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# BMJ Open

**'That's how we got around it': UK healthcare professionals' work with asylum applicants with limited English proficiency during the pandemic**

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3 **'That's how we got around it': UK healthcare professionals' work with asylum applicants with limited**  
4 **English proficiency during the pandemic**  
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8 **Abstract**  
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11 **Objectives**

12 The inadequate provision of language interpretation for people with Limited English Proficiency (LEP) is a  
13 determinant of poor health, yet interpreters are underused. This research explores the experiences of  
14 NHS staff providing primary care for people with LEP: people seeking asylum, housed in contingency  
15 accommodation during COVID-19 - a group known to face multiple healthcare access barriers. Language  
16 discrimination is used as a theoretical framework and the potential utility of this concept is explored as a  
17 way of understanding and addressing inequities in care.  
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25 **Design**

26 Qualitative research using semi-structured interviews and inductive thematic analysis.  
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30 **Setting**

31 Healthcare staff from NHS primary care service for people seeking asylum based in contingency  
32 accommodation during COVID-19.  
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37 **Participants**

38 Ten staff, including doctors, nurses, mental health practitioners, health care assistants and students  
39 participated in semi-structured online interviews. Some staff were redeployed to this work due to the  
40 pandemic.  
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45 **Results**

46 Patients' LEP was significant for all interviewees. Inadequate provision of interpretation services impacted  
47 the staff's ability to provide care and compromised patient safety. Other forms of discrimination, such as  
48 that based on migration status, were recognised and challenged by staff. However, inequity based on  
49 language was not articulated as discrimination. Instead, insufficient and substandard interpretation was  
50 accepted as the status quo and workarounds used, such as gesticulating or phone apps. The theoretical  
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3 lens of language discrimination shows how this propagates existing social hierarchies and further  
4 disadvantages those with LEP.  
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## 8 **Conclusions**

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10 This research provides empirical evidence of how the inadequate provision of interpreters forces the  
11 hand of healthcare staff to use shortcuts. It risks compromising care for people with LEP. Policymakers  
12 must rethink their current approach to interpretation provision which prioritises costs over quality. We  
13 assert that the concept of language discrimination is a valuable framework for clinicians to better  
14 identify and articulate unfair treatment on the grounds of LEP.  
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## 20 **Strengths and limitations**

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- 23 • This paper focuses on language discrimination, a previously under-explored yet important
  - 24 component of ethnic health inequalities
  - 25
  - 26 • The qualitative data is rich and in depth
  - 27
  - 28 • The paper makes novel empirical and theoretical contributions
  - 29
  - 30 • The limited sample size is due to the specialist nature of the service
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  - 32 • Research exploring how these findings operate in other settings would be valuable.
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## Introduction

Good-quality communication between healthcare providers and patients is crucial for safe person-centred care.[1] Although we know the harmful effects of poor communication on care outcomes, there is scarce research focusing on clinicians' experiences and negotiation of language barriers. In English-speaking countries worldwide, including Australia, the US and the UK, patients with Limited English Proficiency (LEP) experience barriers accessing care;[2,3] more medical errors;[4,5] lower satisfaction;[6] and significant misunderstanding of health information.[7]

The benefits of providing high-quality interpretation include: improved clinical care;[8,9] reduced inequalities in healthcare access;[10] and cost savings through decreased hospital readmissions and length of stay.[11,12] Despite this, interpretation services remain underused.[13] This is justified by time constraints, lack of availability of interpreters, and dissatisfaction with the quality of interpretation.[13] Worryingly, a study exploring doctors' reasoning suggested that a clinician-centred approach to communication might be contributory - for some doctors, communication was merely seen as a way of collecting information.[14]

Addressing population health inequalities is touted as a priority for the UK's NHS and is foregrounded in pandemic recovery policy.[15,16] NHS England outlines key principles for the provision of high-quality interpretation and translation services.[17] However, a recent UK review identified that longstanding ethnic inequalities in access, experience and healthcare outcomes are due, in part, to a continued lack of appropriate interpretation services.[18]

## Research context

This paper examines the experiences of NHS staff during the COVID-19 pandemic working in UK asylum contingency accommodation and communicating with people with LEP. People seeking asylum face multiple obstacles to accessing healthcare and frequently have diverse and additional needs to settled populations.[2] Inadequate interpretation is a significant barrier.[19] In addition, migrants to the UK have faced increasingly restrictive welfare rights over the past decade, including some restrictions to entitlements for free NHS care. There is confusion amongst NHS care providers about charging migrants and people seeking asylum often lack awareness of how to navigate the NHS.[20] Even if they do negotiate

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3 these challenges, the time-limited structure of NHS consultations can be inadequate to address their  
4 complex needs.[21]  
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8 The COVID-19 pandemic augmented the difficulties, both in terms of living conditions and healthcare  
9 access. The Home Office's use of contingency accommodation, such as hotels and army barracks,  
10 increased considerably during the pandemic.[22] Healthcare access for people seeking asylum housed  
11 this way was documented as inadequate pre-pandemic; evidence suggests this has since deteriorated  
12 significantly and concerns continue to be raised regarding unsafe conditions.[23] During the pandemic,  
13 many NHS services adopted blanket remote working, worsening existing barriers to access and issues with  
14 communication.[24] In recognition, some primary care services established extra services focusing on the  
15 health needs of those in contingency accommodation.[25] This paper examines NHS staff experiences at  
16 one such primary care service, rapidly implemented in Spring 2020, based on-site for over 200 people  
17 seeking asylum, and providing face-to-face care throughout the pandemic. Many of the staff were  
18 redeployed as part of the COVID-19 response.  
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### 28 Research aims 29

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31 This research aims to investigate the experiences of NHS staff during COVID-19, examining how staff  
32 understood, experienced and negotiated care provision for people seeking asylum with LEP. As a  
33 secondary aim, we scrutinise how staff understood discrimination towards patients and explore the  
34 potential utility of the concept of language discrimination as a way of comprehending inequities in access  
35 to care. The considerable impact of inadequate interpretation provision on healthcare experiences and  
36 health outcomes endorses this as an area in urgent need of action.  
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### 44 Theoretical framework

45 We use the concept of language discrimination as a theoretical framework.[26] For the purposes of this  
46 paper, we understand this concept as articulated by Lippi Green: a sociological theoretical lens to observe  
47 the extent to which discrimination on the grounds of LEP serves to perpetuate inequitable treatment and  
48 reinforces normative power hierarchies. We do so from an anti-racist position that embraces naming  
49 discrimination, then asking 'how is it operating here?' as the first steps to addressing it.[27]  
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3 Lippi-Green's work examines how discrimination on the grounds of accent or LEP serves to perpetuate  
4 normative power hierarchies.[26] That is, how those who speak English as a first language consistently  
5 benefit over those with LEP. US studies have shown how language discrimination causes individuals to  
6 feel overlooked and inferior,[28] and is associated with adverse health outcomes,[29] but there is little  
7 exploration of how language discrimination operates beyond the USA. The scarcity of work describing  
8 language discrimination in UK healthcare is perhaps related to opacity over the legal protection offered  
9 to those with LEP, as it is not considered a 'protected characteristic' under the Equality Act 2010. However,  
10 both socially and legally, language is inextricably intertwined with nationality and race which are  
11 protected characteristics.[29,30,31,32] As a result, NHS England's interpretation commissioning guidance  
12 acknowledges discrimination on the basis of national origin through a lack of language assistance for LEP  
13 persons.[17] Consequently, we must view it as an essential strategic consideration in reducing health  
14 inequalities.  
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## 24 25 **Methods**

### 26 27 **Study design**

28 Twenty-seven healthcare professionals currently or previously working with the asylum seeker primary  
29 care service were invited via email to participate in an online interview about their experiences. In 2021,  
30 ten of these healthcare professionals participated in remote semi-structured qualitative interviews,  
31 lasting between 45 minutes and 2.5 hours. Participants included doctors, nurses, mental health  
32 practitioners, health care assistants and students, some of whom had been redeployed to primary care in  
33 the pandemic. Interviews were conducted using Zoom video conferencing software by author GP, a  
34 clinical academic with no prior relationship to the invited healthcare professionals. Interviews began with  
35 verbal consent and participants shared a brief explanation of their professional background and role.  
36 Participants were told that the research team were interested in migrant health and their experiences  
37 working at the service during COVID-19. Interviews were conversational, with open questioning using an  
38 interview guide on the practical and ethical issues of care provision in contingency accommodation. They  
39 allowed opportunities for participants to discuss issues and experiences important to them. The interview  
40 guide was developed in collaboration with health professionals experienced in migrant health work. Audio  
41 of the interviews was recorded, notes taken by the interviewer, and recordings transcribed verbatim by  
42 GP. No payment was offered for participation. Data was anonymised, with place names changed and  
43 pseudonyms to protect participants. Demographic details for individual participants are not shared due  
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3 to the small sample size, the specialist nature of the service, and to maintain confidentiality. Two site visits  
4 were undertaken by the researchers (LT and GP) to familiarise with the environment.  
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### 8 **Data analysis**

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10 Using inductive thematic analysis, both LT and GP coded data using NVivo 12 to increase robustness.[33]  
11 Dominant themes were derived from the transcripts before data was coded and extracted. First phase  
12 analysis focussed on barriers and mitigations of providing care in contingency accommodation and is  
13 explored elsewhere (*in press*). Language and discrimination appeared as key themes and prompted  
14 additional examination. Secondary thematic analysis was therefore applied to the data using Lippi-Green's  
15 language discrimination as a theoretical framework (by GP, LT, JD, RM and RF). This occurred after data  
16 collection as specific questions about language and discrimination were not in the interview topic guide.  
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18 The University of xxxxx Research Ethics Committee gave approval (NHS001845).  
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### 25 **Research team and reflexivity**

26 The research team are clinical academics with an interest in migrant health. LT (PI) and RF designed and  
27 led the research. LT developed study materials and ethics application. LT supervised GP in recruitment  
28 and interviews. All authors (LT, GP, JD, RM and RF) contributed to the analysis. Our interest in migrant  
29 health risks the imposition of our own beliefs on the research. LT and RF work in migrant health advocacy  
30 which facilitated access to the participants but could also shape both the data interpretation and the ideas  
31 in this paper. The clinical identity of the interviewer (GP) may have promoted a social desirability bias  
32 from participants. In mitigation, the interview topic guide was developed with several clinicians.  
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### 40 **Results**

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43 All participants stressed the importance of patients' LEP and the inadequate provision of interpretation  
44 services on care provision. Many commented on how patients were disadvantaged on the grounds of  
45 language and how this compromised patient safety. However, unlike other forms of discrimination such  
46 as racism, the disadvantage faced by people with LEP was rarely described in terms of discrimination.  
47 Instead, this disadvantage was normalised: inadequate and substandard interpretation was accepted as  
48 the status quo and workarounds were used.  
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3 To illustrate, we present three emergent themes from the data: (i) recognising and resisting  
4 discrimination; (ii) the importance of language in care provision and; (iii) normalising inadequate  
5 interpretation.  
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10 (i) Recognising and resisting discrimination  
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13 Healthcare staff readily recognised that people seeking asylum encountered discrimination on the  
14 grounds of migration status, nationality, and race:  
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18 *'They will face a lot of discrimination in the quality [of care] ... It's been a rude awakening ... there's*  
19 *a lot of prejudice and stereotypes of those seeking asylum.'* Participant 7  
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23 Many noticed discrimination towards their patients from healthcare staff in other settings such as the  
24 pharmacy, hospital, and social care. Staff reported inappropriate questioning of patients' entitlement to  
25 NHS treatments and social care by service providers, resulting in some being denied care which they had  
26 the right to receive. Several portrayed how the local dental surgery had refused to see residents from  
27 contingency accommodation and this was labelled as discriminatory by participants. One participant used  
28 these allegations of discrimination as a way of challenging the dental surgery staff and advocating for all  
29 the residents:  
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37 *'I said, "Can I just get this straight? So, you're telling me that one individual was abusive towards*  
38 *your staff, and because of that, you're going to be discriminating against 250 other individuals*  
39 *because you're deciding that everybody who is seeking asylum must be the same and is going to*  
40 *behave like this one person. Is that what you're saying?" ... "No, no, no. That's not what we're*  
41 *saying." "Okay, good. Because that would have been discrimination, wouldn't it." These are the*  
42 *conversations that we have to have all of the time.'* Participant 1  
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49 This illustrates how recognising inequity as discrimination - and articulating it as such - allows individuals  
50 to challenge and resist inequitable treatment. Importantly, it also demonstrates that some healthcare  
51 staff recognise calling out discrimination as part of their role.  
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(ii) The importance of language in care provision

When asked about wider experiences working in the contingency accommodation, all participants spontaneously stressed the importance of LEP and contrasted it with their previous NHS work. They acknowledged how LEP compounded the multiple complex needs of their asylum-seeking patients and the importance of language interpretation services to reduce inequity:

*'I mean, in my view, [translation services] should be a bare minimum for any service delivering health care in the UK ... Because otherwise, you create instant inequalities. Particularly within this very, very vulnerable group of people. Why that isn't a national standard? I don't know.'* Participant 1

*'It's quite chaotic ... The difference, obviously the patient group have a lot of needs that need to be addressed and to be managed, especially the fact that English is not their first language.'* Participant 7

Participants frequently associated inadequate interpretation provision with inequity in care, even highlighting safety concerns such as COVID-19 transmission risk, illustrating the wider public health implications of the derisory provision of information to patients with LEP:

*'In the really early days when they were not providing information about COVID in their own languages, a lot of them didn't know what COVID was'. Participant 10*

Participant 10 also draws attention to the risks posed by medication errors:

*'The patients here didn't speak English. They can't read road signs, they don't know where the GP practice is, or the pharmacy is. And when they get to the pharmacy, they can't communicate with the lady behind the desk, so it was really difficult in that sense, and then they would get the medication and be like, "I can't read the label. How do I take this?" And then there are safety aspects to that in that they are not ingesting their medication in the right way and things like that, so that was difficult, so things that are normally easy are really, really hard.'* Participant 10

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3 This excerpt illustrates the multiple structural barriers faced by patients with LEP trying to navigate health  
4 systems, access care and to self-manage. It demonstrates the need for improvements in interpretation  
5 services beyond medical consultations. LEP instigates barriers to accessing safe care and achieving good  
6 health that are not encountered by English speakers. This fits with the theoretical framework of language  
7 discrimination as a means of highlighting the propagation of existing social hierarchies. Although  
8 participants recognised clear inequities they did not directly articulate them as being based in  
9 discriminatory practice.  
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18 (iii) Normalising inadequate interpretation provision  
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21 All participants faced challenges accessing adequate interpretation services. Many described the resulting  
22 suboptimal care and inequities. As part of the pandemic response, community volunteers initially  
23 provided face-to-face interpretation at the contingency accommodation for medical consultations. This  
24 in-person service was described by Participant 2 as *'so useful ... made life so much easier ... made such a*  
25 *difference'*. However, this was not possible beyond the first few months as their own voluntary  
26 organisations reopened. The clinical team were left using telephone interpretation services, universally  
27 reported as problematic and often labelled a *'waste'* of time:  
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35 *'The waits for [the telephone interpretation service] were quite extensive. 30 minutes, 45 minutes,*  
36 *which had a huge impact on clinical time. And you would often get through and then not be able*  
37 *to get through to the patient. We were wasting a huge number of clinical hours at that point in*  
38 *just trying to get hold of patients and speak to them.'* Participant 1  
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43 In addition, the poor mobile phone signal in the accommodation caused frequent and lengthy  
44 interruptions. Unfortunately, even when staff were able to connect, the quality of interpretation was  
45 variable and often substandard:  
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50 *'Someone would talk at length sometimes and the interpreter would summarise it in a few*  
51 *sentences, so I don't know if I was actually getting the full picture ... sometimes because [patients]*  
52 *had partial English they would sometimes say 'I'm not saying that.'* Participant 9  
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3 Inadequate interpretation services in secondary care also impacted the workload of the primary care  
4 participants. Here they took time in an already pressured environment to fill the void left by inadequate  
5 language provision:  
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10 *'The doctor sends the referrals, and then the patient gets a letter, but they can't read the letter in*  
11 *English. So, a lot of my job was reading the letter to an interpreter on the phone and explaining it*  
12 *to the patient ... Or telephone appointments without times so we can't organise a translator'*

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14  
15 Participant 2  
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18 Doubts about the quality of interpretation and an imperative to use time efficiently to help as many  
19 people as possible resulted in some participants avoiding the use of telephone interpretation. Instead,  
20 they improvised with non-verbal cues and mobile phone apps:  
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25 *'I think I was very much like, I don't want to use this unless I really have to ... I tried to communicate*  
26 *like, with facial expressions and hand gestures'* Participant 5  
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30 *'we just didn't have the time [to use telephone interpretation] ... we started to use the phone app*  
31 *... I'm sure that it affected care.'* Participant 2  
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35 Many used 'workarounds' to moderate and simplify communication. An awareness of compromises in  
36 standards of care is clearly illustrated in the narrative:  
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40 *'[some people] they would translate for their friends, which again is an issue with confidentiality*  
41 *and safety at times. I'm not sure if I would want to disclose some things to my friends. That was a*  
42 *last resort ... I guess things could have been missed if people didn't want to disclose some*  
43 *information, but that's how we got around it'* Participant 2  
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48 *'it's about how to simplify the language and talk more slowly and talk in shorter sentences because*  
49 *I was going through a translator'* Participant 9  
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3 *'being resourceful, i.e. drawing pictures on paper, using body language or hand gestures as signals*  
4 *and things like that. It is not always easy because of COVID, and you are wearing a face mask ...*  
5 *sometimes I use google translate or 'Siri' will speak.'* Participant 10  
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10 These accounts indicate the participants' resigned acceptance of sub-standard inequitable  
11 communication for people with LEP in order just to get the basics of 'the job' done. Recognising the  
12 importance of good communication for excellent care, they were driven to search for workarounds in the  
13 face of limited time, resources and poor-quality interpretation services. These workarounds became usual  
14 practice as the narratives reveal participants felt these became their only options. Their inability to  
15 challenge poor quality communication through changing the systems, and its consequent inequity, is  
16 implicit. Again, the insufficient provision of interpretation was not articulated as discrimination.  
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## Discussion

The qualitative data in this paper illustrates how staff understood the disadvantage experienced by those with LEP differently from that based on migration status or ethnicity. When discrimination based on migration status was recognised, some staff saw calling it out as part of their role and successfully facilitated change. In contrast, they did not articulate the impact of inadequate interpretation on safe care as discriminatory despite all of the staff interviewed recognising how the care provided to patients with LEP was inferior to those speaking English. Consequently, it was not challenged in the same way. Faced with a lack of available face-to-face interpreters and poor-quality difficult-to-access telephone interpretation, staff instead resorted to workarounds such as using translation apps, gesticulating or using drawings. Thus despite their best efforts, inequitable and suboptimal care for those with LEP was unintentionally normalised.

We appear to be the first to apply the sociological concept of language discrimination to the UK healthcare setting. In doing so, this paper makes an important theoretical contribution. Language discrimination is evident throughout the data: differential treatment on the grounds of LEP perpetuates inequalities in care and maintains the normative power hierarchies where people who speak English receive better care. We caution against the assumption that language discrimination is not challenged as readily as other forms of discrimination, such as racism, because language may be considered a modifiable social characteristic. This speculation overlooks the well-described structural, psychological, social and educational barriers to learning a new language.[34]

Anti-racist scholars assert that naming discrimination and examining how it operates are the first steps in confronting inequitable health systems.[27] We, therefore, uphold that promoting the application of the concept of language discrimination is the first step in addressing inequitable care for those with LEP. Naming inadequate interpretation provision in healthcare as a form of discrimination works to overcome institutional and social inertia, empowering staff and giving them the vocabulary to challenge health inequalities experienced by people with LEP.

Illuminating the issues from a practitioner perspective, this paper makes an important contribution to the literature on the underuse of interpreters in healthcare.[14] We emphasise the chasm between academic knowledge, assertions from policymakers, and the reality of conditions practitioners face. A wealth of

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3 literature documents the harms of inadequate interpretation and healthcare policy proclaims that those  
4 with LEP should not face worse care.[16,17] Yet when healthcare staff face high clinical workloads without  
5 access to user-friendly high-quality interpretation, using workarounds to get the job done becomes usual  
6 practice and inequity becomes institutionalised.  
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11 Our empirical findings illuminate why health outcomes are pitiful when provision of interpretation  
12 services is inadequate and shed light on the variable uptake of healthcare services across different  
13 communities. They should interest practitioners and researchers concerned with the structural causes of  
14 health inequalities. Our analysis highlights that some social groups are underserved and not 'difficult to  
15 reach'. Of particular relevance for policymakers is the lack of transparency around services commissioning  
16 for interpretation provision in England and the marked variability in expenditure for comparable  
17 demographics (35). A radical overhaul of interpretation provision is crucial to address ethnic inequalities  
18 in health.  
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26 This paper focuses on language discrimination, a previously under-explored yet important component of  
27 ethnic health inequalities. The qualitative data is rich and extensive; however, the study does have  
28 limitations. The two most significant are the limited sample size due to the specialist nature of the service;  
29 and the social desirability bias of participants' self-representation to the interviewer, who was a clinician  
30 and researcher. These biases could arguably make the findings more salient. The staff at this specialist  
31 service often went above and beyond usual care and it is likely that the normalisation and  
32 institutionalisation identified here would readily be replicated elsewhere by less committed individuals.  
33 Research exploring how these findings translate to other settings would be valuable.  
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## 42 Conclusion

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45 This research provides empirical evidence of how the inadequate provision of interpreters, shown here  
46 in the context of the pandemic, appears to force the hand of healthcare staff to use shortcuts and risks  
47 compromising the care of people with LEP. Policymakers must rethink the current approach to  
48 interpretation provision which prioritises costs over quality. We advocate that increasing the uptake of  
49 the concept of language discrimination in healthcare would provide a useful framework on which  
50 clinicians can better identify and articulate unfair treatment on the grounds of LEP. Borrowing from anti-  
51 racist scholarship, we argue that this is the first step in shifting the culture around the standard of care  
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3 for LEP patients. Staff were tenacious and challenged discriminatory practice where more overt  
4 examples of discrimination were experienced and named. Future research should examine healthcare  
5 workers' perception of the concept of language discrimination, and the utility and limitations of the  
6 concept in addressing health inequalities.  
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19 None  
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## Standards for Reporting Qualitative Research (SRQR)\*

<http://www.equator-network.org/reporting-guidelines/srqr/>

Page/line no(s).

### Title and abstract

|  |                               |
|--|-------------------------------|
| <p><b>Title</b> - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended</p> | <p>Page 1<br/>Line 1</p>      |
| <p><b>Abstract</b> - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions</p>   | <p>Page 1 lines 3 onwards</p> |

### Introduction

|   |                  |
|---|------------------|
| <p><b>Problem formulation</b> - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement</p> | <p>Pages 3-5</p> |
| <p><b>Purpose or research question</b> - Purpose of the study and specific objectives or questions</p>  | <p>Pages 3-5</p> |

### Methods

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| <p><b>Qualitative approach and research paradigm</b> - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**</p>  | <p>Pages 5-6</p>    |
| <p><b>Researcher characteristics and reflexivity</b> - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability</p> | <p>Page 6</p>       |
| <p><b>Context</b> - Setting/site and salient contextual factors; rationale**</p>  | <p>Pages 3, 5-6</p> |
| <p><b>Sampling strategy</b> - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**</p>  | <p>Page 5</p>       |
| <p><b>Ethical issues pertaining to human subjects</b> - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues</p>  | <p>Page 6</p>       |
| <p><b>Data collection methods</b> - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**</p>   | <p>Pages 5-6</p>    |

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| 3  | <b>Data collection instruments and technologies</b> - Description of instruments (e.g., |           |
| 4  | interview guides, questionnaires) and devices (e.g., audio recorders) used for data     |           |
| 5  | collection; if/how the instrument(s) changed over the course of the study               | Pages 5-6 |
| 6  |   |           |
| 7  | <b>Units of study</b> - Number and relevant characteristics of participants, documents, |           |
| 8  | or events included in the study; level of participation (could be reported in results)  | Pages 5-6 |
| 9  |   |           |
| 10 | <b>Data processing</b> - Methods for processing data prior to and during analysis,      |           |
| 11 | including transcription, data entry, data management and security, verification of      |           |
| 12 | data integrity, data coding, and anonymization/de-identification of excerpts            | Pages 5-6 |
| 13 |   |           |
| 14 | <b>Data analysis</b> - Process by which inferences, themes, etc., were identified and   |           |
| 15 | developed, including the researchers involved in data analysis; usually references a    |           |
| 16 | specific paradigm or approach; rationale**  | Pages 5-6 |
| 17 |   |           |
| 18 | <b>Techniques to enhance trustworthiness</b> - Techniques to enhance trustworthiness    |           |
| 19 | and credibility of data analysis (e.g., member checking, audit trail, triangulation);   |           |
| 20 | rationale**   | Pages 5-6 |

## Results/findings

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| 23 | <b>Synthesis and interpretation</b> - Main findings (e.g., interpretations, inferences, and |            |
| 24 | themes); might include development of a theory or model, or integration with                |            |
| 25 | prior research or theory  | Pages 6-11 |
| 26 |   |            |
| 27 | <b>Links to empirical data</b> - Evidence (e.g., quotes, field notes, text excerpts,        |            |
| 28 | photographs) to substantiate analytic findings  | Pages 6-11 |
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## Discussion

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| 32 | <b>Integration with prior work, implications, transferability, and contribution(s) to</b> |             |
| 33 | <b>the field</b> - Short summary of main findings; explanation of how findings and        |             |
| 34 | conclusions connect to, support, elaborate on, or challenge conclusions of earlier        |             |
| 35 | scholarship; discussion of scope of application/generalizability; identification of       |             |
| 36 | unique contribution(s) to scholarship in a discipline or field                            | Pages 12-14 |
| 37 |   |             |
| 38 | <b>Limitations</b> - Trustworthiness and limitations of findings                          | Page 13     |
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## Other

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| 42 | <b>Conflicts of interest</b> - Potential sources of influence or perceived influence on    |         |
| 43 | study conduct and conclusions; how these were managed                                      | Page 17 |
| 44 |  |         |
| 45 | <b>Funding</b> - Sources of funding and other support; role of funders in data collection, |         |
| 46 | interpretation, and reporting  | Page 17 |
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\*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

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\*\*The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

**Reference:**

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative research: a synthesis of recommendations.** *Academic Medicine*, Vol. 89, No. 9 / Sept 2014  
DOI: 10.1097/ACM.0000000000000388

For peer review only

# BMJ Open

**'That's how we got around it': A qualitative exploration of healthcare professionals' experiences of care provision for asylum applicants' with Limited English Proficiency in UK contingency accommodation**

|                                 |   |
|---------------------------------|---|
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| Date Submitted by the Author:   | 14-Sep-2023   |
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| <b>Primary Subject Heading</b>: | Communication   |
| Secondary Subject Heading:      | General practice / Family practice  |
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3 **'That's how we got around it': A qualitative exploration of healthcare professionals' experiences of**  
4 **care provision for asylum applicants' with Limited English Proficiency in UK contingency**  
5 **accommodation**  
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24 **Abstract**

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27 **Objectives**

28 The inadequate provision of language interpretation for people with Limited English Proficiency (LEP) is a  
29 determinant of poor health, yet interpreters are underused. This research explores the experiences of  
30 NHS staff providing primary care for people seeking asylum, housed in contingency accommodation  
31 during COVID-19. This group often have LEP and faces multiple additional barriers to healthcare access.  
32 Language discrimination is used as a theoretical framework. The potential utility of this concept is  
33 explored as a way of understanding and addressing inequities in care.  
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37 **Design**

38 Qualitative research using semi-structured interviews and inductive thematic analysis.  
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41 **Setting**

42 An NHS primary care service for people seeking asylum based in contingency accommodation during  
43 COVID-19 housing superdiverse residents speaking a wide spectrum of languages.  
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46 **Participants**

47 Ten staff including doctors, nurses, mental health practitioners, health care assistants and students  
48 participated in semi-structured online interviews. Some staff were redeployed to this work due to the  
49 pandemic.  
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52 **Results**

53 All interviewees described patients' LEP as significant. Inadequate provision of interpretation services  
54 impacted the staff's ability to provide care and compromised patient safety. Discrimination, such as that  
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3 based on migration status, was recognised and challenged by staff. However, inequity based on language  
4 was not articulated as discrimination. Instead, insufficient and substandard interpretation was accepted  
5 as the status quo and workarounds used, such as gesticulating or translation phone apps. The theoretical  
6 lens of language discrimination shows how this propagates existing social hierarchies and further  
7 disadvantages those with LEP.  
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### 10 **Conclusions**

11 This research provides empirical evidence of how the inadequate provision of interpreters forces the  
12 hand of healthcare staff to use shortcuts. Although this innovative 'tinkering' allows staff to get the job  
13 done, it risks normalising structural gaps in care provision for people with LEP. Policymakers must  
14 rethink their approach to interpretation provision which prioritises costs over quality. We assert that the  
15 concept of language discrimination is a valuable framework for clinicians to better identify and articulate  
16 unfair treatment on the grounds of LEP.  
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### 21 **Strengths and limitations**

- 22 - There is no existing research exploring UK healthcare professionals' experiences of working with  
23 asylum seekers with limited English proficiency
- 24 - We are the first to use the theoretical framework of language discrimination in a UK healthcare  
25 setting and show how it might be of value in improving care
- 26 - The qualitative data collected is in depth and rich
- 27 - The sample size is modest, due to the specialist nature of the service
- 28 - Our research design stakeholder group was made up of healthcare professionals. Future  
29 research in this area should involve patient and public contributors
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## Introduction

Good-quality communication between healthcare providers and patients is crucial for universal access to safe person-centred care.[1] In English-speaking countries worldwide, including Australia, USA and the UK, patients with Limited English Proficiency (LEP) experience barriers accessing care;[2,3] more medical errors;[4,5] lower satisfaction;[6] and misunderstanding of health information.[7] The benefits of providing high-quality interpretation include: improved clinical care;[8,9] reduced inequalities in healthcare access;[10] and cost-savings through decreased hospital readmissions and length of stay.[11,12] Despite this, interpretation services remain underused.[13] This is justified by time constraints, lack of availability of interpreters, and dissatisfaction with interpretation quality.[13] Worryingly, a study exploring doctors' reasoning suggested that a clinician-centred approach to communication might be contributory - for some doctors, communication was seen merely as a way of collecting information.[14]

Addressing population health inequalities is touted as a priority for the UK's NHS and is foregrounded in pandemic recovery policy.[15,16] NHS England outlines key principles for the provision of high-quality interpretation and translation services.[17] However, a recent UK review identified that longstanding ethnic inequalities in access, experience and healthcare outcomes are due, in part, to a lack of appropriate interpretation services.[18] Despite care providers' duty to provide interpretation services, research shows this is highly variable in practice according to service users. Family members are often used to fill the gap, with implications for patients' confidentiality [2,17,19,20]. Although we know the harmful effects of poor communication on care outcomes, there is scarce research focusing on clinicians' experiences and negotiation of language barriers.

## Research context

This paper examines the experiences of NHS staff working with people with LEP in UK asylum contingency accommodation during the COVID-19 pandemic. This accommodation housed people seeking asylum from multiple countries, i.e. engaged in the lengthy legal process of applying for refugee status. A refugee is a person who 'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country' [21]. Whilst awaiting a decision on refugee status individuals are usually housed in dispersal accommodation. Contingency accommodation - such as hotels or army barracks - is used for extra capacity. Over the last decade the UK government introduced policies purposefully making life difficult for migrants to reduce numbers. These policies and practices, often described as the "hostile environment", embed immigration controls into public services [22].

People seeking asylum face multiple obstacles accessing healthcare and frequently have diverse and additional needs to settled populations. [2] Immigration controls present in UK welfare and healthcare systems include restrictions to entitlements for free NHS care. Since 2017, certain migrants are ineligible for non-emergency care and must pay before receiving treatment. Although GP services remain free for

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3 all, there is confusion amongst NHS care providers about charging and people seeking asylum often lack  
4 awareness of how to navigate the NHS.[23] Inadequate interpretation is a significant barrier to care.[24]  
5 The time-limited structure of NHS consultations can be inadequate to address complex needs.[25]  
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8 The use of contingency accommodation increased considerably in the COVID-19 pandemic [26] amplifying  
9 the difficulties of healthcare access and living conditions. Pre-pandemic healthcare access for people  
10 seeking asylum housed this way was documented as inadequate; evidence suggests this has deteriorated  
11 significantly and concerns continue to be raised regarding unsafe conditions.[27] During the pandemic,  
12 many NHS services adopted remote working, worsening existing barriers to access and  
13 communication.[28] In recognition, some primary care providers established extra services focusing on  
14 health needs in contingency accommodation.[29] This paper examines NHS staff experiences at one such  
15 service, rapidly implemented in 2020, delivering face-to-face primary care on-site for over 200 people  
16 seeking asylum. Many of the staff were redeployed as part of the COVID-19 response. Interpretation for  
17 superdiverse residents who spoke a multitude of languages was from a mix of untrained informal contacts,  
18 community volunteers, bilingual practitioners, and trained professional on-demand telephone  
19 interpreters. It was of variable quality and availability.  
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#### 25 Research aims

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28 This research aims to investigate the experiences of NHS staff during COVID-19, examining how staff  
29 understood, experienced and negotiated care provision for people seeking asylum with LEP. As a  
30 secondary aim, we explore the potential utility of the concept of language discrimination as a way of  
31 comprehending inequities in access to care.  
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#### 34 Theoretical framework

35 We use the concept of language discrimination as a theoretical framework.[30] We understand this  
36 concept as articulated by Lippi Green: a sociological theoretical lens to observe how discrimination on the  
37 grounds of LEP perpetuates inequitable treatment and reinforces normative power hierarchies. We do so  
38 from an anti-racist position that embraces naming discrimination, then asking 'how is it operating here?'  
39 as the first steps to addressing it. [31]  
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43 Lippi-Green's work examines how discrimination on the grounds of accent or LEP benefits those who  
44 speak English as a first language over those with LEP[30]. US studies have shown how language  
45 discrimination causes individuals to feel overlooked and inferior [32] and is associated with adverse health  
46 outcomes [33]. There is little exploration of how it operates beyond the USA. In UK healthcare this scarcity  
47 of work describing language discrimination is perhaps related to opacity over the legal protection offered  
48 to those with LEP. It is not considered a 'protected characteristic' under the Equality Act 2010. However,  
49 both socially and legally, language is inextricably intertwined with nationality and race, which are  
50 protected characteristics.[33,34,35,36] As a result, NHS England's interpretation commissioning guidance  
51 acknowledges discrimination on the basis of national origin through a lack of language assistance for LEP  
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3 persons.[17] Consequently, we view it as an essential strategic consideration in reducing health  
4 inequalities.  
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7 We conceptualise language discrimination as both structural – created and normalised in mainstream  
8 institutions - and structuring – in that it reinforces existing hierarchies of privilege, restricting the  
9 opportunities of already-disadvantaged groups. The inadequate provision of interpretation services  
10 epitomises the operationalisation of language discrimination in healthcare and is entangled in the UK  
11 context of a hostile environment. It is important to note that adequate provision of interpreters alone  
12 would not eradicate language discrimination, as cultural humility remains important. However, for the  
13 purpose of this paper, we use adequate interpretation provision as the bare minimum, thus a proxy  
14 marker of language discrimination, using it as an empirical signal to explore the issue.  
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## 18 **Methods**

### 19 **Study design**

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21 Twenty-seven healthcare professionals currently or previously working with the asylum seeker primary  
22 care service in contingency accommodation were invited via email to participate in an online interview  
23 about their experiences. In 2021, ten of these healthcare professionals participated in remote semi-  
24 structured qualitative interviews, lasting between 45 minutes and 2.5 hours. Participants included  
25 doctors, nurses, mental health practitioners, health care assistants and students, some of whom had  
26 been redeployed to primary care in the pandemic. Interviews were conducted using Zoom video  
27 conferencing software by author GP, a clinical academic with no prior relationship to the invited  
28 healthcare professionals. Interviews began with verbal consent and participants shared a brief  
29 explanation of their professional background and role. Participants were told that the research team  
30 were interested in migrant health and their experiences working at the service during COVID-19.  
31 Interviews were conversational, with open questioning using an interview guide on the practical and  
32 ethical issues of care provision in contingency accommodation. They allowed opportunities for  
33 participants to discuss issues and experiences important to them. The interview guide was developed in  
34 collaboration with health professionals experienced in migrant health work. Audio of the interviews was  
35 recorded, notes taken by the interviewer, and recordings transcribed verbatim by GP. No payment was  
36 offered for participation. Data was anonymised, with place names changed and pseudonyms to protect  
37 participants. Demographic details for individual participants are not shared due to the modest number  
38 of participants, the specialist nature of the service, and to maintain confidentiality. Two site visits were  
39 undertaken by researchers (LT and GP) to familiarise with the environment.  
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### 47 **Data analysis**

48 Using inductive thematic analysis, LT and GP coded data using NVivo 12 to increase robustness.[33]  
49 Dominant themes were derived from the transcripts before data was coded and extracted. First phase  
50 analysis focussed on the moral implications of care in contingency accommodation and is explored  
51 elsewhere.[37] Language and discrimination appeared as key themes and prompted additional  
52 examination. Secondary thematic analysis was therefore applied to the data using Lippi-Green's language  
53 discrimination as a theoretical framework (by GP, LT, JD, RM and RF). This occurred after data collection  
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3 as specific questions about language and discrimination were not in the interview topic guide. The  
4 University of Manchester Research Ethics Committee gave approval (NHS001845).  
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### 7 **Research team and reflexivity**

8 The research team are clinical academics with an interest in migrant health. LT (PI) and RF designed and  
9 led the research. LT developed study materials and ethics application. LT supervised GP in recruitment  
10 and interviews. All authors (LT, GP, JD, RM and RF) contributed to the analysis. Our interest in migrant  
11 health risks the imposition of our own beliefs on the research. LT and RF work in migrant health advocacy  
12 which facilitated access to the participants but could also shape both the data interpretation and the ideas  
13 in this paper. The clinical identity of the interviewer (GP) may have promoted a social desirability bias  
14 from participants. In mitigation, the interview topic guide was developed with several clinicians.  
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18 **Patient and Public Involvement:** None  
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### 21 **Results**

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24 All participants stressed the importance of patients' LEP and the inadequate provision of interpretation  
25 services on care provision. Many commented on how patients were disadvantaged on the grounds of  
26 language and how this compromised patient safety. However, unlike other forms of discrimination such  
27 as racism, the disadvantage faced by people with LEP was rarely described in terms of discrimination.  
28 Instead, staff responded by improvising, using workarounds to get the job done. To illustrate, we  
29 present three emergent themes from the data: (i) recognising and resisting discrimination; (ii) the  
30 importance of interpretation provision for safe care and; (iii) improvisation around inadequate  
31 interpretation  
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#### 35 (i) Recognising and resisting discrimination

36  
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38 Healthcare staff readily recognised that people seeking asylum encountered discrimination on the  
39 grounds of migration status, nationality, and race:  
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42 *'They will face a lot of discrimination in the quality [of care] ... It's been a rude awakening ... there's*  
43 *a lot of prejudice and stereotypes of those seeking asylum.'* Participant 7  
44  
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46 Many noticed discrimination towards their patients from healthcare staff in other settings such as  
47 pharmacy, hospital, and social care. Staff reported inappropriate questioning of patients' entitlement to  
48 NHS treatments and social care by service providers, resulting in some being denied care which they had  
49 the right to receive. Several portrayed how a dental surgery had refused to see residents from contingency  
50 accommodation and labelled this as discriminatory. One participant used these allegations of  
51 discrimination as a way of challenging dental surgery staff and advocating for all the residents:  
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3 *'I said, "Can I just get this straight? So, you're telling me that one individual was abusive towards*  
4 *your staff, and because of that, you're going to be discriminating against 250 other individuals*  
5 *because you're deciding that everybody who is seeking asylum must be the same and is going to*  
6 *behave like this one person. Is that what you're saying?" ... "No, no, no. That's not what we're*  
7 *saying." "Okay, good. Because that would have been discrimination, wouldn't it." These are the*  
8 *conversations that we have to have all of the time.'* Participant 1  
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12 This illustrates how recognising inequity as discrimination - and articulating it as such - allows individuals  
13 to challenge and resist inequitable treatment. Importantly, it demonstrates that some healthcare staff  
14 also recognise calling out discrimination as part of their role.  
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16  
17 (ii) The importance of interpretation provision for safe care  
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20 When asked about wider experiences working in the contingency accommodation, all participants  
21 spontaneously stressed the importance of LEP and contrasted it with their previous NHS work. They  
22 acknowledged how LEP compounded the multiple complex needs of their asylum-seeking patients and  
23 the importance of language interpretation services to reduce inequity:  
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25

26 *'I mean, in my view, [translation services] should be a bare minimum for any service delivering*  
27 *health care in the UK ... Because otherwise, you create instant inequalities. Particularly within this*  
28 *very, very vulnerable group of people. Why that isn't a national standard? I don't know.'*  
29 Participant 1  
30  
31

32  
33 *'It's quite chaotic ... The difference, obviously the patient group have a lot of needs that need to*  
34 *be addressed and to be managed, especially the fact that English is not their first language.'*  
35 Participant 7  
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38 Participants frequently associated inadequate interpretation provision with care inequities, even  
39 highlighting safety concerns, such as COVID-19 transmission risk. This illustrates the wider public health  
40 implications of the derisory provision of information to patients with LEP:  
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43 *'In the really early days when they were not providing information about COVID in their own*  
44 *languages, a lot of them didn't know what COVID was'.* Participant 10  
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47 Participant 10 draws attention to the risks posed by medication errors:  
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49

50 *'The patients here didn't speak English. They can't read road signs, they don't know where the GP*  
51 *practice is, or the pharmacy is. And when they get to the pharmacy, they can't communicate with*  
52 *the lady behind the desk, so it was really difficult in that sense, and then they would get the*  
53 *medication and be like, "I can't read the label. How do I take this?" And then there are safety*  
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3 *aspects to that in that they are not ingesting their medication in the right way and things like that,*  
4 *so that was difficult, so things that are normally easy are really, really hard.'* Participant 10  
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7 This illustrates multiple structural barriers faced by patients with LEP trying to navigate health systems,  
8 access care and self-manage. It demonstrates the need for improvements in interpretation services  
9 beyond medical consultations, including translation of signage, pamphlets and labels. LEP instigates  
10 barriers to accessing safe care and achieving good health not encountered by English speakers, showing  
11 how language discrimination propagates existing social hierarchies. Although participants recognised  
12 structured and structuring aspects of inadequate interpretation provision, they did not articulate it as  
13 discriminatory.  
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### 16 17 (iii) Improvisation around inadequate interpretation 18 19

20 All participants reported facing challenges accessing adequate interpretation services. Many described  
21 the resulting suboptimal care. As part of the pandemic response, volunteers from local refugee charities  
22 initially provided face-to-face interpretation at the contingency accommodation for medical  
23 consultations. This in-person service was described by Participant 2 as *'so useful ... made life so much*  
24 *easier ... made such a difference'*. However, this was impossible beyond the first few months as their own  
25 voluntary organisations reopened. The clinical team were left using telephone interpretation services,  
26 universally reported as problematic and often labelled a *'waste'* of time:  
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30 *'The waits for [the telephone interpretation service] were quite extensive. 30 minutes, 45 minutes,*  
31 *which had a huge impact on clinical time. And you would often get through and then not be able*  
32 *to get through to the patient. We were wasting a huge number of clinical hours at that point in*  
33 *just trying to get hold of patients and speak to them.'* Participant 1  
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37 The poor mobile phone signal in the accommodation caused frequent and lengthy interruptions. When  
38 staff were able to connect, the quality of interpretation was variable and often substandard:  
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41 *'Someone would talk at length sometimes and the interpreter would summarise it in a few*  
42 *sentences, so I don't know if I was actually getting the full picture ... sometimes because [patients]*  
43 *had partial English they would sometimes say 'I'm not saying that.'* Participant 9  
44  
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46 Inadequate interpretation services in secondary care impacted the workload of the primary care  
47 participants. Staff in an already-pressured environment took time to fill the gap left by inadequate  
48 language provision:  
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51 *'The doctor sends the referrals, and then the patient gets a letter, but they can't read the letter in*  
52 *English. So, a lot of my job was reading the letter to an interpreter on the phone and explaining it*  
53 *to the patient ... Or telephone appointments without times so we can't organise a translator'*  
54 Participant 2  
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4 Doubts about the quality of interpretation and an imperative to use time efficiently resulted in some  
5 participants avoiding telephone interpretation. Instead, they improvised with non-verbal cues,  
6 gesticulations and mobile phone apps. This approach is evocative of 'tinkering', described by Mol in  
7 2008 [38], as a way of adjusting towards situationally-determined improved outcomes:  
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11 *'I think I was very much like, I don't want to use this unless I really have to ... I tried to communicate*  
12 *like, with facial expressions and hand gestures'* Participant 5  
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15 *'we just didn't have the time [to use telephone interpretation] ... we started to use the phone app*  
16 *... I'm sure that it affected care.'* Participant 2  
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18  
19 Recognising the importance of good communication for safe care, participants were driven to search for  
20 workarounds in the face of limited time, resources and poor-quality interpretation services. Many  
21 'tinkered' to moderate and simplify communication:  
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23  
24 *'it's about how to simplify the language and talk more slowly and talk in shorter sentences because*  
25 *I was going through a translator'* Participant 9  
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27  
28 *'being resourceful, i.e. drawing pictures on paper, using body language or hand gestures as signals*  
29 *and things like that. It is not always easy because of COVID, and you are wearing a face mask ...*  
30 *sometimes I use Google Translate or 'Siri' will speak.'* Participant 10  
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33 Although some framed this innovation in a positive light, others suggested how this might compromise  
34 care:  
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37 *'[some people] they would translate for their friends, which again is an issue with confidentiality*  
38 *and safety at times. I'm not sure if I would want to disclose some things to my friends. That was a*  
39 *last resort ... I guess things could have been missed if people didn't want to disclose some*  
40 *information, but that's how we got around it'* Participant 2  
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43 Again, the insufficient provision of interpretation was not articulated as discrimination.  
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## Discussion

This qualitative analysis illustrates how staff understood the disadvantage experienced by those with LEP differently from that based on migration status or ethnicity. When discrimination based on migration status was identified, some staff saw calling it out as part of their role and successfully facilitated change. In contrast, the impact of inadequate interpretation on providing safe and trauma-informed care was not identified as discriminatory, despite all of those interviewed recognising the risks. Consequently, it was not challenged in the same way. Instead, when faced with a lack of available face-to-face interpreters and poor-quality difficult-to-access telephone interpretation, staff ‘tinkered’, using workarounds such as translation apps, gesticulating or drawings.

The concept of ‘tinkering’ has been used to explore care practices in various resource-poor contexts. [38,39]. Recently, ethnographic work has demonstrated the resourcefulness of healthcare staff and the necessity of creative innovations in low-income settings: “[i]f the system doesn't work, you have to make it work for you, for the sake of the patient”.[40] However, tinkering has limits - Reider describes how it can lead to physician disenfranchisement and departure.[41] By framing these practices through the lens of language discrimination, we add to this critical perspective on the practice of tinkering. When staff feel workarounds are their only option, it seems that ‘tinkering’ can become usual practice, even in resource-rich countries where healthcare faces ideologically driven cuts. Inequalities are thus reproduced, normalised, and embedded within organisational structures and the ability to change discriminatory systems is diminished.

US-based research links the concept of language discrimination and patients’ poor experiences of healthcare access.[42,43] However, we appear to be the first to apply the sociological concept of language discrimination to the UK healthcare setting, use it to critically analyse healthcare providers’ narratives of care provision, and argue for its more widespread application as a means to address inequalities. In doing so, we make an important theoretical contribution. Empirically, language discrimination is evident throughout this data: differential treatment on the grounds of LEP perpetuates inequalities in care and maintains the normative hierarchies of power and privilege, where people who speak English receive better care. We caution against the assumption that language is a modifiable characteristic and therefore not challenged as readily as other forms of discrimination, such as racism. This speculation overlooks the well-described structural, psychological, social and educational barriers to learning new languages. [44]

Anti-racist scholars assert that naming discrimination and examining how it operates are the first steps in confronting inequitable health systems.[31] We uphold that promoting the application of the concept of language discrimination is the first step in addressing inequitable care for those with LEP. Naming inadequate interpretation provision in healthcare as a form of discrimination works to overcome institutional and social inertia, empowering staff and giving them vocabulary to challenge health inequalities experienced by people with LEP. In the contemporary UK context, the gap in interpretation provision can be understood as part of a broader discriminatory approach to migrants. Technical solutions to improve care are needed, with provision of culturally-sensitive interpreters as the bare minimum.

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3 Moreover, language discrimination is only one facet of the hostile environment facing migrants in the UK  
4 (22). Since undertaking this research, living conditions for people seeking asylum have been further  
5 eroded, with plans for offshore processing and accommodation on sea vessels.  
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8 Illuminating the issues from a practitioner perspective, this paper contributes to the literature on the  
9 underuse of interpreters in healthcare.[14] We emphasise the chasm between academic knowledge,  
10 assertions from policymakers, and the reality of conditions facing practitioners. A wealth of literature  
11 documents the harms of inadequate interpretation alongside healthcare policy proclaiming that those  
12 with LEP should not experience worse care.[16,17] Yet when healthcare staff face high clinical workloads  
13 without access to user-friendly high-quality interpretation, using workarounds to get the job done  
14 becomes usual practice and inequity becomes institutionalised. It is important to note that in countries  
15 where payment is structured differently the extra time required for interpretation may also impact  
16 clinician income.  
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21 Our empirical findings illuminate why health outcomes are pitiful when provision of interpretation  
22 services is inadequate and shed light on the variable uptake of healthcare services across diverse  
23 communities. They should interest practitioners and researchers concerned with structural causes of  
24 health inequalities. Our analysis highlights that some social groups are underserved rather than 'difficult  
25 to reach'. Of relevance for policymakers is the lack of transparency around commissioning for  
26 interpretation provision in England and the marked variability in expenditure for comparable  
27 demographics.[45,46] A radical overhaul of interpretation provision is crucial to address ethnic  
28 inequalities in health.  
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33 This paper focuses on language discrimination, a previously under-explored yet important component of  
34 ethnic health inequalities. The qualitative data is rich and extensive; however, the study does have  
35 limitations. The number of participants is modest due to the specialist nature of the service. There may  
36 be social desirability bias of participants' self-representation to the interviewer, who was a clinician and  
37 researcher. These biases could arguably make the findings more salient. The staff at this specialist service  
38 often went above and beyond usual care and it is likely that the normalisation and institutionalisation  
39 identified here would be readily replicated elsewhere by less committed individuals. Research exploring  
40 how these findings translate to other settings would be valuable.  
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## 45 Conclusion

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47 This research provides empirical evidence of how the inadequate provision of interpreters, shown here  
48 in the context of the pandemic, appears to force the hand of healthcare staff to use shortcuts. This risks  
49 compromising the safe care of people with LEP. Both structural and operational changes are needed to  
50 improve healthcare provision for migrants. Inadequate interpretation provision should be understood as  
51 part of a complex system of discrimination facing people seeking asylum which requires a radical  
52 overhaul. More specifically, policymakers must rethink their approach to interpretation provision  
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3 including training of practitioners to work with interpreters, integrating systems to reduce factors that  
4 prevent their use, and prioritising quality over cost to ensure safety.  
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7 Endorsement of the concept of language discrimination in healthcare would provide a useful framework  
8 for clinicians to better identify and articulate unfair treatment on the grounds of LEP. Borrowing from  
9 anti-racist scholarship, we argue that this is the first step in shifting the culture around the ubiquitous  
10 but hidden acceptance of a poor standard of care for LEP patients. Staff were tenacious and challenged  
11 practices where more overt examples of discrimination were experienced and could be named. Future  
12 research should examine healthcare workers' perception of the concept of language discrimination and  
13 the utility and limitations of the concept in addressing health inequalities.  
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16 None  
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## Standards for Reporting Qualitative Research (SRQR)\*

<http://www.equator-network.org/reporting-guidelines/srqr/>

Page/line no(s).

### Title and abstract

|  |                                   |
|--|-----------------------------------|
| <p><b>Title</b> - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended</p> | <p>Page 1<br/>Line 1</p>          |
| <p><b>Abstract</b> - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions</p>   | <p>Page 1 lines 3<br/>onwards</p> |

### Introduction

|   |                  |
|---|------------------|
| <p><b>Problem formulation</b> - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement</p> | <p>Pages 3-5</p> |
| <p><b>Purpose or research question</b> - Purpose of the study and specific objectives or questions</p>  | <p>Pages 3-5</p> |

### Methods

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| <p><b>Qualitative approach and research paradigm</b> - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**</p>  | <p>Pages 5-6</p>    |
| <p><b>Researcher characteristics and reflexivity</b> - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability</p> | <p>Page 6</p>       |
| <p><b>Context</b> - Setting/site and salient contextual factors; rationale**</p>  | <p>Pages 3, 5-6</p> |
| <p><b>Sampling strategy</b> - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**</p>  | <p>Page 5</p>       |
| <p><b>Ethical issues pertaining to human subjects</b> - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues</p>  | <p>Page 6</p>       |
| <p><b>Data collection methods</b> - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**</p>   | <p>Pages 5-6</p>    |

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| 3  | <b>Data collection instruments and technologies</b> - Description of instruments (e.g., |           |
| 4  | interview guides, questionnaires) and devices (e.g., audio recorders) used for data     |           |
| 5  | collection; if/how the instrument(s) changed over the course of the study               | Pages 5-6 |
| 6  |   |           |
| 7  | <b>Units of study</b> - Number and relevant characteristics of participants, documents, |           |
| 8  | or events included in the study; level of participation (could be reported in results)  | Pages 5-6 |
| 9  |   |           |
| 10 | <b>Data processing</b> - Methods for processing data prior to and during analysis,      |           |
| 11 | including transcription, data entry, data management and security, verification of      |           |
| 12 | data integrity, data coding, and anonymization/de-identification of excerpts            | Pages 5-6 |
| 13 |   |           |
| 14 | <b>Data analysis</b> - Process by which inferences, themes, etc., were identified and   |           |
| 15 | developed, including the researchers involved in data analysis; usually references a    |           |
| 16 | specific paradigm or approach; rationale**  | Pages 5-6 |
| 17 |   |           |
| 18 | <b>Techniques to enhance trustworthiness</b> - Techniques to enhance trustworthiness    |           |
| 19 | and credibility of data analysis (e.g., member checking, audit trail, triangulation);   |           |
| 20 | rationale**   | Pages 5-6 |

## Results/findings

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| 23 | <b>Synthesis and interpretation</b> - Main findings (e.g., interpretations, inferences, and |            |
| 24 | themes); might include development of a theory or model, or integration with                |            |
| 25 | prior research or theory  | Pages 6-11 |
| 26 |   |            |
| 27 | <b>Links to empirical data</b> - Evidence (e.g., quotes, field notes, text excerpts,        |            |
| 28 | photographs) to substantiate analytic findings  | Pages 6-11 |
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## Discussion

|    |   |             |
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| 32 | <b>Integration with prior work, implications, transferability, and contribution(s) to</b> |             |
| 33 | <b>the field</b> - Short summary of main findings; explanation of how findings and        |             |
| 34 | conclusions connect to, support, elaborate on, or challenge conclusions of earlier        |             |
| 35 | scholarship; discussion of scope of application/generalizability; identification of       |             |
| 36 | unique contribution(s) to scholarship in a discipline or field                            | Pages 12-14 |
| 37 |   |             |
| 38 | <b>Limitations</b> - Trustworthiness and limitations of findings                          | Page 13     |
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## Other

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|----|--|---------|
| 42 | <b>Conflicts of interest</b> - Potential sources of influence or perceived influence on    |         |
| 43 | study conduct and conclusions; how these were managed                                      | Page 17 |
| 44 |  |         |
| 45 | <b>Funding</b> - Sources of funding and other support; role of funders in data collection, |         |
| 46 | interpretation, and reporting  | Page 17 |
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\*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

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\*\*The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

**Reference:**

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative research: a synthesis of recommendations.** *Academic Medicine*, Vol. 89, No. 9 / Sept 2014  
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For peer review only

# BMJ Open

**'That's how we got around it': A qualitative exploration of healthcare professionals' experiences of care provision for asylum applicants' with Limited English Proficiency in UK contingency accommodation**

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3 **'That's how we got around it': A qualitative exploration of healthcare professionals' experiences of**  
4 **care provision for asylum applicants' with Limited English Proficiency in UK contingency**  
5 **accommodation**  
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18 Special Interest Asylum Seeker Mental Health, Greater Manchester Mental Health Foundation Trust,  
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24 **Abstract**  
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27 **Objectives**

28 The inadequate provision of language interpretation for people with Limited English Proficiency (LEP) is a  
29 determinant of poor health, yet interpreters are underused. This research explores the experiences of  
30 NHS staff providing primary care for people seeking asylum, housed in contingency accommodation  
31 during COVID-19. This group often have LEP and faces multiple additional barriers to healthcare access.  
32 Language discrimination is used as a theoretical framework. The potential utility of this concept is  
33 explored as a way of understanding and addressing inequities in care.  
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37 **Design**

38 Qualitative research using semi-structured interviews and inductive thematic analysis.  
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41 **Setting**

42 An NHS primary care service for people seeking asylum based in contingency accommodation during  
43 COVID-19 housing superdiverse residents speaking a wide spectrum of languages.  
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46 **Participants**

47 Ten staff including doctors, nurses, mental health practitioners, health care assistants and students  
48 participated in semi-structured online interviews. Some staff were redeployed to this work due to the  
49 pandemic.  
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52 **Results**

53 All interviewees described patients' LEP as significant. Inadequate provision of interpretation services  
54 impacted the staff's ability to provide care and compromised patient safety. Discrimination, such as that  
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3 based on migration status, was recognised and challenged by staff. However, inequity based on language  
4 was not articulated as discrimination. Instead, insufficient and substandard interpretation was accepted  
5 as the status quo and workarounds used, such as gesticulating or translation phone apps. The theoretical  
6 lens of language discrimination shows how this propagates existing social hierarchies and further  
7 disadvantages those with LEP.  
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### 10 **Conclusions**

11 This research provides empirical evidence of how the inadequate provision of interpreters forces the  
12 hand of healthcare staff to use shortcuts. Although this innovative 'tinkering' allows staff to get the job  
13 done, it risks normalising structural gaps in care provision for people with LEP. Policymakers must  
14 rethink their approach to interpretation provision which prioritises costs over quality. We assert that the  
15 concept of language discrimination is a valuable framework for clinicians to better identify and articulate  
16 unfair treatment on the grounds of LEP.  
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### 21 **Strengths and limitations**

- 22 - There is no existing research exploring UK healthcare professionals' experiences of working with  
23 asylum seekers with limited English proficiency
- 24 - We are the first to use the theoretical framework of language discrimination in a UK healthcare  
25 setting and show how it might be of value in improving care
- 26 - The qualitative data collected is in depth and rich
- 27 - The sample size is modest, due to the specialist nature of the service
- 28 - Our research design stakeholder group was made up of healthcare professionals. Future  
29 research in this area should involve patient and public contributors
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## Introduction

Good-quality communication between healthcare providers and patients is crucial for universal access to safe person-centred care.[1] In English-speaking countries worldwide, including Australia, USA and the UK, patients with Limited English Proficiency (LEP) experience barriers accessing care;[2,3] more medical errors;[4,5] lower satisfaction;[6] and misunderstanding of health information.[7] The benefits of providing high-quality interpretation include: improved clinical care;[8,9] reduced inequalities in healthcare access;[10] and cost-savings through decreased hospital readmissions and length of stay.[11,12] Despite this, interpretation services remain underused.[13] This is justified by time constraints, lack of availability of interpreters, and dissatisfaction with interpretation quality.[13] Worryingly, a study exploring doctors' reasoning suggested that a clinician-centred approach to communication might be contributory - for some doctors, communication was seen merely as a way of collecting information.[14]

Addressing population health inequalities is touted as a priority for the UK's NHS and is foregrounded in pandemic recovery policy.[15,16] NHS England outlines key principles for the provision of high-quality interpretation and translation services.[17] However, a recent UK review identified that longstanding ethnic inequalities in access, experience and healthcare outcomes are due, in part, to a lack of appropriate interpretation services.[18] Despite care providers' duty to provide interpretation services, research shows this is highly variable in practice according to service users. Family members are often used to fill the gap, with implications for patients' confidentiality [2,17,19,20]. Although we know the harmful effects of poor communication on care outcomes, there is scarce research focusing on clinicians' experiences and negotiation of language barriers.

## Research context

This paper examines the experiences of NHS staff working with people with LEP in UK asylum contingency accommodation during the COVID-19 pandemic. This accommodation housed people seeking asylum from multiple countries, i.e. engaged in the lengthy legal process of applying for refugee status. A refugee is a person who 'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country' [21]. Whilst awaiting a decision on refugee status individuals are usually housed in dispersal accommodation. Contingency accommodation - such as hotels or army barracks - is used for extra capacity. Over the last decade the UK government introduced policies purposefully making life difficult for migrants to reduce numbers. These policies and practices, often described as the "hostile environment", embed immigration controls into public services [22].

People seeking asylum face multiple obstacles accessing healthcare and frequently have diverse and additional needs to settled populations. [2] Immigration controls present in UK welfare and healthcare systems include restrictions to entitlements for free NHS care. Since 2017, certain migrants are ineligible for non-emergency care and must pay before receiving treatment. Although GP services remain free for



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3 all, there is confusion amongst NHS care providers about charging and people seeking asylum often lack  
4 awareness of how to navigate the NHS.[23] Inadequate interpretation is a significant barrier to care.[24]  
5 The time-limited structure of NHS consultations can be inadequate to address complex needs.[25]  
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8 The use of contingency accommodation increased considerably in the COVID-19 pandemic [26] amplifying  
9 the difficulties of healthcare access and living conditions. Pre-pandemic healthcare access for people  
10 seeking asylum housed this way was documented as inadequate; evidence suggests this has deteriorated  
11 significantly and concerns continue to be raised regarding unsafe conditions.[27] During the pandemic,  
12 many NHS services adopted remote working, worsening existing barriers to access and  
13 communication.[28] In recognition, some primary care providers established extra services focusing on  
14 health needs in contingency accommodation.[29] This paper examines NHS staff experiences at one such  
15 service, rapidly implemented in 2020, delivering face-to-face primary care on-site for over 200 people  
16 seeking asylum. Many of the staff were redeployed as part of the COVID-19 response. Interpretation for  
17 superdiverse residents who spoke a multitude of languages was from a mix of untrained informal contacts,  
18 community volunteers, bilingual practitioners, and trained professional on-demand telephone  
19 interpreters. It was of variable quality and availability.  
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#### 25 Research aims

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28 This research aims to investigate the experiences of NHS staff during COVID-19, examining how staff  
29 understood, experienced and negotiated care provision for people seeking asylum with LEP. As a  
30 secondary aim, we explore the potential utility of the concept of language discrimination as a way of  
31 comprehending inequities in access to care.  
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#### 34 Theoretical framework

35 We use the concept of language discrimination as a theoretical framework.[30] We understand this  
36 concept as articulated by Lippi Green: a sociological theoretical lens to observe how discrimination on the  
37 grounds of LEP perpetuates inequitable treatment and reinforces normative power hierarchies. We do so  
38 from an anti-racist position that embraces naming discrimination, then asking 'how is it operating here?'  
39 as the first steps to addressing it. [31]  
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43 Lippi-Green's work examines how discrimination on the grounds of accent or LEP benefits those who  
44 speak English as a first language over those with LEP[30]. US studies have shown how language  
45 discrimination causes individuals to feel overlooked and inferior [32] and is associated with adverse health  
46 outcomes [33]. There is little exploration of how it operates beyond the USA. In UK healthcare this scarcity  
47 of work describing language discrimination is perhaps related to opacity over the legal protection offered  
48 to those with LEP. It is not considered a 'protected characteristic' under the Equality Act 2010. However,  
49 both socially and legally, language is inextricably intertwined with nationality and race, which are  
50 protected characteristics.[33,34,35,36] As a result, NHS England's interpretation commissioning guidance  
51 acknowledges discrimination on the basis of national origin through a lack of language assistance for LEP  
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3 persons.[17] Consequently, we view it as an essential strategic consideration in reducing health  
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7 We conceptualise language discrimination as both structural – created and normalised in mainstream  
8 institutions - and structuring – in that it reinforces existing hierarchies of privilege, restricting the  
9 opportunities of already-disadvantaged groups. The inadequate provision of interpretation services  
10 epitomises the operationalisation of language discrimination in healthcare and is entangled in the UK  
11 context of a hostile environment. It is important to note that adequate provision of interpreters alone  
12 would not eradicate language discrimination, as cultural humility remains important. However, for the  
13 purpose of this paper, we use adequate interpretation provision as the bare minimum, thus a proxy  
14 marker of language discrimination, using it as an empirical signal to explore the issue.  
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## 18 **Methods**

### 19 **Study design**

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21 Twenty-seven healthcare professionals currently or previously working with the asylum seeker primary  
22 care service in contingency accommodation were invited via email to participate in an online interview  
23 about their experiences. In 2021, ten of these healthcare professionals participated in remote semi-  
24 structured qualitative interviews, lasting between 45 minutes and 2.5 hours. Participants included  
25 doctors, nurses, mental health practitioners, health care assistants and students, some of whom had  
26 been redeployed to primary care in the pandemic. Interviews were conducted using Zoom video  
27 conferencing software by author GP, a clinical academic with no prior relationship to the invited  
28 healthcare professionals. Interviews began with verbal consent and participants shared a brief  
29 explanation of their professional background and role. Participants were told that the research team  
30 were interested in migrant health and their experiences working at the service during COVID-19.  
31 Interviews were conversational, with open questioning using an interview guide on the practical and  
32 ethical issues of care provision in contingency accommodation. They allowed opportunities for  
33 participants to discuss issues and experiences important to them. The interview guide was developed in  
34 collaboration with health professionals experienced in migrant health work. Audio of the interviews was  
35 recorded, notes taken by the interviewer, and recordings transcribed verbatim by GP. No payment was  
36 offered for participation. Data was anonymised, with place names changed and pseudonyms to protect  
37 participants. Demographic details for individual participants are not shared due to the modest number  
38 of participants, the specialist nature of the service, and to maintain confidentiality. Two site visits were  
39 undertaken by researchers (LT and GP) to familiarise with the environment.  
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### 47 **Data analysis**

48 Using inductive thematic analysis, LT and GP coded data using NVivo 12 to increase robustness.[33]  
49 Dominant themes were derived from the transcripts before data was coded and extracted. First phase  
50 analysis focussed on the moral implications of care in contingency accommodation and is explored  
51 elsewhere.[37] Language and discrimination appeared as key themes and prompted additional  
52 examination. Secondary thematic analysis was therefore applied to the data using Lippi-Green's language  
53 discrimination as a theoretical framework (by GP, LT, JD, RM and RF). This occurred after data collection  
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as specific questions about language and discrimination were not in the interview topic guide. The University of Manchester Research Ethics Committee gave approval (NHS001845).

### Research team and reflexivity

The research team are clinical academics with an interest in migrant health. LT (PI) and RF designed and led the research. LT developed study materials and ethics application. LT supervised GP in recruitment and interviews. All authors (LT, GP, JD, RM and RF) contributed to the analysis. Our interest in migrant health risks the imposition of our own beliefs on the research. LT and RF work in migrant health advocacy which facilitated access to the participants but could also shape both the data interpretation and the ideas in this paper. The clinical identity of the interviewer (GP) may have promoted a social desirability bias from participants. In mitigation, the interview topic guide was developed with several clinicians.

**Patient and Public Involvement:** None

### Results

All participants stressed the importance of patients' LEP and the inadequate provision of interpretation services on care provision. Many commented on how patients were disadvantaged on the grounds of language and how this compromised patient safety. However, unlike other forms of discrimination such as racism, the disadvantage faced by people with LEP was rarely described in terms of discrimination. Instead, staff responded by improvising, using workarounds to get the job done. To illustrate, we present three emergent themes from the data: (i) recognising and resisting discrimination; (ii) the importance of interpretation provision for safe care and; (iii) improvisation around inadequate interpretation

#### (i) Recognising and resisting discrimination

Healthcare staff readily recognised that people seeking asylum encountered discrimination on the grounds of migration status, nationality, and race:

*'They will face a lot of discrimination in the quality [of care] ... It's been a rude awakening ... there's a lot of prejudice and stereotypes of those seeking asylum.'* Participant 7

Many noticed discrimination towards their patients from healthcare staff in other settings such as pharmacy, hospital, and social care. Staff reported inappropriate questioning of patients' entitlement to NHS treatments and social care by service providers, resulting in some being denied care which they had the right to receive. Several portrayed how a dental surgery had refused to see residents from contingency accommodation and labelled this as discriminatory. One participant used these allegations of discrimination as a way of challenging dental surgery staff and advocating for all the residents:

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3 *'I said, "Can I just get this straight? So, you're telling me that one individual was abusive towards*  
4 *your staff, and because of that, you're going to be discriminating against 250 other individuals*  
5 *because you're deciding that everybody who is seeking asylum must be the same and is going to*  
6 *behave like this one person. Is that what you're saying?" ... "No, no, no. That's not what we're*  
7 *saying." "Okay, good. Because that would have been discrimination, wouldn't it." These are the*  
8 *conversations that we have to have all of the time.'* Participant 1  
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12 This illustrates how recognising inequity as discrimination - and articulating it as such - allows individuals  
13 to challenge and resist inequitable treatment. Importantly, it demonstrates that some healthcare staff  
14 also recognise calling out discrimination as part of their role.  
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17 (ii) The importance of interpretation provision for safe care  
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20 When asked about wider experiences working in the contingency accommodation, all participants  
21 spontaneously stressed the importance of LEP and contrasted it with their previous NHS work. They  
22 acknowledged how LEP compounded the multiple complex needs of their asylum-seeking patients and  
23 the importance of language interpretation services to reduce inequity:  
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26 *'I mean, in my view, [translation services] should be a bare minimum for any service delivering*  
27 *health care in the UK ... Because otherwise, you create instant inequalities. Particularly within this*  
28 *very, very vulnerable group of people. Why that isn't a national standard? I don't know.'*  
29 Participant 1  
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32  
33 *'It's quite chaotic ... The difference, obviously the patient group have a lot of needs that need to*  
34 *be addressed and to be managed, especially the fact that English is not their first language.'*  
35 Participant 7  
36  
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38 Participants frequently associated inadequate interpretation provision with care inequities, even  
39 highlighting safety concerns, such as COVID-19 transmission risk. This illustrates the wider public health  
40 implications of the derisory provision of information to patients with LEP:  
41  
42

43 *'In the really early days when they were not providing information about COVID in their own*  
44 *languages, a lot of them didn't know what COVID was'.* Participant 10  
45  
46

47 Participant 10 draws attention to the risks posed by medication errors:  
48  
49

50 *'The patients here didn't speak English. They can't read road signs, they don't know where the GP*  
51 *practice is, or the pharmacy is. And when they get to the pharmacy, they can't communicate with*  
52 *the lady behind the desk, so it was really difficult in that sense, and then they would get the*  
53 *medication and be like, "I can't read the label. How do I take this?" And then there are safety*  
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3 *aspects to that in that they are not ingesting their medication in the right way and things like that,*  
4 *so that was difficult, so things that are normally easy are really, really hard.'* Participant 10  
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7 This illustrates multiple structural barriers faced by patients with LEP trying to navigate health systems,  
8 access care and self-manage. It demonstrates the need for improvements in interpretation services  
9 beyond medical consultations, including translation of signage, pamphlets and labels. LEP instigates  
10 barriers to accessing safe care and achieving good health not encountered by English speakers, showing  
11 how language discrimination propagates existing social hierarchies. Although participants recognised  
12 structured and structuring aspects of inadequate interpretation provision, they did not articulate it as  
13 discriminatory.  
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### 16 17 (iii) Improvisation around inadequate interpretation 18 19

20 All participants reported facing challenges accessing adequate interpretation services. Many described  
21 the resulting suboptimal care. As part of the pandemic response, volunteers from local refugee charities  
22 initially provided face-to-face interpretation at the contingency accommodation for medical  
23 consultations. This in-person service was described by Participant 2 as '*so useful ... made life so much*  
24 *easier ... made such a difference*'. However, this was impossible beyond the first few months as their own  
25 voluntary organisations reopened. The clinical team were left using telephone interpretation services,  
26 universally reported as problematic and often labelled a '*waste*' of time:  
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30 *'The waits for [the telephone interpretation service] were quite extensive. 30 minutes, 45 minutes,*  
31 *which had a huge impact on clinical time. And you would often get through and then not be able*  
32 *to get through to the patient. We were wasting a huge number of clinical hours at that point in*  
33 *just trying to get hold of patients and speak to them.'* Participant 1  
34  
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37 The poor mobile phone signal in the accommodation caused frequent and lengthy interruptions. When  
38 staff were able to connect, the quality of interpretation was variable and often substandard:  
39  
40

41 *'Someone would talk at length sometimes and the interpreter would summarise it in a few*  
42 *sentences, so I don't know if I was actually getting the full picture ... sometimes because [patients]*  
43 *had partial English they would sometimes say 'I'm not saying that.'* Participant 9  
44  
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46 Inadequate interpretation services in secondary care impacted the workload of the primary care  
47 participants. Staff in an already-pressured environment took time to fill the gap left by inadequate  
48 language provision:  
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51 *'The doctor sends the referrals, and then the patient gets a letter, but they can't read the letter in*  
52 *English. So, a lot of my job was reading the letter to an interpreter on the phone and explaining it*  
53 *to the patient ... Or telephone appointments without times so we can't organise a translator'*  
54 Participant 2  
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4 Doubts about the quality of interpretation and an imperative to use time efficiently resulted in some  
5 participants avoiding telephone interpretation. Instead, they improvised with non-verbal cues,  
6 gesticulations and mobile phone apps. This approach is evocative of 'tinkering', described by Mol in  
7 2008 [38], as a way of adjusting towards situationally-determined improved outcomes:  
8  
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10  
11 *'I think I was very much like, I don't want to use this unless I really have to ... I tried to communicate*  
12 *like, with facial expressions and hand gestures'* Participant 5  
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14  
15 *'we just didn't have the time [to use telephone interpretation] ... we started to use the phone app*  
16 *... I'm sure that it affected care.'* Participant 2  
17

18  
19 Recognising the importance of good communication for safe care, participants were driven to search for  
20 workarounds in the face of limited time, resources and poor-quality interpretation services. Many  
21 'tinkered' to moderate and simplify communication:  
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23  
24 *'it's about how to simplify the language and talk more slowly and talk in shorter sentences because*  
25 *I was going through a translator'* Participant 9  
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27  
28 *'being resourceful, i.e. drawing pictures on paper, using body language or hand gestures as signals*  
29 *and things like that. It is not always easy because of COVID, and you are wearing a face mask ...*  
30 *sometimes I use Google Translate or 'Siri' will speak.'* Participant 10  
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32  
33 Although some framed this innovation in a positive light, others suggested how this might compromise  
34 care:  
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37 *'[some people] they would translate for their friends, which again is an issue with confidentiality*  
38 *and safety at times. I'm not sure if I would want to disclose some things to my friends. That was a*  
39 *last resort ... I guess things could have been missed if people didn't want to disclose some*  
40 *information, but that's how we got around it'* Participant 2  
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43 Again, the insufficient provision of interpretation was not articulated as discrimination.  
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## Discussion

This qualitative analysis illustrates how staff understood the disadvantage experienced by those with LEP differently from that based on migration status or ethnicity. When discrimination based on migration status was identified, some staff saw calling it out as part of their role and successfully facilitated change. In contrast, the impact of inadequate interpretation on providing safe and trauma-informed care was not identified as discriminatory, despite all of those interviewed recognising the risks. Consequently, it was not challenged in the same way. Instead, when faced with a lack of available face-to-face interpreters and poor-quality difficult-to-access telephone interpretation, staff ‘tinkered’, using workarounds such as translation apps, gesticulating or drawings.

The concept of ‘tinkering’ has been used to explore care practices in various resource-poor contexts. [38,39]. Recently, ethnographic work has demonstrated the resourcefulness of healthcare staff and the necessity of creative innovations in low-income settings: “[i]f the system doesn't work, you have to make it work for you, for the sake of the patient”.[40] However, tinkering has limits - Reider describes how it can lead to physician disenfranchisement and departure.[41] By framing these practices through the lens of language discrimination, we add to this critical perspective on the practice of tinkering. When staff feel workarounds are their only option, it seems that ‘tinkering’ can become usual practice, even in resource-rich countries where healthcare faces ideologically driven cuts. Inequalities are thus reproduced, normalised, and embedded within organisational structures and the ability to change discriminatory systems is diminished.

US-based research links the concept of language discrimination and patients’ poor experiences of healthcare access.[42,43] However, we appear to be the first to apply the sociological concept of language discrimination to the UK healthcare setting, use it to critically analyse healthcare providers’ narratives of care provision, and argue for its more widespread application as a means to address inequalities. In doing so, we make an important theoretical contribution. Empirically, language discrimination is evident throughout this data: differential treatment on the grounds of LEP perpetuates inequalities in care and maintains the normative hierarchies of power and privilege, where people who speak English receive better care. We caution against the assumption that language is a modifiable characteristic and therefore not challenged as readily as other forms of discrimination, such as racism. This speculation overlooks the well-described structural, psychological, social and educational barriers to learning new languages. [44]

Anti-racist scholars assert that naming discrimination and examining how it operates are the first steps in confronting inequitable health systems.[31] We uphold that promoting the application of the concept of language discrimination is the first step in addressing inequitable care for those with LEP. Naming inadequate interpretation provision in healthcare as a form of discrimination works to overcome institutional and social inertia, empowering staff and giving them vocabulary to challenge health inequalities experienced by people with LEP. In the contemporary UK context, the gap in interpretation provision can be understood as part of a broader discriminatory approach to migrants. Technical solutions to improve care are needed, with provision of culturally-sensitive interpreters as the bare minimum.

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3 Moreover, language discrimination is only one facet of the hostile environment facing migrants in the UK  
4 (22). Since undertaking this research, living conditions for people seeking asylum have been further  
5 eroded, with plans for offshore processing and accommodation on sea vessels.  
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7

8 Illuminating the issues from a practitioner perspective, this paper contributes to the literature on the  
9 underuse of interpreters in healthcare.[14] We emphasise the chasm between academic knowledge,  
10 assertions from policymakers, and the reality of conditions facing practitioners. A wealth of literature  
11 documents the harms of inadequate interpretation alongside healthcare policy proclaiming that those  
12 with LEP should not experience worse care.[16,17] Yet when healthcare staff face high clinical workloads  
13 without access to user-friendly high-quality interpretation, using workarounds to get the job done  
14 becomes usual practice and inequity becomes institutionalised. It is important to note that in countries  
15 where payment is structured differently the extra time required for interpretation may also impact  
16 clinician income.  
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21 Our empirical findings illuminate why health outcomes are pitiful when provision of interpretation  
22 services is inadequate and shed light on the variable uptake of healthcare services across diverse  
23 communities. They should interest practitioners and researchers concerned with structural causes of  
24 health inequalities. Our analysis highlights that some social groups are underserved rather than 'difficult  
25 to reach'. Of relevance for policymakers is the lack of transparency around commissioning for  
26 interpretation provision in England and the marked variability in expenditure for comparable  
27 demographics.[45,46] A radical overhaul of interpretation provision is crucial to address ethnic  
28 inequalities in health.  
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33 This paper focuses on language discrimination, a previously under-explored yet important component of  
34 ethnic health inequalities. The qualitative data is rich and extensive; however, the study does have  
35 limitations. The number of participants is modest due to the specialist nature of the service. We did not  
36 collect data about the languages spoken by healthcare staff or how patients' English language proficiency  
37 was assessed, both are areas which warrant further investigation. There may be social desirability bias of  
38 participants' self-representation to the interviewer, who was a clinician and researcher. These biases  
39 could arguably make the findings more salient. The staff at this specialist service often went above and  
40 beyond usual care and it is likely that the normalisation and institutionalisation identified here would be  
41 readily replicated elsewhere by less committed individuals. Research exploring how these findings  
42 translate to other settings would be valuable.  
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## 47 Conclusion

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50 This research provides empirical evidence of how the inadequate provision of interpreters, shown here  
51 in the context of the pandemic, appears to force the hand of healthcare staff to use shortcuts. This risks  
52 compromising the safe care of people with LEP. Both structural and operational changes are needed to  
53 improve healthcare provision for migrants. Inadequate interpretation provision should be understood as  
54 part of a complex system of discrimination facing people seeking asylum which requires a radical  
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3 overhaul. More specifically, policymakers must rethink their approach to interpretation provision  
4 including training of practitioners to work with interpreters, integrating systems to reduce factors that  
5 prevent their use, and prioritising quality over cost to ensure safety.  
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8 Endorsement of the concept of language discrimination in healthcare would provide a useful framework  
9 for clinicians to better identify and articulate unfair treatment on the grounds of LEP. Borrowing from  
10 anti-racist scholarship, we argue that this is the first step in shifting the culture around the ubiquitous  
11 but hidden acceptance of a poor standard of care for LEP patients. Staff were tenacious and challenged  
12 practices where more overt examples of discrimination were experienced and could be named. Future  
13 research should examine healthcare workers' perception of the concept of language discrimination and  
14 the utility and limitations of the concept in addressing health inequalities.  
15  
16  
17

### 18 **CONTRIBUTORSHIP STATEMENT**

19 Louise Tomkow was Principal Investigator of the project. Louise Tomkow and Rebecca Farrington  
20 designed the research protocol. Louise Tomkow developed study materials and led ethics application.  
21 Gabrielle Prager undertook interviews and coded data. Louise Tomkow and Gabrielle Prager led the  
22 analysis. Jessica Drinkwater, Rebecca Farrington and Rebecca Morris undertook analysis. Louise Tomkow  
23 led the write up. Louise Tomkow, Gabrielle Prager, Jessica Drinkwater, Rebecca Farrington and Rebecca  
24 Morris all contributed to the final manuscript.  
25  
26  
27

### 28 **COMPETING INTERESTS**

29 None  
30  
31  
32

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38 publication are those of the author(s) and not necessarily those of the NIHR, NHS or the UK Department  
39 of Health and Social Care.  
40  
41  
42

### 43 **DATA AVAILABILITY STATEMENT**

44 Data contains sensitive information. Please contact lead author to discuss access.  
45  
46

### 47 **ETHICS APPROVAL STATEMENT**

48 This study involves human participants and was approved by the University of Manchester Research  
49 Ethics Committee gave approval (NHS001845).  
50  
51

### 52 **References**

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## Standards for Reporting Qualitative Research (SRQR)\*

<http://www.equator-network.org/reporting-guidelines/srqr/>

Page/line no(s).

### Title and abstract

|  |                                   |
|--|-----------------------------------|
| <p><b>Title</b> - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended</p> | <p>Page 1<br/>Line 1</p>          |
| <p><b>Abstract</b> - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions</p>   | <p>Page 1 lines 3<br/>onwards</p> |

### Introduction

|   |                  |
|---|------------------|
| <p><b>Problem formulation</b> - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement</p> | <p>Pages 3-5</p> |
| <p><b>Purpose or research question</b> - Purpose of the study and specific objectives or questions</p>  | <p>Pages 3-5</p> |

### Methods

|   |                     |
|---|---------------------|
| <p><b>Qualitative approach and research paradigm</b> - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**</p>  | <p>Pages 5-6</p>    |
| <p><b>Researcher characteristics and reflexivity</b> - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability</p> | <p>Page 6</p>       |
| <p><b>Context</b> - Setting/site and salient contextual factors; rationale**</p>  | <p>Pages 3, 5-6</p> |
| <p><b>Sampling strategy</b> - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**</p>  | <p>Page 5</p>       |
| <p><b>Ethical issues pertaining to human subjects</b> - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues</p>  | <p>Page 6</p>       |
| <p><b>Data collection methods</b> - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**</p>   | <p>Pages 5-6</p>    |

|                       |   |           |
|-----------------------|---|-----------|
| 1<br>2<br>3<br>4<br>5 | <b>Data collection instruments and technologies</b> - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study | Pages 5-6 |
| 6<br>7<br>8           | <b>Units of study</b> - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)  | Pages 5-6 |
| 9<br>10<br>11<br>12   | <b>Data processing</b> - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts    | Pages 5-6 |
| 13<br>14<br>15<br>16  | <b>Data analysis</b> - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**                                 | Pages 5-6 |
| 17<br>18<br>19<br>20  | <b>Techniques to enhance trustworthiness</b> - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**  | Pages 5-6 |

## Results/findings

|                      |   |            |
|----------------------|---|------------|
| 23<br>24<br>25<br>26 | <b>Synthesis and interpretation</b> - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory | Pages 6-11 |
| 27<br>28<br>29       | <b>Links to empirical data</b> - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings   | Pages 6-11 |

## Discussion

|                                  |   |             |
|----------------------------------|---|-------------|
| 32<br>33<br>34<br>35<br>36<br>37 | <b>Integration with prior work, implications, transferability, and contribution(s) to the field</b> - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field | Pages 12-14 |
| 38<br>39                         | <b>Limitations</b> - Trustworthiness and limitations of findings  | Page 13     |

## Other

|                |   |         |
|----------------|---|---------|
| 42<br>43<br>44 | <b>Conflicts of interest</b> - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed | Page 17 |
| 45<br>46       | <b>Funding</b> - Sources of funding and other support; role of funders in data collection, interpretation, and reporting                      | Page 17 |

\*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

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\*\*The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

**Reference:**

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative research: a synthesis of recommendations.** *Academic Medicine*, Vol. 89, No. 9 / Sept 2014  
DOI: 10.1097/ACM.0000000000000388

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