"I FELT THAT THE INTERPRETER WAS SO CRITICAL FOR US TO UNDERSTAND THE CONTEXT OF THE SITUATION": STUDENTS' PERSPECTIVES OF MEDICAL EDUCATION'S INTRODUCTION OF SERVICES FOR LIMITED ENGLISH PROFIENCY PATIENTS

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ABSTRACT

Interpreter services play an integral role in ensuring equity in healthcare for patients with limited English proficiency (LEP), whose language barrier places them at increased risk for healthcare disparities. Even with the growing number of non-English-speaking patients, a sizeable number being Spanish-speaking, and although such training leads to more culturally competent care with better patient outcomes, there is little curricular time during medical school devoted to effectively using interpreters. This study aimed to understand better how medical education prepares future physicians for their encounters with LEP patients and what experiences they would appreciate in their medical training. Temple LKSOM student from the class of 2024-2027 (M1-M4s), were recruited through flyers and educator announcements to participate in three virtual focus groups with a total of 26 participants. Qualitative data analysis resulted in five themes which were: students felt that interpreters were integral to culturally competent care, students who speak another language have the undue burden of interpreting even when not comfortable doing so, students felt that there was not enough training in medical school regarding various types of interpreters, how to reach them or how to use them properly, students are open to doctoring sessions or simulations with non-English speaking standardized patients and interpreters, and the final theme was that there mixed feelings amongst students regarding the desire to have OSCEs with non-English speaking standardized patients and interpreters.

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CHAPTER 1

INTRODUCTION

Given the growing immigrant population in the United States, the number of those whose primary language is not English continues to rise. Patients who cannot read, write, or speak English at a level that permits effective interaction with healthcare providers are labeled as having limited English proficiency (LEP). This language barrier can directly impact many aspects of their life, including their healthcare experience, with LEP patients often having worse healthcare access, lower patient satisfaction, and poorer clinical outcomes. Language accessibility is a right for individuals with limited English proficiency in our health care system, ensuring patients receive culturally competent care. Such is defined as the ability of providers and organizations to effectively deliver healthcare services that meet patients' social, cultural, and linguistic needs [1]. A culturally competent healthcare system can help improve health outcomes and quality of care and contribute to eliminating health disparities [1].

For this reason, it is standard of care that when a non-English-speaking patient is provided services through our healthcare system, they are provided access to an interpreter, making them an integral tool in the equity of LEP patient healthcare. Inappropriate or lack thereof of interpreter use can negatively affect patients, which is deserving of emphasis when educating future physicians. Medical education can significantly change how future physicians interact with LEP patients; however, a uniform curriculum has yet to be created to target student training efficiently. As the patient population changes, some schools have begun incorporating more training regarding interpreters and medical Spanish

opportunities. However, it is often optional training, or there is not enough support and resources for long-lasting changes in how students are trained.

All physicians will eventually encounter LEP patients for whom they must use interpreters, so appropriate training and information should be dispersed to medical students. Prior literature explains that physicians who received training on cultural competence and the proper use of medical interpreters were likelier to utilize LEP services in the hospital. Thus, this should be a motivator within medical education to ensure that future physicians utilize their resources to treat LEP patients and provide culturally competent care. Given the significant impact this can have on patient care, I wanted to hear directly from medical students about how their medical education was training them to do so. This qualitative research project entailed hosting focus groups with Temple Lewis Katz School of Medicine students to better understand their feelings and experiences with their training in working with interpreters when they have LEP patients. My goal was to gather information to understand better what is being done well and what could be improved.

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CHAPTER 2

LITERATURE REVIEW

Limited English proficiency is the term used to describe patients who cannot read, write, or speak English at a level that permits effective interaction with healthcare providers [5]. Patients who are not proficient in English tend to be more likely to report a problem with their care, to be less satisfied, and to be at a higher risk of medical error [4]. They have decreased access to preventative health services, reduced understanding of instructions and medications, and more extended hospital stays [2]. Using a professional interpreter has improved the quality of care to a standard equal to those who do not need an interpreter [4]. Patients who do not receive interpreters have the lowest satisfaction ratings regarding the interpersonal aspects of their care [2]. Satisfaction amongst patients after their visit is paramount since it is known that they are more likely to follow medical advice, have better clinical outcomes, have fewer issues with continuity of care [4], and overall improved clinical care [3].

Language accessibility is a right for individuals with limited English proficiency in our health care system [3]. Thus, it is standard of care that when a non-English-speaking patient is provided services through our healthcare system, they are provided access to an interpreter. This service can be through an in-person interpreter, via telephone, or video [3]. A systematic search of articles published in the US was performed, which aimed to explore if there was a difference between these different modalities and patient satisfaction [4]. Higher satisfaction was reported by LEP patients when using hospital-trained interpreters when compared to ad hoc – family and friends [4]. Overall, no modality was superior when measuring patient satisfaction, but in-person interpreter services allowed

for a more precise body language assessment, which played a role in increased patient satisfaction [4]. When not only language-proficient interpreters were used but also those who were culturally educated, higher levels of satisfaction were reported [4].

Although these services exist, a study in 2006 found that both residents and medical students still use sub-optimal Spanish language skills to provide medical care using ad-hocs [2]. Internal medicine programs are mandated to ensure education on cultural competency and health disparities [2]. However, a 2016 study explored the degree to which residency programs incorporate this in their curriculums through a survey disseminated to internal medicine residency programs [2]. Findings showed that there was no uniform training curriculum to target this goal, mostly due to a lack of faculty expertise, as reported by program directors [2]. It was also found that resident physicians who received prior training about cultural competence and appropriate use of medical interpreters were more likely to utilize LEP services [2]. This highlights the importance of training being introduced earlier on before reaching the workforce.

Yale Resident Spanish Initiative took it a step further and created an OSCE (Objective Structured Clinical Examination) with Spanish standardized patients as a tool for their learning, as elective training [6]. After surveying residents, they reported that the encounter was effective at emulating what a real encounter with an LEP was like, including the time challenges and accurately depicting the personal and emotional context of illness [6]. Overall, these OSCE trials highlighted areas that could be targeted in medical training, such as addressing cultural beliefs as well as understating the role of the interpreter, thus suggesting that there is utility in these OSCE sessions outside of this study and conveying plans to be used for undergraduate medical learners as well [6].

Even with the growing number of non-English-speaking patients, there is typically little curricular time during medical school devoted to effectively using interpreters (Taylor). Most medical schools reported to have a Spanish curriculum were elective, offered no course credit, and were taught by faculty/students [5]. It was reported that student interest and the diverse patient population in their service area drove interest in course development [5]. A survey performed in medical schools regarding preparedness to work with medical interpreters found that only 20% of students felt prepared [3]. In a study that surveyed medical schools regarding the service offered for training to work with LEP, 38 respondents stated that their institutions offered a curriculum for such, with 34 of those schools having a standardized patient experience where students could practice one-on-one with patients and interpreters [3]. Another study found that out of the schools that did have a curriculum, many different modalities were used, with the majority being didactic instruction and student-to-student role play, and some included interpreter shadowing, online modules, case discussions, and OSCEs [5].

Even with the growing LEP population demanding more medical provider training, many medical schools face significant barriers to implementing Medical Spanish in their curricula [5]. Those with a one noted their most significant obstacles were lack of time, overly heterogeneous student skill level, cost of running the courses, and lack of student retention (due to too many students signing up, making it too expensive to support) [5]. One significant study by Reuland et al. established six principles as core components of a medical Spanish curriculum after conducting a survey in a North Carolina medical school with a growing Spanish-speaking population [7]. They developed a "longitudinal program designed to maintain or improve the Medical Spanish communication skills of students

entering with intermediate to advanced proficiency to graduate cohorts of physicians who are demonstrably capable of providing language-concordant clinical care in Spanish" [7]. Such was done by outlining six principles, which were: 1) the program should be longitudinal and provide multiple modalities for learning 2) the program should focus resources on students entering with intermediate/advanced level Spanish 3) the program should have an official status and students should receive academic credit 4) if feasible, the program should be integrated with existing medical school curricula 5) the primary focus should be on language and communication skills 6) validated reliable sources should be used to measure language proficiency [7].

CHAPTER 3

METHODS

Before any data collection began to better understand student's feelings and experiences with their training in working with interpreters and LEP patient, we underwent an IRB review after I submitted the necessary documentation. In September 2023, they determined that the proposed activity was not research involving human subjects as defined by DHHS or FDA regulations. I obtained approval from the Master's in Urban Bioethics Center faculty and the Temple Lewis Katz School Of Medicine (LKSOM) Administration to contact students to conduct focus groups before participant recruitment.

The focus groups were open to any medical student at Temple Lewis Katz School of Medicine from any class 2024-2028 (M1-M4s), and they would confirm their enrollment by providing their school email. There were no specific exclusion criteria. I recruited participants by distributing flyers explaining the research project with a QR code so that students could fill out a survey if they were interested in participating. These were distributed around the medical education building and through other student communication channels. Interested students completed the redcap survey with their basic demographic information, including name, ethnicity, school year, languages spoken, as well as their availability from select potential dates for the focus groups. I contacted the 31 students who expressed interest in participating and scheduled three focus groups held on November 27th and December 19th of 2023, with the last one held on January 30th, 2024, with a total of 26 participants. All focus groups, which lasted roughly 1.5 to 2 hours, were held virtually, and recorded. All participants received a compensation of a $15 gift card. All audio data will be password-protected and saved on Temple University's secured

OneDrive server. All three audio files were transcribed verbatim by Otter AI software after which I went through to de-identify participants. I then conducted a qualitative data analysis, reviewing each transcript to find themes expressed by participants.

Some potential limitations of this study's use of focus groups are the possibility of moderator bias, the size of the group of participants, and the potential for group dynamics to influence people's responses. Furthermore, specifically, by conducting this study in Philadelphia, we are gathering responses from a medical school in an urban setting, which might not be generalizable to other areas of the United States.

CHAPTER 4

RESULTS

In this section I will discuss my findings after analyzing the focus group transcripts from the three virtual focus groups hosted. There was a total of 26 participants, with a distribution of the first one having nine, the second one having nine and the third having eight. Out of the 26 participants, 88% were females. The class breakdown was 7.7% first years (class of 2027), 19.2% second years (class of 2026), 34.6 % third years (class of 2025) and 38.5% fourth years (class of 2024). From this group, 15% reported that they only spoke English while the rest spoke other languages with varying levels of proficiency.

Through qualitative analysis of the focus group transcripts, I found the following five themes. The first theme was that students felt interpreters were integral to culturally competent care. One student who was an interpreter before medical school expressed that "my job was to connect the patient to what was actually happening because it is scary not really understanding what the doctor is saying," highlighting the importance of interpreters in patient care. One student said, "They act as great cultural liaisons not just linguistically, but body language, eye contact, lots of layers that go into really establishing a connection with someone." Both statements by students highlight that the role of the interpreter went beyond just the language but instead building a connection, making all the difference for patient care.

Additionally, interpreters often catch on to nuances due to their cultural awareness, which may be lacking if they were not present. One student mentioned how the interpreter was the one who pushed a team to address a situation using a different dialect because they realized that theirs were not matching up. Another student shared how, in their experience

interpreters can make a difference in patient care, after which they explained how the interpreter noticed someone thought to have altered mental status was simply hard of hearing. Moreover, a fourth-year medical student explained how valuable the interpreter was by offering a different meaning of a particular word the patient was using based on context clues, stating, "But in this like, small way, I felt like the interpreter was so critical for us to understand" because the story was initially not making any sense. These comments by students showcase how they understand the importance of interpreters in these situations, acknowledging how cultural nuances that may be impeding communication between patient and provider vanish using these services.

The second theme in data analysis was that students who speak another language have the undue burden of interpreting even when uncomfortable doing so. For example, one female fourth-year medical student stated “An issue that keeps popping up is that we're placed in these uncomfortable situations, even when I've told physicians I'm not that good at speaking Spanish, I could have very simple conversations, but I don't know enough medical Spanish to feel comfortable”. Another one shared a story about how she was asked to interpret for parents their child's medical updates, to which she said "I don't know why we're trusting me, the first year, to adequately provide the information. I eventually said - I don't think I should be the one to tell them - but it's awkward to say that to your preceptor". Another fourth-year medical student shared a similar experience where she stated “I feel like it's also partially being in that medical student role where it's very hard to say no to an attending, sometimes it's very uncomfortable. It shouldn't be a position that we're in”. She went on to explain how she has told attendings before “Hey, I'm not a legally certified translator or interpreter and can't do that. I'm not supposed to do that." and their

response was "Oh, no, but do it anyway."" These instances display how the bureaucracy within medicine can make these situations even more burdensome for medical students, feeling that they cannot create a safe boundary with their supervisors.

Furthermore, another fourth-year medical student shared her concerns, stating, "Sometimes when attendings use you as a translator, they only see you as a translator from then on where it's like you are no longer a med student you are almost like a paid employee. So that's unfortunate". A similar experience was shared by another fourth year when they were seeing a Spanish-speaking patient, and "the attending said 'I wish someone in this room could speak Spanish' knowing full well that I spoke Spanish as sort of to force me to interpret for him, instead of calling the interpreter." She then went on to express how she wonders how these scenarios affect students professionally regarding grades and swaying attendings evaluations. Overall, this displayed that students feel burdened to play a role that is not theirs to take that of an interpreter in a position where they can feel unable to say no to their attending overseeing their grading.

Instances, where student learning was affected by being inappropriately used, were mentioned by various students throughout all focus groups. One example was a female third-year medical student who noted, "I've had instances where I was the only one in clinic that spoke Spanish, so I offered my skills, and the residents knew. But there were times I would be pulled out of rooms to go into a Spanish-speaking room." She went one to express "In my head, I'm thinking what if I'm seeing something really cool, or I am into this patient, and I want to help this patient, I want to see it through." Similarly, a third-year female medical student shared, "I remember I was in a clinic, and this poor girl was the only student that spoke Spanish, and they just kept pulling her out of whatever room she

was already in to come and speak to the patients." These stories further showcase how multilingual students can be misused during their clinical rotations, leaning away from their learning goals, and instead potentially affecting their training.

The third theme I found throughout my data analysis was that students felt that there was not enough training in medical school regarding various types of interpreters, how to reach them, or how to properly use them. Most students expressed that although they felt that the importance of using interpreters was relayed efficiently through various lectures, the training to support appropriate usage and a smooth transition to clinical years needed improvement. One third-year medical student stated, "I would not say I was as prepared to use an interpreter as I feel like I should have" after she struggled to connect with an interpreter on her first time needing one and then went on to explain, "maybe a more streamlined way to get that information across would have been better." Many of her peers throughout the three focus groups shared this sentiment.

When it came to students sharing their experience contacting interpreters, one fourth-year medical student shared, "I think the first way I learned about it was that someone was like, ‘oh, call the translator’ And I was like, ‘what's the number’, that was my intro. Just kind of go with the flow from there." This was supported by a third year who after a peer talked about one of the doctoring sessions where they talked about patient communication she said "I was recalling that same doctoring session that was like ‘communication something’ and going into it I thought ‘Oh, great this is where they're going to teach us how to use interpreter services’ And that's not what it was at all." Moreover, a third-year medical student shared, “When I am on a rotation, the attendings and residents just expect that you know how to grab an iPad and get the service, that you

know how to do it. And that's not the case at all." Clear instructions on how to contact interpreters (which can vary between the various types of interpreters) can go a long way in making students feel adept in an environment where there is already a lot of doubt that comes with being in the student role.

Training regarding the various types of interpreters available was also lacking, leading to students not being aware of their resources. This was evident when multiple students shared their disapproval at not knowing there was such a thing as in-person interpreters, with one fourth-year medical student stating, "I was so mad that nobody told me about this critical resource" since she found out when she was on the floors rotating. Another one stated, "I did not know about in-person interpreters until quite literally fourth year of medical school," with many stating they were actively finding out during the focus group discussion.

Furthermore, students expressed their need for more training on properly using interpreters with patients. One third-year medical student stated, "There's an art to using the interpretation service. And that is something I feel like we specifically could be trained on because I see so many people struggle with it." after which she went on to explain that she was only familiar with the technique because she used to be a teacher and used a lot of interpreters. Another third-year explained her concern stating "I bet there are people who are in my class who have never used it before, and they're seeing these interactions that aren't correct, then that might be what they would do." after she shared she has worked with some residents who have not used the interpreter the right way, where they will talk directly to the iPad, and be on their phone when the iPads translate.

The fourth theme was that students are open to doctoring sessions or simulations with non-English speaking standardized patients and interpreters during their medical education. One student stated, "I feel that if you don't get that practice (either through OSCE or through doctoring sessions), you're losing out on an educational experience that will prepare you for your career." Another fourth-year medical student stated, "We all have these doctoring sessions where we go in and examine patients; why do we never try those in a different language?" pointing out that students have the same ideas about how their education can be improved. A female third-year medical student also stated, "I agree about having a doctoring session, at least one with an interpreter, would be really nice, especially learning what different interpreter services could be like with a phone or with an in-person interpreter." These statements highlight the medical student's desire to incorporate this training into their education through doctoring sessions.

Many students shared the sentiment of wanting increasing training in proper use of the different types of interpreters. One fourth-year female medical student stated, "Okay, yes 'here is stressing the importance of interpreters' now 'this is what it's actually like using the interpreters and having a practice run with each type'. I think that would help set people up for success in the clinical years". Another student shared "It could have been useful to at least have an experience doing that in a doctoring session or some simulation. And we really didn't get that. I feel the onus is on the student to learn to figure that out." Evidently, students would have valued hands-on experiences that emulated the real patient experience.

The fifth and final theme observed in data analysis was that there was mixed feelings amongst students regarding the desire to have OSCEs with non-English speaking

standardized patients and interpreters. OSCEs are Objective Structures Clinical Experiences, which is a form of testing to evaluate clinical skills with standardized patients. One third year suggested before prompting, "But I also think it would be really helpful to use it (our time) as like part of OSCEs with standardized patients, there should be an interaction where we have a standardized patient who's Spanish speaking." This was further supported by various students throughout the focus groups, with one third-year medical student stating, “An OSCE would be a really good idea as well, to help in that format because I take them a little bit more seriously than I do a doctoring session”. These students were happy to be challenged by OSCEs in a way that would ensure that their training involved an experience working with non-English speaking patients and interpreters.

On the other hand, several students opposed it due to the increased stress level that would add to OSCEs, which are already high-stress testing environments. One fourth-year medical student stated, "I don't think I'm for it in an OSCE just because that grading is already super subjective. Each interpreter will be different in how well they interpret and how much they pick up on, like tone and things like that” and then went on to explain “I think it just comes down to practice, just getting comfortable navigating the technology and just the awkwardness. That could easily be in more doctoring sessions, where the setting is more comfortable, it's less pressure". This was supported by another third-year medical student who stated, "I think the OSCE is nerve-racking enough already for a lot of people. So adding on this component of, ‘oh my god, am I getting through to this patient through this interpreter?’ It would bring a lot of nerves to a lot of people”. She expanded her thought process by stating “I agree with having a safe space. There is a lot of room in

doctoring where we can put this in, there are plenty of sessions where we can practice seeing a patient with an interpreter." These students felt that the stress of adding this component to an OSCE was more than the benefit gained due to the intricacies that surround this testing method already.

Overall, there were mixed feelings on the use of OSCEs as the best way to target training with non-English speaking patients. One third-year student stated, "I agree. Maybe it would be tricky to grade people on getting certain information because I also know that a lot of times in the OSCE, the standardized patients are very specific”. Another stated, "I think it would also be difficult to use it for an OSCE because of the time constraints. It was 20 minutes or something in a room, and when you use an interpreter service, it takes twice as long because everything gets said twice”. She went on to explain “I don't know if I would love the idea when the time is already crunched, having that additional time crunch as well. I would love to see it used in doctoring sessions and work with a standardized patient." Amongst the discussion one student made an impactful statement: “In the real world, we do have to interpret. Over half of the country speaks Spanish, and we're going to have to do it. And I think that should be reflected in the curriculum”. She went on to state “We shifted when we had COVID and now telehealth as part of our OSCEs. So, I don't see how adding an interpreter portion wouldn't be another shift to reflect what's happening in our world," which highlights an important perspective on the need for change in how we approach this topic. Students are aware of how in a system where the population continues to change, our training practices need to do as well.

CHAPTER 5

DISCUSSION

Future physicians deserve training that empowers them to treat their patients with cultural competence. Part of that involves being able to communicate with their patients, which often requires an interpreter due to the large non-English speaking patient population in the United States. It has been found that medical students who received prior training on cultural competence and the appropriate use of medical interpreters were more likely to utilize LEP services. With that in mind, medical education can significantly change how future physicians interact with LEP patients by providing appropriate education on interpreter services either through doctoring sessions or OSCEs, meanwhile lowering the burden placed on multilingual students who are inappropriately often used as interpreters.

Per the literature, we know that LEP patients are at risk for worse outcomes if an interpreter is not used, with those treated without one reporting the lowest satisfaction ratings, putting them at risk for worse clinical care. Medical education has the chance to change these odds by ensuring that students not only understand the importance of using interpreters in providing culturally competent care when treating their LEP patients but also by adequately training them on how to do so. Although the medical students surveyed through these focus groups felt that interpreters were integral to culturally competent care (theme 1), they were also in consensus that they did not feel that they received enough training regarding various types of interpreters, how to reach them, or how to use them properly (theme 3). Such was evident by stories shared where they were unaware of various types of interpreter services they could contact when they began clinical rotations,

many finding out late in their clinical years or through their experience at these focus groups. There is no reason why students should not be informed of the interpreters available at the hospital system where they train. Although their superiors assumed that they knew how to do it, students often felt unprepared and lost when it was time to request interpreter services without clear instructions on how to do so. Lastly, the students felt they lacked proper instruction on the correct techniques for using an interpreter and were forced to learn on their own as they experienced those encounters. Taking time in the curriculum to address these student concerns can make the transition to the clinical years more straightforward.

The literature found that when surveying medical students, only a low percentage of them felt prepared to work with interpreters, and this was mirrored in my findings as well. With students feeling unprepared to tackle their interactions with LEP patients, the question becomes what the best way is to address this and effectively impact student learning. Without prompting, many students mentioned their thoughts on using a simulation or hands-on training with a non-English speaking standardized patient and an interpreter (theme 4). There was a consensus across all three focus groups that this approach would be a memorable way of instruction that would better prepare them for their clinical years and futures as physicians.

However, students were more favorable of this opportunity to be offered as part of doctoring rather than through OSCE (Objective Structured Clinical Examination), which was found in the literature to be used by the Yale Resident Spanish Initiative with Spanish standardized patients. Students were not sure how this would affect their grading, which is already subjective in OSCEs based on the various nuances between standardized patient

interactions, as well as how adding an interpreter interaction would play a part in the already existing time constraints of an OSCE. Some felt that the stress level of this testing type is already very high and that it would serve them better to work with interpreters in a more relaxed environment, such as a doctoring session where they could practice rather than be under a grading microscope.

A similar theme from prior literature, where the use of sub-optimal language skills to provide medical care due to the usage of ad-hocs or complaints of long waiting times, was observed through the discussions in the focus groups as well. Many students face the undue burden of interpreting during their clinical rotations because they speak another language, even when they reported being uncomfortable doing so (theme 2). Students often stated that they felt this was driven by a desire to save time due to the added time reaching and using an interpreter can add to the visit. This places students at a disadvantage in their learning because they can often be used as such rather than remain in their role as learners. Additionally, they often feel unable to speak up against their superiors due to the power dynamics between them and those who ultimately impact their course evaluations.

Overall, qualitative data analysis resulted in five themes, which were: students felt that interpreters were integral to culturally competent care, students who speak another language have the undue burden of interpreting even when not comfortable doing so, students felt that there was not enough training in medical school regarding various types of interpreters, how to reach them or how to use them properly, students are open to doctoring sessions or simulations with non-English speaking standardized patients and interpreters, and the final theme was that there mixed feelings amongst students regarding the desire to have OSCEs with non-English speaking standardized patients and interpreters

These findings leave room for future research exploring a more concise response to which instruction methodology students preferred between doctoring sessions or through OSCEs, given the mixed feelings amongst students. Furthermore, although more support is needed to qualify as a theme, some students did mention their desire to learn and have a general understanding of the laws surrounding these issues since they are often put in uncomfortable situations and unsure if they are breaking the rules, etc.

CHAPTER 6

CONCLUSION

To conclude, medical education can directly impact how future providers interact with their patients. With the growing LEP patient population, regardless of where you continue your training as a resident or work as an attending, the odds are that, at some point, you're going to have to use an interpreter. If we want to provide culturally competent care to the patients who are entitled to such care and are already at a disadvantage regarding clinical outcomes, it is paramount that we dedicate more time to this patient population. This becomes important not only for future physicians' interactions with patients but also for learners negatively affected by the current medical education system.

The weight that this carries in medical training, the direct consequences it can have on patient care, and my own lived experiences motivated me to understand better how medical education is approaching this field. Overall, I found that students felt they were taught and understood the importance of interpreters in culturally competent care, but this was not mirrored in their training. They feel that they could be better prepared in their training to work with LEP patients and that there is room in the curriculum to do so. It also became evident that a specific group of students who have a language advantage are placed in disadvantageous learning environments inappropriate use from their superiors.

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APPENDIX A

RECRUITMENT QUESTIONS

Name:

Email:

Phone number:

Year in school:

- M1
- M2
- M3
- M4

List languages you speak:

Race/Ethnicity:

- American Indian/Alaskan Native
- Asian
- Black or African descent
- Hispanic/Latinx
- Native Hawaiian or Pacific Islander
- White/Caucasian
- Other

Select your preferred choice of meeting:

- Virtual
- In person
- No preference

Choose the available dates/times that would work for you availability as tentative focus group dates: (*Mark as many dates as you would be available for*) – listed the various dates to choose from.

APPENDIX B

FOCUS GROUP QUESTIONS

Start off with ice breaker questions including:

1. What medical school year are you in?
2. What languages do you speak?

Once everyone has familiarized themselves, and stated they are willing to participate will jump into following questions:

1. When I say culturally competent health care – what does that mean to you?

2. What do you feel that an interpreter's role is in providing culturally competent health care?

3. Do you feel that your medical school training has incorporated the importance of the use of interpreter services in patient care – and if so, expand on how so.

4. Would you like for your medical school training to incorporate more teaching on why interpreters are so valuable to patient care/how they ensure patients receive culturally competent care?

    a. If so, in what modalities would you want this teaching to be incorporated?

5. Tell me about your experience working with interpreters, and especially if you felt prepared to work with them the first time you did.

6. Any type of interpreter you felt was better or worse and why?

7. What have your experiences been when doing the OSCE with standardized patients? Do you feel that this has been beneficial to your learning?

8. What are your thoughts when I mention an OSCE (Objective Structured Clinical Examinations) with standardized Spanish speaking patients and interpreters to be incorporated into the doctoring course or some other modality throughout medical school?

9. Do you feel that this has been beneficial to your learning?

    b. Do you foresee any barriers?

10. Who has taken medical Spanish elective? For those that have not, why?

    c. Do you feel that it was beneficial to your medical school training?