Lived experiences of palliative care physicians on the impacts of language and cultural discordance on end-of-life care across Ontario, Canada: a qualitative study using the intersectionality-based policy framework

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Abstract

Background Language and cultural discordance refer to when a physician and patient do not share the same language or culture. This can create barriers to providing high-quality care at the end-of-life (EoL). This study explores the intersections of language, culture, geography, and care model in EoL care from the perspectives of palliative care physicians.

Methods In this exploratory-descriptive qualitative study, semi-structured interviews (1-h) were conducted virtually between July and November 2023. We interviewed 16 family physicians with experience providing linguistic and/or culturally discordant palliative/EoL care in various urban, suburban, and rural regions of Ontario, who practiced at community and hospital outpatient clinics, home-based care, or long-term care homes. We used reflexive thematic analysis to identify themes across the interviews guided by the intersectionality theoretical framework.

Results We identified three themes 1) Visible barriers to care access due to the inability to communicate accurate information and insufficient time spent during appointments with patients; 2) Invisible barriers to care access, shaped by the Eurocentric approach to palliative care and physicians' lack of awareness on cultural discordance; 3) Workplace supports that currently exist and interventions that physicians would like to see. Community physicians following fee-for-service models were less likely to have access to professional interpreter services. Physicians in long-term care emphasized resource limitations to providing culturally-appropriate care environments.

Conclusion Cultural discordance required awareness of personal biases, while language discordance hindered basic communication. These findings will be useful in informing clinical practice guidelines and mobilizing policy-level change to improve palliative/EoL care for patients from linguistic and cultural minority groups.

Keywords Language, Cultural competency, Palliative medicine, Primary care, Health policy, Qualitative research, Antiracism

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Lee *et al. International Journal for Equity in Health*   (2024) 23:229

Page 2 of 13

Introduction

In Canada, over 20% of the population are immigrants with permanent residence and more than 9 million people speak a minority language that is not officially recognized in any province or territory [1]. When patients do not share the same language or culture as their physician, referred to as language and cultural discordance respectively, they have significantly poorer quality of and access to care [2]. Numerous studies have shown that language discordance can lead to less adherence to follow-up care, more adverse events, and increased healthcare costs [3–7]. Likewise, cultural discordance can negatively affect trust and relationship building among patients and physicians, thus reducing transparent decision-making around treatment options and goals of care [8, 9].

Terminally ill patients from linguistic minority groups are particularly vulnerable to issues related to language and culturally discordant care due to age-related communication problems and the increasing need to have difficult conversations around age-related illness [10, 11]. Additionally, nearly three-quarters of palliative and end-of-life (EoL) care is delivered by family physicians. This places older linguistic minority patients at the intersection of challenges related to accessing primary care, which can vary between geographic locations and primary care funding models [12]. Compared to urban settings, patients in rural communities are less likely to receive specialist palliative care and more likely to die in an acute care hospital [13]. Furthermore, capitation model in primary care (compensation based on set roster of patients) has a stronger incentive for providing comprehensive and longitudinal care for chronic disease management compared to fee-for-service (FFS) model [14, 15].

Several studies have demonstrated negative outcomes of patient-provider language discordance when managing chronic conditions such as diabetes, tuberculosis, and cancer [16–18]. Though language and cultural-concordant care are important across all medical specialties, these disparities are especially pronounced in palliative and end-of-life settings where sensitive life or death topics are discussed regularly. Additionally, a recent population-based study in Ontario, Canada showed higher rates of in-hospital deaths and adverse outcomes for frail home-care patients receiving language discordant care [19]. However, there is limited research on the social contexts of language discordant care in palliative/EoL settings comparing across geographic regions and/or funding models in Canada. Likewise, research exploring the interconnections between language and cultural discordance in palliative/EoL care and the implications for care provision and provider experience is virtually absent in the Canadian context. To our knowledge, this is the first study to investigate the intersectionality of language, culture, geography, and care model in palliative/EoL care quality and access through qualitative data [20].

This study explored the perspectives of family physicians with experience providing language and/or culturally discordant palliative/EoL care in Ontario, Canada and compared experiences across different geographic regions and primary care models.

Methods

Study design

An exploratory-descriptive qualitative (EDQ) study was conducted to explore the lived experiences of family physicians providing palliative and/or EoL care to patients across a language and/or cultural barrier. The EDQ design is a hybrid methodology for understanding new aspects of under-researched phenomena through flexible data collection while providing detailed accounts of the phenomenon from participants' insights without deep theoretical interpretations [21]. See Lee et al. 2023 for the study protocol [22].

Recruitment

Study participants included family physicians providing palliative and/or EoL care to adult patients living at home or in long-term care in Ontario, Canada. Participants working at non-home care settings such as hospices, inpatient units, and emergency departments were excluded because these patients often have different characteristics, needs, and health statuses. We recruited 16 participants using purposive and snowball sampling by leveraging the professional networks of the palliative care clinician-scientists and researchers on the study team. We sought to capture participants of diverse genders, primary languages, ethnicities, and from different practice models and geographic regions across Ontario. We ceased data collection at 16 participants when additional interviews did not yield new findings thereby achieving data saturation [23]. This study met all aspects of COREQ to ensure qualitative rigor (Appendix 1) [24].

Data collection

After providing informed consent, participants completed a 5-min demographic survey before the interview (Appendix 2). Semi-structured interviews were conducted via video conferencing by two researchers between July to November 2023 following an interview guide developed by the research team in partnership with a linguistics expert and a patient partner (Appendix 3). All interviews lasted approximately 1 h and were audio recorded and transcribed verbatim. Interviewers also engaged in reflexive journaling and memo-writing after each interview [25].

Lee *et al. International Journal for Equity in Health*   (2024) 23:229

Page 3 of 13

Data analysis

We used MAXQDA software for data management [26]. Interview transcripts and reflexive journals were analyzed using Braun and Clarke's approach to reflexive thematic analysis, using a hybrid approach of inductive and deductive theme development [27]. Inductive analysis focused on pattern recognition that helped generate initial codes and defined themes that represented the dataset [28]. Deductive analysis was informed by the Intersectionality-Based Policy Analysis (IBPA) Framework to clarify complex relationships between ethnic background, care setting, remuneration model, and geographic region in the current socio-economic context [29]. One researcher and one caregiver partner with lived experience on the topic independently read, coded, and analyzed all transcripts. Findings were discussed biweekly among the research team (S.H.L, M.G., M.C. and K.K.M.) and results were reflexively updated as interviews were ongoing and reviewed for cohesiveness. Team consensus was achieved through five post-interview collaborative meetings (S.H.L, M.G., M.C. and K.K.M.) where we shared our interpretations of the data, reflected on each team member's perspectives, and agreed on how to present and discuss the themes.

Ethical considerations

This study received approval from the Bruyère Research Institute Ethics Board (project ID M16-23–015). All participants provided written informed consent.

Results

The demographic characteristics of the 16 family physician participants are summarized in Table 1. All participants acknowledged a close, often intertwined, association between language and cultural discordance, where language represents just one aspect of a person's cultural background (Fig. 1). However, language and cultural discordant care manifested and were handled differently in clinical practice, reflecting 3 major themes: Visible barriers to care – inability to communicate and insufficient time spent with patients; Invisible barriers – the Eurocentric approach to palliative care and physician's lack of awareness of cultural discordance; Workplace supports – interventions that currently exist and that physicians would like to have to cope with patient-provider language and cultural discordance. These themes are described in detail below and synthesized in Table 2. Supporting quotes are in Table 3.

Table 1 Participant demographic characteristics

| Characteristic	No. of participants $n = 16$
Age, yr	
≤ 30	0
31–40	8
> 40	8
Gender	
Female	8
Male	8
Ethnic background	
European	7
East Asian	6
South Asian	2
Caribbean	1
Multilingualism	
Yes	11
No	5
Years of practice as staff	
0–10	6
11–20	9
> 20	1
Formal training in palliative/end-of-life care	
Yes	11
No	5
Geographic location	
Urban	8
Suburban	3
Rural	5
Primary practice setting	
Hospital	7
Community clinic	6
Long-term care	2
Home care	1
Employment status	
Full-time	14
Part-time	2
% time spent in palliative care	
5–25%	5
26–50%	3
> 50%	8
Remuneration model	
Fee-for-service	4
Capitation	2
Alternate funding plan (salary)	6
Mixed	4
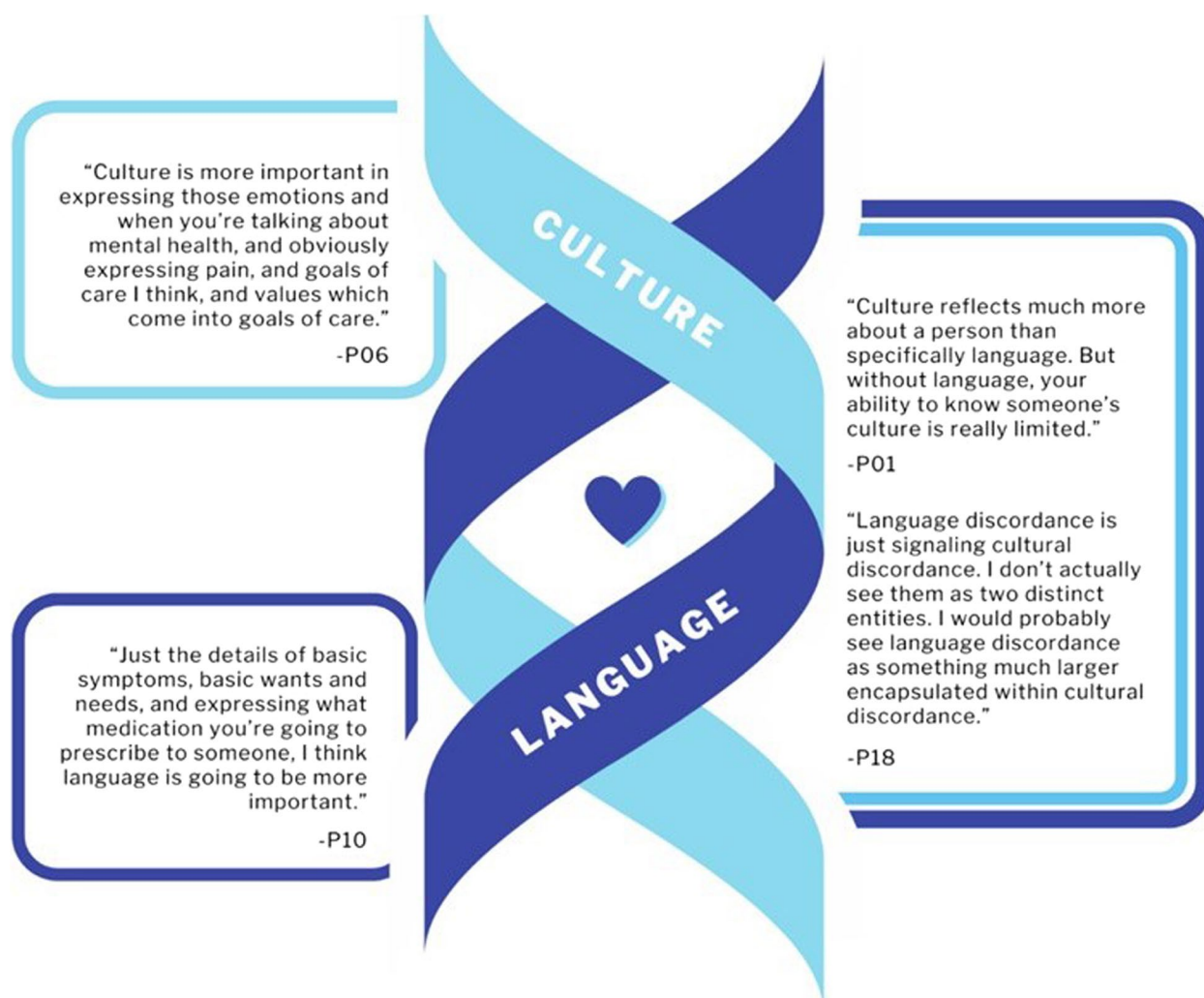
Fig. 1 Similarities and differences within the interrelation between language and cultural discordance in palliative/EoL care practice

Theme 1: Visible barriers in language and cultural discordant care

Most participants reported relying on family or professional interpreters to overcome issues of language discordance when providing palliative/EOL care, but mentioned both benefits and drawbacks to these forms of interpretation. Family interpreters were more available and facilitated family involvement in decision-making. However, participants suggested that family interpreters were more selective about what they translated and had a higher emotional involvement during discussions of care when they were required to translate these discussions. Most participants preferred to rely on professional interpreters for impartial and more complex translations, but felt that they were less accessible during acute situations and were more costly. Some participants specified that their attempts to use non-verbal communication to evoke comfort or

reassurance for patients who did not speak the same language tend to get lost in translation:

"As decisions become more complex, that's where you truly end up having to rely on a [professional] interpreter. But at the same time, a lot of these conversations are very nuanced, and there is something about language and how we convey information that can easily get lost in translation" – P02.

Participants highlighted that they felt that in language discordant care interactions, patients could not accurately express their preferences and gain a detailed understanding of the options for treatments and care plans. Many expressed concerns with symptom miscommunication during emergency situations after hours when formal interpretation was often unavailable.

Participants also remarked on the considerable amount of time required to assess patients during language

Table 2 Overview of physician perspectives on language and cultural discordance in end-of-life care

Theme	Subthemes and descriptions
Visible barriers to access and quality of care	Inability to communicate • Biased and filtered translation when relying on family interpreters • Loss of non-verbal emotional communication and rapport when relying on professional interpreters • Multilingual physicians not comfortable with medical terminology when speaking patient's language • Patients unable to express their preferences and gain an in-depth understanding of treatment options
	Insufficient time with patients • More time and effort spent when facing language discordance • Physicians resort to a quick menu of options, rather than counselling • Some remuneration models (ie. fee-for-service) prioritize efficiency over patient-centered care
Invisible barriers to access and quality of care	Eurocentric approach to palliative care • Canada's palliative care model inherently favours English-speaking patients with Western values • Patients' lack of knowledge on nature of palliative care and navigating healthcare system • Major differences arise when approaching conversations on death and patient autonomy
	Physician's lack of awareness of cultural discordance • Difficult to overcome cultural discordance if physicians are not culturally self-aware, sensitive or curious • Physicians having to figure it out themselves due to insufficient emphasis on culture during training • Lack of institutional initiatives in emphasizing cultural resources or competencies at the workplace
Workplace supports	Currently existing interventions • Physician interpersonal skills for those who are aware of these challenges • Translator services like Google translate, families, and professional interpreters (scarce and costly in community settings) • Workplace colleagues who provide administrative support or mentorship
	Interventions that physicians would like to see • 24/7 professional interpreters, as well as making it standard protocol • More systemic and early training emphasis on enhancing cultural sensitivity in healthcare workers • More linguistically and culturally diverse healthcare workers • More culturally-friendly long-term care homes

discordant interactions. They spoke about being able to provide limited information to patients due to time constraints associated with each visit and the time consumed from the interpretation process ("we're advised to provide information in short sentences so that the interpreter can then repeat the sentence back to the patient" – P12). Some participants spoke about resorting to a superficial rundown of options, rather than providing in-depth counselling on the risks and benefits:

"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." – P13.

However, the amount of time spent with patients differed between care settings and remunerations models. Participants following salary models indicated being able to spend more time with patients than those working under the fee-for-service (FFS) model:

"[The Ministry] wants turnover. They want new number of patients that we're seeing on a daily basis, rather than following up or spending more time with those that we think equitably need it. Because I'm

in an alternate funding model (AFP) position, I'm afforded that time. But someone is carrying the load, which is probably my colleagues in the community who are seeing many more patients, just so that I could spend a bit more time on my patients with limited English proficiency." – P01.

Theme 2: Invisible barriers in language and cultural discordant care

Many participants commented on the Eurocentric approach to care that continues to shape palliative and EoL care provision in Ontario. They saw this as a systemic barrier to providing equitable care for patients from non-European backgrounds. They felt that patients who do not speak English encountered challenges in finding a suitable family physician for palliative referrals or even understanding the concept of palliative care. For example, participants recounted specific situations when cultural discordance impacted decision-making and EoL discussions, which contrasted with Canada's healthcare values on transparency and autonomy. Some noted that patients from certain cultures were not comfortable engaging in open discussions about death, and instead wished to exhaust curative options in hospital settings as opposed to maximizing quality-of-life through community palliation. Moreover, participants discussed

Lee *et al. International Journal for Equity in Health*   (2024) 23:229

Page 6 of 13

Table 3 Illustrative quotes by theme

Theme	Subtheme	Illustrative quotes
Visible barriers to access and quality of care	Inability to communicate	"It is very, very challenging to explain to families who don't understand English or French what's happening to their loved one. Why they're having the symptoms that they're having, why we're using the treatments that we're using. I think those conversations are challenging because they're evolving and molding over time. When someone's vigil-ing next to someone's bed, those conversations are changing minute by minute, hour by hour, and without the accessibility of that third person, sometimes it's really difficult." – P05
		"We have a 24 h, seven days a week on-call service. There are instructions for them to call the hospital and speak to the on-call palliative care physician after hours. If they can't speak English, then there's no way that they would be able to effectively communicate with the palliative care physicians they're trying to contact after hours." – P13
		"People are not going to be disclosing things possibly the same way around a random translator on the phone. And we talked about people requesting MAID and thinking about suicide and severe depression and existential distress. Like, it's not often light banter, necessarily. It's a privileged conversation. And it's harder to do that with somebody between me and the patient, unfortunately." – P16
	Insufficient time with patients	"When it comes to the physician side of providing care, obviously the length of the encounter is longer, and I think that sometimes may deter people from using interpretation. It also may limit the amount of things you talk about because everything takes longer, so sometimes you might be more focused on the specific things you need to discuss that visit and less on the contextual pieces: getting to know the person, building the relationship." – P08
		"It takes a lot more time and effort. Unless you have the luxury of a specialty where you can take the time and effort or you can build in extra time to truly care for them, I think that it's very easy to just rush off, pretend they understand, and move on, which obviously has dire health outcomes because if someone can't articulate themselves properly, then they can't get the right care." – P15

Table 3 (continued)

Theme	Subtheme	Illustrative quotes
Invisible barriers to access and quality of care	Eurocentric approach to palliative care	"Navigating the healthcare system if you're an immigrant to Canada and you've not grown up with our system, even just knowing how to access a walk-in clinic or when to call your family doctor versus just going to emerge. The system is very hard to navigate, even if you're Canadian. Even if you're a healthcare worker, it's not easy to navigate." – P16
		"Language probably is the biggest barrier, given the fact that how people get to care almost always requires literacy. Even if you're googling where the hospital is or where the clinic is, that requires some linguistic ability. So if you don't have a basic facility in the dominant language, which in Ontario is generally English, it makes it harder for you to know where to go for care." – P18
		"Hospital care versus primary care; palliative care versus do everything. That cultural discordance is huge. Our Western culture is very much around autonomy and making sure that the patient has the ability to determine their wishes. It's all maximizing quality of life. That is not necessarily true across different cultures. Whereas, if we were in another country, they would not define it as such. They would define good care as you've done everything you can, and you've found the nine diagnoses this person has, and you've tried to do all this stuff." – P02
	Physician's lack of self-awareness on cultural barriers	"Unfortunately a lot of these interventions you create or implement, the uptake is usually only with the people with the highest interest in wanting to learn those skills. Whereas the people who need those skills the most, they don't pursue it. So at what level do you also need to mandate it or have a culture of accountability?" – P10
		"I think that we have a healthcare system which does not prioritize cultural safety, although we are trying to introduce initiatives which will improve the care that we provide. The system is very inflexible, where the frontline health workers themselves are not allowed much autonomy on how to make these decisions and make sure that people are getting the right care. And also the system itself is under-serviced. So with that, you have people that are stretched and less likely, unfortunately, to take these issues into account." – P12
		"I think it's shaped by our experiences. Where I might navigate those languages and those accents more easily because I've grown up around them, I can see that it can lead to frustration in those who aren't part of that." – P15

Lee *et al. International Journal for Equity in Health*   (2024) 23:229

Page 8 of 13

Table 3 (continued)

Theme	Subtheme	Illustrative quotes
Workplace supports	Currently existing interventions	"In long-term care, I have very few resources. I have the personal support worker there who is able to translate and at least be able to speak to the person in a bit more objective way than what a family member can. I do utilize families quite a bit around question and answer." – P02
		"I certainly make heavy use of Google Translate. It's not ideal; it's something I'm not happy to be doing at times. Do I wish I had access to quick translation services, as we might have in big academic facilities? Yes." – P11
		"[At our hospital], we have a little booklet about symptoms at end of life. It talks the caregivers, family, and patient around common symptoms you might expect to see as patients are approaching end of life. They're trying to expand the languages it's available in. When I first started, it was in English and French. Then earlier in the year, they found people to translate it into Chinese, Mandarin, Cantonese, and different languages. They're trying to expand the language availability so they can hand that to patients and families." – P04
	Interventions that physicians would like to have	"I really think that true medical translation services should be broadly, widely, and freely available, and it's not eight-to-five or nine-to-four. It can't be just in that time period. It has to be 24/7 because care does not just happen in business hours, and we need to make that available." – P02
		"I'd like to think that patients feel like they can maybe feel more comfortable finding somebody that looks like them. It may not necessarily be the same because I'm not assuming that everybody that I speak with is Haitian. But they can have an openness, or they can have the option to maybe be speaking the language, or somebody that understands the culture." – P09
		"We need to make sure that all health workers have some training in cultural safety, anti-racism, and health equity. This should be integrated into medical school, nursing school, and so on. So people understand that these disparities are important and that they need to understand that, even on a micro level when they're providing care to their individual patient, they need to recognize some of these issues and think about applying this lens to their daily work" – P12

the nuances of patient autonomy across different cultures, where some cultures view the family interpreter's selective disclosure of information as a family decision-making process and protecting their loved ones. All participants acknowledged that these differences could create fundamental tensions in the patient-physician relationship if not approached carefully. As one participant explained:

"Other cultures may value suffering. Or other cultures may value the prolongation of life higher than suffering. I think that those clashes in values can certainly affect the dynamics between the healthcare team and the patient. But saying again, what is right? Right tends to be the prevailing beliefs of a culture, of the values of a society." – P09.

All participants remarked on the importance of being culturally unbiased, sensitive, and curious when interacting with patients ("reminding myself that the person I'm seeing is a fellow Homo sapien." – P10), but also acknowledged that developing these professional traits

can be shaped by prior medical training and their own upbringing:

> "We're not necessarily taught in medical school how to be culturally-sensitive at end-of-life for the many different cultures that exist. You maybe get a little nod to it in one lecture or something. But most of the time, I think that's picked up within the group that you work with." – P03.

Some participants felt that more rural and culturally-homogenous cities may impact physicians' frequency of encounters with culturally-discordant patients. They worried that this might limit physicians' opportunities for reflexivity and awareness of their own cultural biases and assumptions. This could limit their abilities to properly navigate cultural discordance or find appropriate community resources when faced with patients from different cultural backgrounds.

Theme 3: Workplace supports

Participants discussed a variety of workplace supports and coping strategies. All participants relied on their interpersonal skills to recognize the need for cultural competency and awareness of personal biases. Some suggested that, while it made them a bit uncomfortable, they made the effort to speak a second or third language to communicate with patients who did not speak their first language. Participants did not like to use medical jargon and have sensitive EoL care discussions in a non-primary language. However, they felt their multilingualism at least helped build some level of rapport with patients and facilitated more cultural understanding:

> "Despite having taken some lessons on how to speak in particular medical-related Mandarin, my Mandarin is still not strong. But even with that, I think that the fact they're able to express themselves in their own language is very helpful for them to feel like they can share more." – P09.

All participants had used professional and family interpreters, as well as Google translate in situations when interpreters were not available ("I would never do a diagnosis by Google Translate, but I will use it to ask symptoms" – P02). Participants in hospital settings were better equipped with professional interpreters than physicians in other settings. Hospital-based physicians also had better access to colleagues providing administrative support and mentorship, and institutional initiatives to enhance inclusivity such as multilingual information handouts and basic online courses on cultural competency. Participants in community and long-term care settings expressed often lacking these resources due to cost or having to pay for these services out-of-pocket:

> "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, which I understand." – P13.

For preferred solutions for overcoming language discordance in palliative/EoL care provision, participants highlighted the need for routinely available and less costly access to professional interpreter services that can include after-hours emergency care. Preferred solutions for cultural discordance were more nuanced and varied. Participants acknowledged that there would not be one universal resource for all cultures. Participants working in long-term care settings underscored more funding for culturally-preferred food options and building more culturally-appropriate environments for residents. Some emphasized the need for more cultural competency training embedded throughout medical education and promotion of cultural empathy by institutional leaders. Others advocated for more linguistically and culturally diverse hiring strategies for healthcare teams (ie. nurses, social workers, cultural navigators, senior leaders) so that the linguistically and culturally diverse interprofessional teams could be leveraged for interpretation and could better reflect the cultural diversity of the patient population:

> "I'd like to think that patients feel more comfortable finding somebody that looks like them. They can have an openness, or they can have the option to maybe speaking the language, or somebody that understands the culture." – P08.

Discussion

This study explored language and cultural discordance and their intersections during the provision of palliative/EoL care in Ontario from the experiences of family physicians. Cultural discordance reflected fundamental tensions between the physician and patient related to developing trusting relationships and goals of care. Conversely, language discordance led to breakdown in basic communication about symptoms, patient wishes, and counselling. Specific to care delivery, we observed the inability to communicate and insufficient time spent with patients as visible barriers, and the Eurocentric approach to palliative care and physician's lack of awareness as invisible barriers, all of which reduce patient autonomy. Participants described various workplace or community supports they use and wished they had to effectively provide care across language and cultural barriers, but cited

concerns about availability of resources across practice locations and funding models.

Communicating with patients in palliative care is inherently challenging, and language discordance exacerbates miscommunication of symptoms and medical history [18]. Our study adds to prior research confirming that sensitive information (ie. discussions about death, do-not-resuscitate (DNR) orders, or family sentiments) can be lost in translation during language and culturally discordance care interactions even in the presence of professional and family interpreters [18, 30, 31]. Furthermore, translation can attenuate non-verbal communication strategies (ie. tone and connotations) meant for comforting patients or navigating complex topics, which negatively impact patient satisfaction and trust with their physicians [32]. When information becomes obscured due to biased translation or linguistic jargon, the ability of patients to make informed choices is compromised. This can contribute to patients having an incomplete understanding their prognosis and/or treatment options, which aligns with past studies on ethical challenges related to language discordant care [30, 33, 34]. Thus, unclear patient history can prevent physicians from understanding patients' preferences for palliative/EoL care and tailoring treatment plans to the patients' specific needs and wishes [35, 36]. Additionally, participants acknowledged the time-consuming aspect of language discordance, losing the opportunity to engage in detailed conversations on the purpose of palliation and developing goals of care that are required for better health outcomes [35, 37]. When physicians are pressured for time, a common challenge faced by participants following FFS models, complex care-related discussions are less likely to occur and create barriers for patients to make informed decisions [17, 38]. Consequently, miscommunication and lack of time are visible barriers that hinder transparent conversations and by extension the delivery of culturally-appropriate care.

The choice between curative and palliative approaches to EoL care is often influenced by cultural factors, reflecting a discordance between predominantly Eurocentric ideas in Canada and various other ethnocultural interpretations of EoL care [39, 40]. Past studies have found immigrants including Chinese and South Asians were more likely to be admitted to hospitals for "aggressive care" compared to White patients due to different EoL preferences and communication, a similar issue encountered by our participants [41–43]. Thus, limited knowledge of palliative care or its potential benefits may limit patients to seeking only acute hospital care [44]. Understanding and accessing palliative care can be even more challenging for minority patients who are unfamiliar with navigating the Canadian healthcare system [45, 46].

Furthermore, appropriately and sensitively engaging in cross-cultural palliative/EoL care discussions requires physicians' awareness of diverse cultures and their own personal biases when communicating with patients from minority ethno-cultural groups. Physicians who face difficulties accessing knowledge with respect to providing culturally-competent care may be ill-equipped to cope with language and cultural discordance. When physicians are less culturally competent, the literature shows that patients are less medically compliant, can lose dignity from unshared decision-making, and often have less access to community supports [9, 47, 48]. One study found that physician insensitivity towards cultural/spiritual needs made patients feel more reluctant to express their values and engage in EoL discussions [49]. Our findings show the importance of taking the time to help patients understand their condition and emphasizing mutual understanding of goals of care before proceeding with treatments. To strengthen patient autonomy over preferred care settings, it is also paramount to prioritize patient-centred care in a current healthcare system that emphasizes efficiency and reimburses physicians mainly for treatments and procedures [50, 51].

Professional interpreters were viewed by participants as the gold standard solution for language discordance. However, all participants echoed their limited availability during medical emergencies and after hours care, potentially leading to more emergency department visits and hospital deaths due to a lack of access to community or on-call care [52]. This can lead to using family interpreters, raising issues about patient autonomy (ie. withholding or "shielding" information from patients) which was especially prevalent in some non-Western cultures [33]. Physicians in community settings were less likely to have access to professional interpreters due to cost and instead rely on families or other means to "get by", thus leading to more autonomy issues and frustration [53]. Participants argued that funding for widely available professional interpreters should be a government priority and could contribute to a reduction of overall healthcare burden by providing access to preventative palliative care more broadly [54]. On the other hand, there was no consensus on best strategies to overcome cultural discordance in palliative/EoL care. Our findings show that organizational emphasis on culture depends on geography and individual experiences [55–57]. Cultural awareness is often higher in physicians with more lived experience with different cultures, which can vary between geographic locations [58]. Additionally, urban cities with more culturally diverse patients may be reflected by more cultural resources in the community and institutional initiatives related to cultural training and diverse hiring strategies [13, 59, 60]. Thus, minority patients, particularly First

Nations in rural areas may have significantly reduced access to culturally sensitive palliative/EoL care [61–63]. Additional research is needed to understand barriers and facilitators to providing culturally competent care for palliative/EoL patients from minority ethno-cultural groups in different geographic regions across Ontario.

Limitations

Although this study provided in-depth insight on the perceived impacts of language/cultural discordance on health outcomes across different primary care settings and models, we are unable to establish a causal relationship between language/cultural discordance and the described challenges when providing care. Though the experiences could be related to the general nature of palliative care interactions with all patients, our data strongly suggests language and cultural discordance intersect in ways that amplify communication and valued-based challenges during end-of-life [8, 64]. Additionally, our sample was limited to Ontario which is not representative of family physicians in other provinces, which may differ in level of resources, demographics, and healthcare priorities. While our study offers a range of in-depth perspectives on the nature of language and culturally discordant care, mixed methods studies are necessary to assess population-based health outcomes stratified by geographic location, funding model, and care settings such as inpatient units and hospices. Finally, our study only represents family physicians providing palliative/EoL care. We are currently working on future studies that study the issue of language and cultural discordant care from the perspectives of patients and allied health professionals (ie. nurses, social workers, caregivers) to provide more balanced perspectives on the topic.

Conclusion

Language and cultural discordance intersect to present significant visible and invisible barriers to effective delivery of palliative and EoL care, limiting the ability of patients from linguistic and ethno-cultural minority groups to make informed decisions about their care. Physicians rely on various strategies for overcoming these challenges and improving patient autonomy, though resources are notably diminished in the FFS model and community practice settings. To equip physicians with better innovative tools to help reduce barriers to health access, consideration of more inclusive care delivery mechanisms to better account for the important impacts of language and culture on care and their connection to patients' health outcomes can help to better align care according to patient wishes and needs at the EoL.

Supplementary Information

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Supplementary Material 1.

Declarations

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