. Only through new communication training approaches augmented by system-level changes that cultivate simultaneous translation, alongside the use of short phrases, can the clinician-patient relationship be restored to its proper place (Gany et al., 2013, Silva et al., 2015).

HPs in our study asked for communication skills training where role play workshops would allow the face-to-face experience of working with interpreters. Clinicians could learn to maintain eye contact with the patient, use the first person, practice ‘sound bites’, get a rhythm going in alternating their talk with any consecutive translation, and empower their non-verbal interaction to empathise with the patient (Butow and Baile, 2012, Kissane et al., 2012, Gany et al., 2007). The barriers to training are primarily at the level of the health care organisations and educational institutions. The organisational culture of “learning on the job” needs to be challenged as there is no evidence that communication skills of the type needed here are learnt when the “hidden curriculum” is so strongly cast against this.

Examination of the current findings within the context of the broader interpreting literature, suggests many similarities and highlights that many of the systemic barriers to the optimal use of interpreters are not unique to the oncology context. This includes the finding that when professional interpreters are not used due to lack of availability, minority patients have inadequate understanding about diagnosis and prognosis and worse symptom management (Brisset et al., 2013). This broader body of literature also shows that there is frequently no consensus over the role of interpreters as either exclusively transmitting information, or playing the role of cultural broker, clarifier or patient advocate, thus highlighting the importance of specifically clarifying the interpreter’s function before the health care encounter takes place (Sleptsova et al., 2014).

Study limitations include the inability to make causal inferences as it was a qualitative exploration. The opt-in nature of the study introduces some selection bias. Nevertheless, the views expressed by HPs closely align with those reported by minority cancer patients (Butow et al., 2011b) thus providing support for the veracity of the current findings. Focus groups can discourage the expression of divergent views. However our focus group themes were similar to those obtained from individual interviews.

Clinical Implications

Improvements in HPs' communication skill usage with interpreters, together with the employment of qualified interpreters who are open to continual training will enrich the cultural sensitivity of our care. Access to interpreters would grow, the trustworthiness of their translation increase and thus language barriers would be ameliorated. We need to correct the systemic barriers including a shortage of interpreters, poor processes for alerting HPs to minority patients, and limited availability of culturally appropriate written materials. The responsibility for these improvements rests with both institutions and providers.

Conflict of Interest

David Goldstein has consulted to the following companies, without remuneration: Pfizer, Bayer, and Celgene. Bettina Meiser has a remunerated consultant role with the company Astrazeneca with respect to an unrelated project.

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Table 1: Stages of qualitative analyses

Stage	Description of approach
1. Initial coding	Reading and re-reading of transcripts, noting down initial codes (MT)
2. Deductive coding	Using the interview schedule and research questions to develop the coding structure (MT)
3. Inductive coding	Searching for potential themes and subthemes by comparing and contrasting these to identify recurring themes and discrete codes (MT)
4. Reviewing themes	Checking if themes work in relation to coded extracts and the entire data set (MT)
5. Involvement of multiple analysts	Defining and naming themes relating to develop and agreed set of themes and subthemes (EZ, AP, MT)
6. Producing the report	Final stage of analysis, selection of compelling extracts and quotes (MT)

Table 2. Defining the minority population and the impact of minority status on the consultation: selected quotes from health professionals

Theme	Participant details	Selected quotation
Sub-theme		
Defining the minority population Change in the cultural context	Participant 26 – O,S,E	“Most ethnic groups are diverse as well. <i>I mean they’re</i> more open to communication now than they would have been 20 years ago.”
Impact of minority status Minority consultations require more time	Participant 16 – N,S,E	“ <i>I</i> sense that they are disadvantaged because they – it actually takes longer time-wise.”

Notes. Professional background is denoted by: N = nurse, O = oncologist. Level of work experience is denoted by J = junior status – less than 5 years’ experience, S = senior status – 5 years or more experience. Whether participant spoke a language other than English is denoted by E = English only, A = another language.

Table 3. Language barrier: selected quotes from health professionals

Sub-theme	Participant details	Selected quotation
Limits the amount, quality and depth of information conveyed	Participant 27 – O,S,E	<i>“I told him the side effects but I didn’t dwell on each of them in great detail...it just seemed like too much information, so that was a change that I made that I probably would not have made if he had been English speaking.”</i>
	Participant 4 – N,S,E	<i>“I think overall no, I would have to say no. I mean we try our best but often due to limitations mentioned before it’s just not possible for everyone to get the same level of information, yeah, I just think some patients, I mean generally we try our best.”</i>
Lack of culturally appropriate written resources	Participant 9 – N,S,O	<i>“The lack of really good and useful written resources, in their language are very, very limited. The written resources that are available in other languages are very, very generic.”</i>
	Participant 16 – N,S,E	<i>“They only absorb the first little bit, we know that and we know that I mean it’s not uncommon for patients to really have no idea what the real diagnosis is.”</i>
	Participant 12 – N,J,A	<i>“The majority of information that’s in the cancer arena hasn’t really been developed in consultation with the cultural group as to how appropriate the information is that has been translated, so some of that may not translate and it may not be appropriate because it doesn’t get the message across.”</i>

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Table 4. Working with interpreters: selected quotes from health professionals

Sub-theme	Participant details	Selected quotation
Shortage of interpreter services	Participant 10 – O,J,A	<i>“Even if you try and get one in advance and not for some uncommon languages for example, you know just the secretarial staff will come back and say no can’t get a face-to-face interpreter, have to you use a phone interpreter or can’t get a phone interpreter or you’re waiting on hold on the phone for twenty minutes.”</i>
	Participant 6 – O,S,E	<i>“The immigration we’re seeing currently from China is much more diverse and much more a dialect diverse and so us not being able to get an interpreter or getting an interpreter that doesn’t really understand what the person’s saying is a bigger issue.”</i>
Poor processes for identifying need for interpreters	Participant 3 – O,S,A	<i>“It’s very difficult unless you know the patient or the referring doctor tells you that so-and-so requires a Mandarin interpreter and so book them way in advance, you know it’s often impossible.”</i>
Positive impact of the interpreter	Participant – 28 – O,J,A	<i>“For the most part I found that if anything the patients are maybe you know more comfortable having somebody who they can maybe relate to.”</i>
Presence of an interpreter changes the interaction	Participant 15 – O,S,E	<i>“People love stories, people love to tell stories and a lot of, I mean I think I know some of my patients pretty well and it’s because they like, they like to tell stories, like to chat and you can’t chat with an interpreter, it doesn’t make any sense.”</i>
Need to simplify information in the presence of an interpreter	Participant 3 – O,S,A	<i>“You have to make it simple for the interpreter to then interpret it for the patient, so because it’s difficult to talk sort of philosophical or abstract type ideas with the interpreter going through the patient, so I guess I try and simplify the consultation as much as possible.”</i>
Concerns about accuracy of	Participant 7 –	<i>“Scenarios where the interpreter has withheld information because they thought that it might be of</i>

interpretation	O,S,E	harm to the patient or hurt the patient. And that <i>obviously presents challenges.</i> ”
Concerns about privacy	Participant 12 – N,J,A	<i>“I was using an interpreter for quite a rare dialect they didn’t want us to use that interpreter because the group was really quite a small group and they just a bit too confronting for people within the social group to know what was going on. They thought it was a bit intrusive.”</i>
Concerns about use of telephone interpreter service	Participant 14 – N,J,E	<i>“We would have to get a face-to-face because it just wouldn’t work, but for those subsequent follow-up appointments when you’re asking the basic side effects and getting questions answered you know back from the patient, yeah they seem to work okay.”</i>
Challenges of using family as interpreters	Participant 1 – O,S,E	<i>“I much prefer to use the hospital interpreters rather than relatives. That’s one situation I don’t like is other people interpreting for me but I have had situations where the families refuse a medical interpreter, and insist on using a family member to interpret and I am concerned that they are not translating what I’m saying and I’m concerned that I’m not hearing what the patient is saying.”</i>

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Table 5. Training needs and preferences – selected quotes from health professionals

Sub-theme	Participant details	Selected quotation
Barriers to training – lack of funding	Participant 11 – N,S,E	<i>“If you want to translate you have to translate in all these languages and there’s just no funding, there’s just, to actually do that for patients.”</i>
Barrier to training –learning on the job	Participant 23 – N,S,E	<i>“Basically thrown in aren’t we and we just pick it up ourselves”.</i>
Barrier to training – time constraints	Participant 17 – N,J,O	<i>“Working here now I see the time pressures, there just is no time for online and there’s so much being dumped online, so you know coming to face reality now and realising there is a limitation. I still like education the notion of providing the theory via online and then the workshop.”</i>
Preference for face-to-face training	Participant 17 – N,J,O	<i>“We have a lot of online stuff so it’s like a, just another online thing to do – I think a workshop would be better.”</i>
Need for cultural awareness training	Participant 7 – N,(M),O	<i>“As someone who’s lived most of life in Australia I think it’s important that we sort of understand and appreciate people different cultural settings and different attitudes to death and dying and cancer and it’s something which we really don’t, we certainly don’t get taught in medical school.”</i>
Putting systems in place to improve management of minority patients	Participant 19 – N,J,E	<i>“There needs to be a better system of alerting us to the fact that they’re a non-English speaking background whereas, because we’ll get them in and then go oh you have no way of communicating with us and we don’t realise that prior.”</i>
Training in individualised care	Participant 6 – O,S,E	<i>“How you individualise therapy for people and how you individualise conversations for people and how what, what you assume and what you ask me, so I think it would also fit into a broader communication skills</i>

agenda about asking rather than assuming.”

Training in how to use interpreters	Participant 10 – O,J,A	<i>“Some training on how to effectively use an interpreter would be a fairly basic level of training that I think would be required.”</i>
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