CULTURAL SENSITIVITY EXPERIENCES OF SOUTH ASIAN PATIENTS IN PRIMARY CARE

by

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ABSTRACT

Racial and ethnic minorities can encounter systemic barriers and injustices when accessing healthcare. These injustices can sometimes be attributed to healthcare providers' poor demonstration of cultural awareness or sensitivity. Cultural sensitivity practices of primary care providers (PCPs) can affect a South Asian's access to primary care. To explore matters relating to cultural sensitivity and lack thereof, this study is focused on the healthcare experiences of South Asian (SA) individuals in the context of primary care.

This manuscript is written in an article-based format. The first section consists of an introductory chapter delineating a literature review on cultural sensitivity and its importance in primary care. This section also discusses SAs' health care needs and demonstrates the gap in literature regarding SAs' primary care experiences in Atlantic Canada. The second chapter is the research article, outlining the study, research design, findings, as well as discussion and implications. The third and final chapter is the conclusion and summarizes the research, recommendations for future research, as well as the strengths and limitations of the study.

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List of Abbreviations

1. Primary Care Provider(s)……PCP(s)
2. South Asian(s)…….SA(s)
3. American Psychological Association……..APA
4. Young Men Christian Association…….YMCA

Chapter One: Introduction

This thesis is focused on the experiences of South Asian (SA) patients when accessing and receiving primary care services in an Atlantic Canadian city, including how the cultural sensitivity practices of Primary Care Providers (PCPs) affects SAs' healthcare experiences. For this thesis, an article-based format was used, beginning with an introductory chapter, followed by a research article, and finally, a concluding chapter. The manuscript is formatted as per the requirements outlined by the School of Graduate Studies at the University of New Brunswick. The research article is titled *South Asian Patients' Experiences with Cultural Sensitivity in Primary Care*. My responsibilities as principal author included identifying the research topic, developing the research design, and leading the study, all with the help and insight from my supervisors: Dr. Shelley Doucet, Dr. Alison Luke, and Dr. Julie Easley. I was also responsible for conducting and transcribing interviews, analyzing the data, and writing the research article. Additionally, I wrote the first and third chapters of this manuscript, which are the introduction and conclusion, respectively. The manuscript was edited by my supervisors, all of whom will be co-authors on the research article when it is submitted for publication. The article is formatted for submission to the "Social Science and Medicine" journal for publication, and the references and in-text citations are completed in American Psychological Association (APA) format. The goal of *Social Science and Medicine* is to publish research articles that focus on social science research in health and provide insight on health issues to inform current research.

Literature Review

This literature review focuses on primary care from a culturally sensitive perspective, as well as the perceived barriers SAs face in healthcare. The review is organized into the following sections: (1) defining culturally sensitive care; (2) health care needs of SAs; and (3) cultural sensitivity within a healthcare context in Atlantic Canada. Online academic platforms were used such as Google Scholar and Pubmed. Additionally, articles from peer-reviewed journals were accessed, such as the Journal of Transcultural Nursing and the Journal of Immigrant Health. Searches were conducted using key words, such as: South Asian, healthcare, cultural sensitivity, primary care providers, Atlantic Canada, biases, barriers, racism, discrimination, and needs.

Defining Culturally Sensitive Care

When carrying out culturally sensitive care in a healthcare environment, PCPs must consistently work toward decreasing racial and cultural inequities (Geiger, 2001), as it can positively or negatively influence the type of care given to minority patients. Cultural sensitivity involves being both self-aware and aware of others when encountering diverse groups or individuals and using one's own knowledge and understanding to respect and adapt to the needs of others (Foronda, 2008). It also refers to the ability to respond appropriately to the attitudes, feelings, or settings of groups who share a common and distinct cultural, racial, religious, national, or linguistic heritage (Tucker et al., 2011). Cultural sensitivity leads to effective communications, interventions, and satisfaction among diverse groups (Foronda, 2008). The omission of culturally sensitive standards in the healthcare profession and the failure to translate multicultural competencies into actual practice contribute tremendously to cultural

insensitivity (Sue, 2011). Therefore, PCPs must work to develop their cultural sensitivity skills to best understand and identify the similarities and differences across different cultures, what they mean, and how to bridge those differences to achieve clear communication (Vidaeff et al., 2015).

Although the term cultural competency is often interchangeable with cultural sensitivity, for the purposes of this study, the term cultural sensitivity will be used. According to Foronda (2008), the term cultural sensitivity is preferred over cultural competence or cultural care as it embraces the broadest audience possible in terms of its global interpretation and use. Cultural sensitivity is a term that is "utilized ubiquitously within multiple contexts from healthcare to business to education" (Foronda, 2008, p. 207). Culturally sensitive care is crucial in fostering safe and effective healthcare interactions in the hopes of providing equitable care; this begins with those in positions of power (i.e. PCPs) unmasking marginalizing practices and working to transform healthcare environments into inclusive and welcoming spaces (Johnson et al., 2004). Marginalizing practices, such as excluding and belittling ethnic minorities in work environments, is also known as othering, wherein individuals label those they believe are different from themselves (Johnson et al., 2004; Weis, 1995). PCPs' "othering" individuals can come in several different forms, such as racializing explanations (Johnson et al., 2004). Racializing explanations refers to not understanding the historical, political, and social factors that may contribute to an ethnic minority's circumstances (Adelson, 2004). This can often lead to stereotyping, which influences PCPs' professional judgements, leading to poor interactions with ethnic minorities, and perpetuating racism and discrimination in the healthcare system (Goodman et al., 2017).

Identifying culturally sensitive practices and establishing them in the healthcare field is crucial to ensuring patients feel comfortable and accepted. In their study, Betancourt et al. (2016) established a framework of culturally sensitive interventions to address and resolve racial and ethnic disparities in the United States. Interventions included recruitment of minorities into the health professions, development of interpreter and translation services on materials regarding health education, and creation of provider education tools on cross-cultural issues (Betancourt et al., 2016). It was concluded that the anticipated demographic changes over the next decade magnify the importance of addressing racial and ethnic disparities in healthcare. Finally, identifying patterns of disparities in medical care and treatment is also important when cultivating a valuable culture of medicine and health care (Good et al., 2005). Therefore, the training of medical, nursing and allied health students, as well as the organization and delivery of health care allows healthcare professionals to determine factors that affect patient treatment, as well as illuminate disparities in patient care.

Geiger (2001) states that cultural insensitivity implies the presence of pragmatic and ethical issues. This is because any systemic disparities in treatment conflict with the fundamental professional commitment to equitable care and concern for every patient (Geiger, 2001). Equitable care stems from ensuring that a patient is treated from a fair and impartial view. If a PCP, such as a physician, is not treating their patients from an ethnic minority background with fairness and equity, they, in turn, are breaking their Hippocratic Oath. This is an oath all physicians take before beginning their medical journey as a promise to treat all their patients to the best of their ability, striving for patient autonomy, non-maleficence, beneficence, and justice in all aspects of their work

(Sritharan et al., 2001). However, despite this, there are still many PCPs who contribute to racial and ethnic disparities, and in doing so, contribute to a decrease in the quality of medical care (Geiger, 2001). These disparities manifest in the form of poor patient-provider communication and treatment, thereby contributing to lower quality diagnostic work-ups for minority patients (Saha et al., 2008). Due to provider bias and judgement, many ethnic minority patients are given lower dosages for pain medication and, at times, have been denied appropriate or necessary care, resulting in accelerated mortality as a consequence (Geiger, 2001). Ultimately, it is clear that PCPs' cultural biases contribute to lower quality of healthcare services; hence, overcoming cross-cultural barriers is crucial to providing equitable care to patients (Vidaeff, Kerrigan, and Monga, 2015; Nelson et al., 2002). This is especially relevant as more people immigrate to Western countries and are seeking, as well as deserve, optimal care from culturally sensitive PCPs (Ahmed & Lemkau, 2000).

Health Care Needs of South Asians

There is a growing body of evidence that demonstrates that the health of minority groups is distinctly different to that of White people (Vydelingum, 2000). SAs may have diverse cultural beliefs, attitudes, and practices that are not only different from the majority White population, but from other ethnic groups as well. This is because each ethnic group has its own distinct culture, lifestyle, religion, and language (Vydelingum, 2000; Balarajan, Raleigh, & Cumberlege, 1993). Looking specifically at the cultural lifestyle of SAs, their traditional religious, dietary, and healthcare practices may not always match modern Western medical practices and clinical research approaches (Quay et al., 2017). Additionally, some SAs' may not be proficient in English and lack both

familiarity with local healthcare services, as well as knowledge of western medicine, which all serve as challenges to healthcare providers who are culturally insensitive and unaware of such barriers (Nilaweera et al., 2014). Therefore, identifying unique cultural beliefs and values are essential for healthcare providers if they wish to build a rapport and provide high quality health care to their patients (Ahmed & Lemkau, 2000).

Studies surrounding cultural sensitivity found that when compared with White patients, minority patients report lower-quality interactions with their physicians (Saha, Arbelaez, & Cooper, 2003). According to the results from the Canadian Community Health Survey, it was concluded that SAs are more likely to report poor self-rated health than Whites (Quay et al., 2017). Currently, SAs are the largest ethnic minority in Canada, comprising 1.6 million Canadian residents and citizens, resulting in a quarter of the visible minority population (Quay et al., 2017). Unfortunately, SAs experience specific health problems at a higher rate than White individuals, including type 2 diabetes, cardiovascular disease, and asthma (Quay et al., 2017). Suffering from such grave health conditions can make SAs more likely to seek help from healthcare providers. This is relevant for PCPs as they are often the first point of contact for many individuals seeking primary care and their entry to the healthcare system. Additionally, insensitive care on PCPs' behalf can dissuade ethnic minorities from not only seeking help, but if help is sought and culturally insensitive care is given, it will limit ethnic minorities from receiving optimal care (Holden, 2014).

When looking at the religions that dominate SA countries, Bangladesh and Pakistan are often home to many Muslims (Ahmed & Lemkau, 2000). When providing care to Muslim patients, it is important to understand how the Islamic faith influences the

type of medical care they may wish to receive that adheres with their traditional beliefs and customs (Attum & Shamoon, 2019). For this reason, PCPs need to be aware of cultural differences regarding issues such as privacy, personal touch, medicinal preferences, and dietary practices (Attum & Shamoon, 2019; Aboul-Enein & Ahoul-Enein, 2010). Ultimately, the need for more culturally sensitive care demonstrates the increasing urgency to educate healthcare professionals and help them reflect on their own and others' cultural attitudes, beliefs, behaviours, and communication strategies, as well as modify practice skills that enable quality, non-discriminatory care (Guilfoyle & Harryba, 2009).

Cultural Sensitivity Research in Atlantic Canada

Atlantic Canada consists of four provinces, which are New Brunswick, Newfoundland and Labrador, Prince Edward Island, and Nova Scotia (Samuel, 2009). These provinces are said to be “lagging behind in the integration process” (p. 17); this integration process refers to ensuring newcomers feel welcomed, adjusted, and have access to vital and essential resources and services, such as financial aid, social support, and employment (Samuel, 2009). Newcomers, also known as immigrants, are those individuals who migrate to a new country (Founer, 2012). A study carried out in Elsipogtog First Nation, formerly known as Big Cove, NB, explored cultural sensitivity from the perspectives Mi’kmaq peoples’ through their interactions with healthcare providers during recent hospitalizations (Baker & Daigle, 2000). After learning that the patients overwhelmingly felt misunderstood and experienced cultural insensitivity, Baker and Daigle (2000) concluded that compassion and non-discriminatory attitudes among care providers were essential in creating effective cross-cultural relationships.

Reitmanova and Gustafson (2009) consulted with visible minority immigrants in Atlantic Canada to discover gaps in healthcare services and opportunities for increasing accessibility. The authors concluded that information about services was limited and, moreover, did not effectively address and examine the complex health care needs of immigrants from diverse cultural and religious backgrounds. Factors that contributed to this finding include lack of information; language and literacy issues; a mistrust of mental healthcare services; mental illness stigma; long wait times; financial instability; and religious and cultural differences and insensitivity (Reitmanova & Gustafson, 2009). The need for further research in Atlantic Canada that explores PCPs' cultural sensitivity practices, or lack thereof, toward SA patients is apparent. Ultimately, this is a gap that has been identified in the literature, as studies seldom explore the experiences of ethnic minorities, specifically SAs to discover whether PCPs need to improve or establish cultural sensitivity practices.

Study Objective and Research Question

The purpose of this phenomenological study was to describe the lived experiences of SA patients when accessing and receiving primary care services in an Atlantic Canadian city, including how the cultural sensitivity practices of PCPs affect SAs' healthcare experiences. The research question posed, therefore, was: what are the lived experiences of SA patients when accessing and receiving primary care services, including their experiences related to the cultural sensitivity practices of their PCPs? This question was explored through conducting qualitative interviews with anyone who identified as SA and had at least one interaction with a PCP in the past five years.

Summary

A review of the literature suggests that there is limited research exploring SA patient experiences with healthcare practitioners in Canada, particularly in Atlantic Canada. Patient populations are becoming more diverse each day; therefore, becoming conscious of both covert and overt bias that leads to the projection of stereotypes and racism, as well as implementing culturally sensitive practices in workplaces are increasingly urgent professional responsibilities (Geiger, 2001). Morency (2017) states that by 2036, visible minorities will constitute between 35 to 40 percent of Canada's population, totaling about 14.5 million people. To adapt to this increase, PCPs should alter the care they provide to be more inclusive and empower patients to interact with the healthcare system, all while fostering a safe environment for them to do so (Butler et al., 2016). It is important to remember that PCPs are part of two cultural environments: mainstream society and the culture of healthcare. Both areas have bias to some degree, as well as beliefs, assumptions, and perceptions of how and what should be done (Geiger, 2001). Therefore, it is important for PCPs to have the proper education and training to provide culturally sensitive care (Butler et al., 2016). Specifically, Nair and Adetayo (2019) mentioned the power of educating healthcare students to instigate positive change and improve cultural sensitivity practices of physicians in the future.

Shedding light on culturally insensitive care is crucial for propelling both society and the Canadian healthcare system forward because patients' mistrust and negative views of the health care system is often based on past discriminatory clinical experiences (Geiger, 2001). Lack of cultural sensitivity practices in primary care facilities may be easily remediable, so long as such practices are recognized and programs are designed to

address them (Geiger, 2001). To learn more about how to improve the healthcare experiences of SAs, it is critical to learn firsthand about their experiences with cultural sensitivity, or lack thereof, in primary care settings.

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Chapter Two: Cultural Sensitivity Experiences of South Asian Patients in Primary Care

Abstract

Racial and ethnic minorities face many barriers in their everyday lives due to systemic injustices ingrained into modern-day society. These injustices can percolate in any environment, including the field of healthcare, leading to negative experiences for ethnic minority groups. Negative experiences in healthcare can sometimes be attributed to poor cultural awareness or sensitivity on the part of healthcare providers. Cultural sensitivity practices of primary care providers (PCPs) can affect a South Asian's (SA) access to primary care. Therefore, to explore matters relating to cultural sensitivity and lack thereof, this study focuses on the healthcare experiences of SA individuals in the context of primary care. A qualitative phenomenological approach was used to highlight SA patient experiences with PCPS through in-person semi-structured interviews with a sample of 19 SA individuals living in an Atlantic Canadian city. Data was transcribed verbatim and analyzed using an inductive thematic approach, focused on finding common themes and meanings through participants' shared experiences. Results demonstrated that SA patients encountered substantial barriers and challenges when accessing primary care, such as communication barriers and cultural stereotypes and assumptions. To combat these barriers, participants shared suggestions for improvements such as additional cultural sensitivity training implemented for PCPs, as well as for PCPs to take their time when talking to patients. The results of this study contribute to a better understanding of

SA' experiences with PCPs, the barriers they may encounter, and the factors that affect the quality of care they receive.

Introduction

Racial and ethnic minorities encounter systemic injustices in their everyday lives (Van Wormer, 2005). These injustices are present in all types of environments, including the healthcare field, and can lead to negative experiences for patients from ethnic minority backgrounds. Such negative experiences in healthcare can sometimes be attributed to poor cultural awareness or sensitivity on the part of PCPs. PCPs include general practitioners and family physicians, as well as physician assistants and nurse practitioners (Hébert et al., 2012). PCPs who exhibit poor cultural sensitivity can be perceived as discriminatory from the patients' perspective; this would lead to a significant and inequitable gap experienced by racial or ethnic minority groups (Geiger, 2001). Nair and Adetayo (2019) state that diverse populations require specific and individualized approaches to meet their health care needs. Unconscious bias on the part of PCPs can lead to a lack of cultural sensitivity in the form of stereotypes and prejudice, perpetrated toward ethnic minorities. Because of this, members of minority groups can find seeking medical treatment or assistance daunting, contributing to avoidance of gaining appropriate health care (Caulford, 2014).

Racial and ethnic minorities often face discrepancies in quality of care received, which can contribute to their lack of access to healthcare (Nair & Adetayo, 2019). Racial minority groups, such as SAs, already face disparities in health compared to White people, such as higher rates of diabetes and lower levels of subjective wellbeing (Ward et al., 2004). Such disparities are often attributed to social determinants, such as

socioeconomic status, education, and employment; however, differences in social determinants only partially explain differences in care received for ethnic minorities (Michalopoulou et al., 2009). When healthcare access-related factors are controlled, such as insurance status and income, ethnic minority patients can still face lower quality of care when compared to White people (Michalopoulou et al., 2009). Having inequities when it comes to accessing health care can be troubling for any minority group as it can pose a significant barrier to improving or maintaining one's health. This is especially relevant to the SA patients in Canada as they are the country's largest minority group, comprising about 30% of the country's population (Islam, Khanlou, & Tamim, 2014). Evidence has shown that SAs have decreased access to healthcare, resulting in a greater number of emergency room visits, dire health outcomes, and an increase of cardiovascular disease, diabetes, cancer, and mental illness (Chatterji, Joo, & Lahiri, 2012).

Ultimately, ethnic minorities can be subjected to biases, racism, and unfair treatment by healthcare providers, and these injustices can be attributed to poor cultural sensitivity awareness. Despite these concerns, there is little research focused on exploring SAs' experiences when accessing primary care. Therefore, to address this gap and shed light on cultural sensitivity practices of PCPs from SA patients' perspectives, this study explored the following research question: what are the lived experiences of SA patients when accessing and receiving primary care services, including their experiences related to the cultural sensitivity practices of their PCPs?

Methodology

The methodological approach for this research study is phenomenology. Creswell and Poth (2018) state that a phenomenological study describes the shared or common meaning for individuals regarding their lived experiences. Phenomenology is a useful approach when asking what someone's lived experience is like regarding a certain phenomenon (Jackson et al., 2018). The goal of phenomenology is not to generalize specific theories, but instead to accurately describe the participant's experience of the phenomenon (Krefting, 1991). Semi-structured interviews were used in this qualitative study as it offered significant benefits in terms of bringing forward authentic patient experiences (Anthony & Jack, 2009).

Study Design

The goal of this study was to explore the experiences of SA patients with PCPs. Phenomenology was appropriate for this study design as it places the person(s) being interviewed in an emotional and organizational context (Czarniawska, 1997). This allowed participants to share their personal stories or narratives openly and honestly in a setting where they felt comfortable to do so (Czarniawska, 1997). Upon hearing the experiences of the participants, phenomenological researchers hope to derive and understand the knowledge and essential 'truths' of one's lived experiences, not quantifying the information gained in numbers or statistics, but rather, describing and demonstrating that truth can transpire as a result of peoples' experiences (Byrne, 2001). The line of questioning that was used for this study was based off a phenomenological study performed by Tucker et al. (2003) who investigated the effects of cultural competence among PCPs in their interactions with minority patients in the United States.

Because Tucker's study had a similar goal to this study where it explored what minority patients considered to be culturally sensitive care from healthcare providers, a few questions asked in this study are largely similar to Tucker's questions.

From a healthcare lens, phenomena of providers' interactions with their patients can be closely linked to the subjective experiences of patients seeing they are part of an environment where health care is managed (Vydelingum, 2000). According to Creswell and Poth (2018), social constructivist worldviews are an inherent part of phenomenology as they manifest themselves in the description of individuals' experiences. This can lead to understanding the meanings participants assign to their healthcare experiences (Taylor, 1993; Vydelingum, 2000). When using a phenomenological approach, it is also vital to encode words such as "describe", "experiences", and "essence" (Creswell & Poth, 2018, p. 135) to ensure that the phenomenon is being clearly described. For this reason, in this study, participants were asked questions that included: can you describe your experiences with a primary care provider(s), and has there been a time or an experience you had where you found there to be a barrier between you and a primary care provider when seeking help? Rodriguez (2018) defines experience as involving thoughts, intentions, and emotions in events. Suddick et al. (2019) state experiences and authenticity are an integral aspect of a researcher's work. Therefore, a phenomenological researcher asks questions such as: what is the experience of this participant with seeking help from their PCPs; what does the experience signify; and how does the world present itself to the researcher or the participant? After participants shared their stories, the interview data was scrutinized for themes that would help the researcher to understand the meaning

behind the participants' experiences, as well as construct a stronger understanding of the phenomenon (Creswell & Poth, 2018).

Study Population

The focus of this study was on individuals from SA backgrounds, regardless of gender, who accessed healthcare services from PCPs in an Atlantic Canadian city. For this study, purposeful sampling was one strategy utilized in selecting participants. Purposeful sampling is commonly used in qualitative research for selecting participants based on their ability to provide information relevant to the phenomenon at hand (Padgett, 2008; Palinkas et al., 2015). Maximum variation is a type of purposeful sampling and was used as a sampling strategy to gain a holistic understanding of the phenomenon and representation of diverse experiences relevant to answering the research question (Gentles, Charles, Ploeg, & McKibbon, 2015; Hammarberg, Kirkman, & de Lacey, 2016; Suri, 2011). Maximum variation sampling was achieved through recruiting SA participants who differed in age, country of birth, number of years resided in Canada, and locations accessing health care. By employing maximum variation sampling, common patterns that emerged from variation in the data and focused on the participants' shared lived experiences were identified (Hoepfl, 1997). Identifying common patterns led to capturing central or shared aspects of a phenomenon and yielded descriptive stories (Hoepfl, 1997; Kitto, Chesters, & Grbich, 2008).

The inclusion criteria for this study was as follows: participants must identify as SA individuals who have interacted with PCPs at least once within the past five years. Lastly, the participant had to be at least 19 years of age and able to articulate their experience(s) in English, Urdu, or Hindi. SAs encompass individuals from Sri Lankan,

Pakistani, Afghan, Bangladeshi, Nepalese, Bhutanese, Maldivian, and Indian backgrounds (Quay et al., 2017; Requejo et al., 2010). However, it is important to note cultural insensitivity on the part of PCPs can occur to a SA born in any country, even in Western countries, such as Canada.

Study Setting

For this study, interviews were conducted with 19 people who currently lived or had lived within this Atlantic Canadian city and accessed primary care services there. This proved to be a feasible location to recruit participants as there was a strong representation of minority population participants in this region. According to a 2016 census conducted by Statistics Canada, this city hosts between 5000 to 10,000 individuals from visible minority backgrounds. Specifically, the SA population serves as one of the top three largest minority populations, with Chinese and Black individuals comprising the other two groups (Statistics Canada, 2016). Additionally, some SA households may consist of Muslims; a religious minority that is the most discriminated against group in Canada (Anderson & Colleto, 2016). This discrimination against Muslims can be present in many environments, including healthcare, proving SA Muslims to be a promising group to recruit for this study. This ultimately allowed for a greater and more diverse pool of information to be collected from the interview questions.

Recruitment

Participants were recruited through a variety of strategies, all of which were virtual due to the COVID-19 pandemic. For example, organizations that work with newcomers, such as the local Asian Heritage Society, Young Men Christian Association (YMCA), and Multicultural Council, as well as local religious organizations (i.e.

churches, mosques, and temples) were contacted via email and Facebook. Leaders of such organizations, such as Board members or executive teams, were asked to disseminate an open call for participants for this study. Online posters (see Appendix I) were provided for them to disseminate to their members. Additionally, local health clinics and community health centres, such as the Downtown Community Health Centre, were contacted via email to advertise recruitment for the study. Virtual recruitment also included advertising the study on various social media platforms such as Twitter and Facebook. Additional recruitment strategies included advertising to students studying at a local university campus, particularly targeting those who actively participated in multicultural clubs and international students' societies. These students were asked to share the recruitment study in their respective Facebook groups, as well as individually on their personal social media platforms such as Facebook and Instagram, if they felt comfortable doing so.

Data Collection

Semi-structured interviews were conducted with a total of 19 individuals. These interviews were conducted virtually either over-the-phone or through virtual interfaces, such as Skype or Zoom. When participants showed interest in the study, they were asked to first read the informed consent form (see Appendix II) and were reminded that their personal stories would not be shared with anyone, including their care team. To officially obtain consent prior to commencing the interview, the oral consent script was read aloud to the participants virtually (see Appendix III). Once oral consent was obtained, the interview took place (see Appendix IV for interview guide), in which all information collected from the transcribed interviews and audio recordings were kept in a secure

location and password-protected computer, and all quotes used were de-identified. Lastly, the information collected was only privy to the principal researcher and her supervisors.

Theme saturation was effectively achieved at 19 people. Theme saturation refers to when researchers conduct interviews and collect enough data to the point that new information does not add significantly to the existing data, as signified by data replication or redundancy (Bowen, 2008). Ultimately, a saturation point from a sample size of 19 was achieved when new data did not considerably add to the already collected data, and a stage was reached where the research findings presented could be analyzed and generated (Saunders et al., 2018).

The interviews consisted of general questions regarding participants' healthcare experiences and whether they had experienced any culturally sensitive or insensitive care and discomfort when meeting with PCPs, including both family physicians and nurse practitioners. If they responded yes to the aforementioned questions, additional questions were asked, such as "what does/could your PCP do to make you feel comfortable with them" or "what could your PCP do to show that they are sensitive to your needs and is respectful of your ethnicity" (Tucker, 2003, p. 861). By asking follow-up questions, this led to a greater understanding of how participants' healthcare experiences could be improved if needed, or on the other hand, what PCPs may have done that enabled their patients to feel comfortable and supported. The interview data was stored on a secure online server to ensure that participants' personal information and stories were kept confidential.

Data Analysis

Following data collection, the recorded interviews were transcribed verbatim and thoroughly read a few times to attain an overall comprehension of the data. Data was then coded using inductive thematic analysis. Gibbs (2007) defines coding as how a researcher describes the data they are analyzing. In this case, coding consisted of noticing phenomena that were relevant to the study, gathering examples supporting that phenomena, and analyzing the data to find similarities, differences, and patterns (Seidel & Kelle, 1995; Basit, 2003).

Qualitative studies also often rely on inductive reasoning processes to infer and organize the collected data and its meanings (Thorne, 2000). This relates to thematic analysis, which is a strategy to interpret the meanings of a phenomenon that is being studied (Van Manen, 2016). In this study, thematic analysis was also employed to identify particular themes and topics that were relevant for exploring the research question at hand (Clarke & Braun, 2013). To expand, applying inductive reasoning to a thematic analysis approach entailed the following: identifying and organizing the collected data into distinct themes that capture the shared meanings and experiences of the participants and then generating ideas based on those shared meanings (Clarke & Braun, 2013). This allowed for questions to be asked, comparisons to be made, or categories to be adjusted in the data (Basit, 2003). Finally, the results were then integrated into an overall description of the phenomenon, ensuring data trustworthiness through establishing credibility, transferability, dependability, and confirmability.

Results

Overall, 19 people participated in the research study. Eleven were females and eight were male. The median age of participants was 22 years old, and the range consisted of the youngest four participants being 20 years old and the oldest being 51. Fourteen were born outside of Canada and nine had lived in Canada for between 1 to 5 years, while the remainder had lived in Canada for at least 15 years. Participants spoke a variety of languages with the most popular being Hindi and Urdu. Additionally, 10 participants considered English their primary language. See Table 1 for additional demographic details. An important note to distinguish is that not all SAs who participated in this study were newcomers; some of them were born in Canada, and the majority of those who were not born in Canada had resided in Canada for at least four years. Finally, when looking at the experiences of SA patients, two major themes emerged: 1) barriers and challenges and 2) recommendations for future healthcare practices. The study themes and subthemes are outlined in Table 2.

Table 1: Study Sample Characteristics

Study sample characteristic	*n*	%
Gender identity		
Female	11	57.9
Male	8	42.1
Born in Canada		
Yes	5	26.3
No	14	73.7
Cultural heritage by country		
Bangladesh	3	15.8
Bhutan	2	10.5
India	7	36.8
Nepal	2	10.5
Pakistan	3	15.8

Sri Lanka	2	10.5
English as primary language		
Yes	10	52.6
No	9	47.4
Religion practiced		
Buddhism	1	5.3
Islam	5	26.3
Hinduism	7	36.8
Christianity	1	5.3
Not applicable	5	26.3
Marital status		
Single	16	84.2
Married	3	15.8
Having a PCP		
Yes	9	47.4
No	10	52.6
Location primary care is mostly accessed		
Student Health Centre (SHC)	4	21.1
Family Doctor's office	3	15.8
Walk-in clinic and a combination of other locations mentioned above	11	57.9
Other	1	5.3
How often a PCP is seen per year		
Less than once or once a year	6	31.6
2-5 times a year	8	42.1
More than 5 times a year	5	17.9
Highest level of education		
High school diploma	8	42.1
Bachelor's degree	7	36.8
Master's degree	2	10.5
Doctorate (e.g. PhD, EdD)	2	10.5
Employment status		
Unemployed, looking for work	3	15.8
Employed full-time (30 or < hrs/wk)	5	26.3
Student and employed full-time currently	6	31.6
Student & currently employed part-time	3	15.8
Student	2	10.5

Note. N = 19. Median age of participants = 22 (range = 20-51; SD 8.74).

Table 2: Study Themes and Subthemes

Themes	Subthemes
Barriers and Challenges	1. Communication barriers
	2. Lack of South Asian representation
	3. Cultural stereotypes and assumptions
	4. Lack of awareness of SA cultural customs and norms
Recommendations for Future Healthcare Practices	1. Cultural sensitivity training
	2. Gaining exposure to SA culture
	3. Taking time to talk to patients
	4. Navigational support

Barriers and Challenges

Pertaining to barriers and challenges, four subthemes emerged: 1) communication barriers; 2) lack of representation; 3) racist attitudes, stereotypes, and cultural assumptions; and 4) lack of awareness of SA cultural customs, norms, and traditions. These subthemes focused on issues and problems that participants commonly encountered with their PCP, predominantly due to provider assumptions and lack of knowledge regarding SA culture.

1. Communication Barriers

Participants reported experiencing a variety of communication barriers when interacting with their PCP, such as the provider's condescending tone and lack of patience with translation, which led to feelings of general anxiety among the participants. One participant shared her experience by stating the following:

> *They'll [PCPs] talk to me like I'm a kid and I don't know better. Or like they'll always say things like 'in CA-NA-DA, this is what we do' like they'll like slow it down for me to hear… I think when they do talk to me in that tone and when they say things that are problematic like that, it does create a fine line between them and us… I think they do more harm than good. I know maybe sometimes that comes from a good place. But I think, like when they do say things like 'in Ca-na-da' or when they they change their tone very slow for us to hear, it's almost condescending to who we are. It doesn't make us feel like we're human. It dehumanizes our needs for seeking health care* (FD8).

One primary barrier experienced by many patients was the lack of a proper introduction and welcome by the PCPs, which set a negative tone for the appointment. PCPs' condescending tone and attitude led patients to feeling intimidated and their voices not heard. Many patients also reported a perceived lack of patience from PCPs during their appointments which left them feeling rushed and uncomfortable.

In addition to these communication barriers, the majority of patients stated language as a major barrier for SA patients, particularly for newcomers whose first language is not English. A few patients also stated that when a translator was present, additional barriers were also encountered as a few PCPs would not allow time for proper translation between patient, translator, and PCP to take place; instead, the PCPs would continue on with asking questions, making both the translator and patient feel overwhelmed. One participant described her experience in acting as a translator while accompanying her mother on doctors' appointments as follows:

> *Before me interpreting what she said, they [PCPs] just come along with another question. Also, it is very awkward, the whole environment situation. Makes me think 'ok I just want to get done and get out of here as soon as possible so I don't have to experience this again.'... In this situation, the doctors also have to be very much patient…* (FI5).

Furthermore, issues with translation were exacerbated when PCPs would use medical jargon that could not be easily translated. This resulted in participants feeling like they could not properly communicate their health problems effectively to their PCP. Lastly, consistent mispronunciation of names despite correction from patients led participants to feel irritated, not acknowledged, and unwelcomed. When asked to expand on why correct pronunciation of names was so important, one patient reported that it would be a PCP's way of saying *"I see you as a person. I respect you, I acknowledge you"* (FD7).

Participants also reported feeling anxious after experiencing communication issues and feeling that PCPs were at times unaware of their feelings, background, and culture. Patients also experienced anxiety when being intimidated by their PCP due to their condescending tones and attitudes, which ultimately added to patients' reluctance to share information. One participant shared her experience of taking her parents to a doctor's appointment by stating

> *… When you're dealing with a patient from a different culture, there's a slight attitude [from the PCP]. Like a 'do you understand what I'm saying?' attitude and just different way of interacting with the patient. Made them [parents] a little bit reluctant to share information… [Parents] didn't ask as many questions as they wanted, didn't give all the answers*

> *that they should have probably, didn't complete information just because of a little bit of anxiety there* (FI4).

2. Lack of Representation

The majority of participants shared that there were very few visible minorities in both the community and among PCPs practicing in the city. One participant stated that it's "*uncommon here to have a doctor that looks like you"* (FD3). This posed as a barrier because many participants felt having a care provider that shared the same cultural community would better understand SAs' cultural needs. One participant who experienced the challenge of having a PCP not understand her cultural needs shared the following:

> *If you lived in Ontario… they're used to seeing a wide variety of patients from different cultures. Here the challenges are that there aren't so many. Now I think as the population is aging, even the SA population is aging- do they get the right care when they go into the hospital?* (FI4).

For such reasons, many participants expressed their comfort and desire in having a SA PCP as they are better able to understand the backgrounds and cultural norms of SA patients, including traditional practices, language, diet, importance of education, and home remedies. A few participants who had grown up in this Atlantic Canadian city also noted that when they did have a SA PCP who also grew up in Canada, these doctors could better understand SAs' needs and cultural practices. One participant expanded on this as follows: *"SA PCPs who have grown up here are able to better understand our experiences as opposed to Caucasian doctors"*.

As a result of often only having access to White doctors, some patients reported that they had to overemphasize their needs and symptoms in order to be taken seriously. Finally, in terms of gender, a few female participants shared that they would feel more comfortable with a PCP who was female as opposed to male. This is because during appointments, physical examinations of the body can take place and personal questions regarding sexual intercourse and menstruation can arise- topics that are traditionally not discussed with men in SA culture. Therefore, some female participants reported feeling uneasy and uncomfortable when discussing such areas of health with male PCPs. One participant shared her views on this as follows:

> *I think the reason why it may be preferred to have a female doctor is because there are some cultural norms surrounding which topics are not necessarily considered 'normal' to discuss with someone of the opposite sex or who is not a close friend or family member. So things around sexuality or birth control or menstruation, I think I was raised to understand that these are not things that are spoken to my dad or a male in general* (FD3).

3. Racist Attitudes, Stereotypes, and Cultural Assumptions

Many participants, regardless of gender, stated how difficult it was for people of colour, particularly women, to have their health concerns taken seriously by PCPs. One participant stated that as a Brown woman, she found she had to do research about her symptoms and medical problems, as well as 'over present' her feelings and symptoms to be taken seriously. Another participant shared the following:

> *…My own mother, for example, she had appendicitis, went to the hospital and the doctor said, 'no, I don't think you have anything wrong…, you're not in enough pain, you're not screaming enough, you're not making enough of a show'. And you know she had appendicitis in the end* (MD2).

A few participants reported PCPs displaying racist attitudes by believing that SAs and their countries are dirty and have diseases. One participant shared the following experience:

> *I was getting ready to travel to [country X] for my internship and I just remember, like the like the tone my doctor had. And what she was talking about 'oh you're going to be going to [country X] you don't want to be like picking up any diseases there or are you going to be picking up any.' Like just the thing where she was talking down to like these countries and [country X] in specific, 'how it's dirtier, it's not as clean' like it was just like that tone… It really bothered me that you would think you would talk down to another country and deem it not being clean and a place we can get a lot of diseases, which a lot of countries are like that. But I find most of time we focus on ones where like brown people are or countries like in South Asia* (FD7).

Finally, one participant shared how their PCP had trouble understanding and distinguishing differences between Canadian-born and SA-born individuals. She also clarified that in this case 'Canadian-born' was interchangeable with Caucasian for some PCPs. This led PCPs to assume that certain offensive things were acceptable to say,

simply because the participant was light-skinned and white-passing. The participant explained this by stating the following:

> *Because I find with me where I am more like I'm lighter skinned, where people don't really know what ethnicity or what region I do come from, where like sometimes I feel like they just they make assumptions or like they'll say things about something else that will lead me to think 'I wonder if you actually knew that I was from Sri Lanka or my family's from South Asia?' would you say things like that?... I do think that if there if it's [darkness of skin] more visible, I feel like they're more cautious of what they say or and that's not just for doctors, but for like healthcare providers* (FD7).

This experience was disconcerting for the participant because although she was lighter-skinned as a SA, she worried what type of stigma and racial stereotypes other darker-skinned Asians may be exposed to if their PCP held similar stereotypical views.

Pertaining to cultural assumptions, a few participants pointed out that if their PCP was SA (which was a rare occurrence), the physician might assume that the patient was not sexually active or did not drink alcohol seeing as these are cultural taboos in many parts of South Asia. One participant shared her experiences when being asked questions as the following:

> *… I wouldn't say just like sexual history, even other questions like I think another question that is on the questionnaire is like, 'do you consume alcohol?' and stuff like that. And those are questions that are kind of just*

> *skipped over because of the cultural background of it and the assumptions of what the answers are* (FD9).

4. Lack of awareness of SA cultural customs, norms, and traditions

SA communities have different views on traditional aspects of culture, including body, religion, and diet. Often, these aspects can be intertwined with one another. For example, certain SA cultures have different views on types of food they eat depending on the religion they follow. However, participants shared that PCPs do not always know about this or offer individualized options for their diet. A few participants noted this by pointing out how Hindus are traditionally vegetarian and may have certain vitamin deficiencies. When PCPs notice these deficiencies, participants stated that PCPs simply tell them to eat more meat but would not offer them alternatives that aligned with their religious preferences. One participant shared his experience as follows:

> *I don't eat fish. But I know that omega-3 is an important nutrient for my body. But I have gone all of my life without eating or consuming omega-3. Now that is not something a White doctor would know just because they don't know I'm completely vegetarian and that my diet doesn't let me have omega-3. That being said, them suggesting other food that can help me get that nutrient would be good* (MI3).

Other participants also pointed out PCPs' lack of knowledge regarding SA foods, particularly how much oil it contains or the popularity of desi *mithai* (traditional sweets and desserts). It was mentioned by a few participants that they were advised to start eating healthier by their PCPs; however, their doctor did not offer concrete action and

insight into what modifications can be made to the participants' traditional cuisine and how healthy eating can still be accomplished while still eating SA food.

In terms of health views and beliefs, many participants shared the experiences they had in convincing their PCP to explore alternative solutions that were not, otherwise, the common solutions providers were used to prescribing. For example, in some SA households, people might be unaware that birth control may be used for reasons other than sexual activity (i.e. alleviating period pains) and some would believe that usage of this contraception before one is married would indicate that they are sexually active- a taboo in SA culture. One participant shared that when trying to communicate her discomfort with using birth control because of such cultural reasons, the nurse practitioner was quite insistent on recommending it initially, leading the participant to feel defensive and anxious when trying to convey her preference. She explained her discomfort in the following way:

> *She [the PCP] automatically assumed that I would want birth control because I was sexually active which was not the case. It was a little uncomfortable for me to have to explain to her that 'actually no, the opposite reason' and maybe if she had had a better knowledge of the cultural norms from which I was coming from, she wouldn't have made that assumption so quickly* (FD3).

Additionally, many participants who were international students at the local university, regardless of gender, were surprised at how openly and often PCPs would ask questions regarding the patients' sexual health as topics surrounding sexuality, menstruation, and birth control- topics not commonly talked about in SA culture. One participant shared the

following: *"I was very taken aback because I was like 'ok can you even ask me that?'… but now that makes sense. They had a list of questions which they had to ask."* (FI2). However, on a different note, many participants stated that they were pleasantly surprised as to how openly PCPs discussed mental health with their patients. Mental health awareness is not something traditionally discussed in SA countries, even in medical settings with professionals. Therefore, having the opportunity to discuss one's mental health and not worry about facing stigma from PCPs was welcomed by many participants.

Recommendations for future healthcare practices

Another predominant theme that emerged from the interviews was recommendations for future healthcare practices through the lens of the participants. Throughout the interviews, many participants expressed their thoughts and desires to see improvement and proactive action taken by PCPs to address the ethnic disparities and barriers they encountered. The four subthemes in this category were: 1) cultural sensitivity training; 2) learning about and gaining exposure to SA culture; 3) taking time to talk to patients; and 4) helping newcomers navigate the Canadian health care system.

1. Cultural sensitivity training

The overwhelming majority of participants stated that cultural sensitivity training implemented for PCPs would be beneficial as they felt many of the barriers and challenges that transpired were due to a lack of cultural sensitivity from their PCP. Participants shared how cross-cultural understandings with a skills-based approach could be taught to medical and nursing students, as well as those currently practicing in primary care post-licensure, and applied universally through the form of seminars and

presentations. Although many participants were cognizant of the fact that not every aspect of each culture in this world could be taught, a few did express that teaching common health beliefs or behaviours specific to different cultures could be taught. This included communicating specific do's and don'ts of cultures while being cognizant of avoiding stereotyping. Participants also shared specific examples of cultural sensitivity training, such as establishing curriculums and informative resources. For instance, participants recommended incorporating diverse examples into training that actively include people of colour in both medical and nursing textbooks. One participant stated the following: *"specific diseases or illnesses are based on ethnicity (i.e. skin diseases), but most studies are done on White men."* (FD9). Finally, it was also pointed out by participants that cultural sensitivity training should be over the long-term, not merely a three-hour workshop, as it is quite difficult to truly become culturally sensitive from one workshop or seminar. Instead, cultural sensitivity should serve as a framework for a PCP's work and a lens through which they see everything when treating the patient, including when they prescribe medications and recommend changes to their diets.

2. Gaining exposure to SA culture

Many participants expressed the importance of hiring more minority staff, particularly SA PCPs. One participant said: *"it's more comforting to me when I see somebody of my ethnicity or my background helping me out"* (MI3). Other participants also shared the importance of PCPs gaining exposure to SAs, especially seeing there is a lack of diversity in the city this study was conducted in. One participant recommended engaging with the SA community outside the medical field by attending cultural events in the city. Participants also recommended that an excellent way for PCPs to become more

informed about different cultures would be asking healthcare colleagues from other backgrounds questions and engaging with them to learn and understand traditional practices and customs, particularly regarding how they intersect with the healthcare system. Another suggestion shared by participants was for PCPs to conduct their own research in the form of background reading about SA culture to become aware of traditional norms and customs, as well as disseminate surveys to patients. These surveys would entail questions about one's lifestyle, background, and other cultural factors that may influence health. One participant expanded on this by sharing the following:

> *[PCPs could] ask very detailed questions about your heritage, your religion, your ethnicity, whether you drink, drug usage, and all of those things. Basically, questions that get to know you better as a person and as a patient- doctors would be able to better approach their patients* (FD3).

This would allow PCPs to become aware of any cultural norms and traditions SAs have.

3. Taking time to talk to patients and being open-minded to alternative health care approaches

The majority of participants expressed the importance of PCPs talking to their patients slowly, asking culturally relevant questions, and allowing patients time to ask questions, especially with those whose first language is not English. One participant shared her experience of when a PCP had taken the time to ask her about her culture and talk about her country. This experience was quite uplifting for her and despite having had a negative experience with a different PCP previously and being quite hesitant in seeking primary care again, this recent experience re-instilled confidence in her. She shared the following:

> *She asked me where I am from. She wanted to know where I'm actually from and how my culture is different from her and also she had been to [country X] as well. Not her but I think her husband had been to [country X] so I was like 'wow' then we had a common topic to talk about and those kinds of talk and I feel very happy talking about my country with Canadians… so next time, I wouldn't think twice just booking an appointment* (FI5).

Participants also expressed that when PCPs ask patients if they understood everything or if they had any questions, this enabled participants to feel more comfortable knowing that their PCP was open-minded to hear what they had to say. Some participants expressed a desire for PCPs to address individual needs and understand that one cannot treat each patient in the same way. One participant expanded on this by sharing the following: *"take the time to figure out how you can help your patients. It's challenging to find the time but necessary if you want to provide proper care"* (FI4). Participants also shared that PCPs should not assume that every patient has the same types of needs and intentions. They suggested that care providers should consult with the patient first and understand their cultural norms and allow them to tell their PCPs about their preferences.

Finally, participants expressed the importance that PCPs take the time to listen and explore alternative health care approaches if that is their patient's desire due to cultural reasons. Newly moved SAs sometimes lack exposure to Western medical treatments and procedures, which can differ greatly to medical practices in their home country. An example of this was highlighted by a few participants as they pointed out that in Canada, PCPs' training usually focuses on prescribing medications at the first sign of a

health problem as opposed to exploring homeopathic solutions and alternative paths, which are sometimes preferred by SAs as they are accustomed to this sort of approach. As one participant noted:

> *I think doctors need to be understanding if somebody says, 'hey, I've heard this other procedure, or this is my approach to it, this is my perspective'. I feel like they [PCPs] need to have that understanding to say 'ok' and not just be like, 'well, this is what I know and this is this is what makes sense.'* (FD7).

4. Navigational support

Finally, participants shared that SAs who have recently moved to Canada find it hard to acclimatize to a new healthcare system. As indicated by the study, many participants sought primary care from at least two different locations in the city but navigating a new healthcare system, especially from a variety of clinics could prove challenging for those new to the country. Therefore, many international student participants shared that it would be helpful for local clinics or educational institutions to hold short presentations for international students, educating them on healthcare resources available and how to navigate the Canadian healthcare system. One student expanded on this by sharing:

> *I would love to get raw information from the people who are working there [student health centre] themselves. A person of staff like a nurse coming in and sharing their experience of the work, as well as providing the benefits the students can avail and telling us whatever resources are available* (MI6).

Discussion

As indicated in the results, many barriers and challenges were presented, including poor communication; cultural assumptions and stereotypes; and lack of representation and awareness of SA traditions and culture. This led to many participants also sharing proactive solutions to address these issues, including implementing and enhancing cultural sensitivity training into school curriculums for medical and nursing students. Other solutions also included that PCPs take their time in appointments when talking to patients, gain exposure to SA culture, and finally, help newcomers navigate the Canadian healthcare system. Participants stated this may allow patients to not feel as intimidated when asking questions. Additionally, PCPs were encouraged to speak slowly for those patients who may not be fluent in English or are accompanied by a translator, as well as speak in a friendly tone, which would enable patients to have their voices heard and concerns addressed.

As mentioned earlier, communication was raised as an important barrier to accessing and receiving primary care in this study. This finding is consistent with Ahmed et al.'s (2016) study, which found that SAs, especially those whose first language is not English, often encounter misunderstandings due to communication barriers during cross-cultural patient-physician interactions. Studies have also found that when physicians use a patient-centred approach when communicating with their patients, patients report higher rates of trust and satisfaction with their PCP (Street et al., 2008). Additional challenges SAs faced in a more recent study by Sohal et al. (2015) included lack of knowledge, cultural adaptation, and culturally appropriate medical advice (Sohal et al., 2015). This is reflected in the responses which participants shared that when advised by

their PCP to improve their diet, no acknowledgement or help was given as to how SA foods could be incorporated into a healthy diet. For instance, SAs have one of the highest rates of type 2 diabetes (Sohal et al., 2015, Ward et al., 2004); however, SAs have found there to be a lack of culturally appropriate dietary advice and exercise communicated (Sohal et al., 2015). Participants in this study also shared the importance of treating patients holistically and taking into account intersecting aspects of their identity that can affect their health, such as cultural and socioeconomic backgrounds. Abrishami (2018) agreed with this notion as he discussed the need for using a patient-centred care approach to appropriately respond to a patient's unique needs. Ultimately, this would help decrease health disparities among minority patient populations and could effectively be accomplished by training culturally sensitive healthcare professionals (Abrishami, 2018).

Many participants pointed out the lack of representation of SAs in primary care settings as a barrier they encountered when expressing their cultural needs, which influenced their health care preferences and led to greater misunderstandings and assumptions made by non-SA PCPs. One of the best ways to develop true cultural sensitivity is through increased diversity and representation in the physician and nursing workforce (Gates et al., 2018; Marrast et al., 2014). Phillips and Malone (2014) express the importance of concentrating efforts on diversifying the healthcare workforce in order to mirror a nation's changing racial and ethnic demographics and in doing so, best serve patients from all backgrounds. Phillips and Malone (2014) discuss the increasing need for diversity in nursing as they believe it to be a great predicator in reducing health disparities. Love (2010) states that a lack of diversity in the nursing workforce can lead to nurses sharing a predominantly White perspective, subsequently resulting in unconscious

biases being exhibited in their attitudes, values, and medical beliefs. It has also been shown that a lack of SA representation exists deeper at the core of the medical curriculum. Louie and Wilkes (2018) state that light skin was disproportionately overrepresented in medical textbooks. A specific example relates to imagery of common cancers for medical students to learn about and identify; however, none of these images were featured on people of colour or with dark skin tones (Louie & Wilkes, 2018). A few participants in this study shared how seeing a lack of SA PCPs at their healthcare practices would sometimes lead to discomfort with their White PCP, as they did not seem to understand the patient's issues due to a lack of cultural awareness. Street et al. (2008) supports this finding as they state that the relationship between a patient and their physician is strengthened when patients see themselves as ethnically similar as their physician in terms of having similar beliefs, values, and communication styles. Gates et al. (2018) also states that access to effective healthcare is increased when registered nurses are familiar with the cultural and linguistic needs of minority patients.

As demonstrated in this study, translators often accompany patients to their medical appointments; these translators can be official translators or family/friends of the patient. Grewal, Bottorff, and Hilton (2005) specifically state that family members often accompany patients to their appointments because of their unfamiliarity with the healthcare system, as well as discomfort with English language barriers. However, it can be quite difficult to translate when the PCP does not allow proper time for understanding and translation. This lack of acknowledgement and understanding can hinder communication with patients, leading to patients' poor interpretation of the instructions for their medical care (Uba, 1992).

Participants in this study also shared the importance of PCPs researching alternative solutions that they may not have necessarily learned in medical or nursing school but may be just as effective and better aligned with their patients' preferences and needs. Hilton et al. (2001) supports the finding that SAs may rely on home remedies and non-Western medicines as opposed to Western healthcare. However, Hilton et al. (2001) state that SAs have encountered criticism and ridicule from their PCPs regarding traditional medicine usage, forcing some SAs to abstain from revealing their use of traditional practices. In their study, Hilton et al. (2001) share that SAs may like to be offered choices that can integrate both SA medical practices with Western medicine. This aligns with the findings of this study and participants' preferences of being offered holistic health care advice and help.

Finally, in this study, cultural insensitivity on behalf of the PCP was heavily reported by participants as a reason for cultural stereotypes and ignorance. Sing, King-Shier, and Sinclair (2020) state that to combat cultural insensitivity, it is important to recognize patients' religious, ethical, and spiritual traditions, in order to treat SAs compassionately, while providing ethnically and culturally sensitive care. Based on the barriers and challenges presented, many studies have supported and demonstrated the positive impacts of cultural sensitivity training for those venturing into healthcare professions. Majumdar et al. (2004) supported the importance of incorporating cultural sensitivity training into the healthcare field by stating that training has resulted in a greater understanding of multiculturalism, increased open-mindedness and cultural awareness, as well as an enhanced ability to communicate with people from minority backgrounds. Betancourt et al. (2016) spoke about the importance of establishing a

framework of culturally sensitive interventions, such as minority recruitment in health care professions, development of interpreter and translation services, language-appropriate educational materials relating to health, and other strategies that help address and work to resolve racial disparities in health care.

Limitations

There were a few limitations for this study. The first was that the majority of participants were students between the ages of 20-23. This narrowed the range of healthcare experiences one may have had to share simply because of their young age. A second limitation was the sample pool of participants, though diverse in countries and religions, did not fully encompass and represent all SA countries and cultures. A third limitation was that this research was conducted in only one region of Atlantic Canada. Finally, seeing this was a phenomenological study drawing on participants' lived experience, there was a chance that participants were hesitant to share their experiences regarding their visits with their PCPs. To mitigate this fear, the participants were reassured that their personal experiences would not be shared with anyone; however, hesitations to share certain experiences were still expressed by a few participants. Of course, participants were assured that they did not have to share anything they did not feel comfortable sharing.

Conclusion

The results have demonstrated there are substantial barriers SA patients may encounter when accessing primary care services, but there are also considerable suggestions for improvements PCPs can take into account to overcome these barriers to work towards establishing a culturally sensitive and welcoming environment. The

barriers and challenges pointed out by participants align with what previous research regarding ethnic minority patients' experiences in healthcare and cultural sensitivity has demonstrated. In this study, participants had trouble communicating effectively and comfortably, endured stereotypes from PCPs, and noticed that in the city where the study was conducted, the healthcare workforce lacked diversity and SA representation. These barriers could be reduced by implementing additional cultural sensitivity training into the curriculums for medical and nursing students. Additionally, holding seminars on cultural awareness and encouraging those providers post-license to continuously engage in learning about SA culture and how certain norms may intersect with health care would diminish barriers. Ultimately, participants wanted their voices and ideas to be heard by PCPs when asking questions and exploring healthcare solutions, as well as for PCPs to be aware of cultural customs and traditions SAs may traditionally adhere to. With these findings, this qualitative study provides insight into SAs' experiences with cultural sensitivity and can inform PCPs of the actions they can take to make their workplaces more inclusive and culturally sensitive.

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Conclusion

This chapter includes a summary of the thesis manuscript, as well as an overview of the ethical considerations taken, and how data trustworthiness was ensured for this research. Following this, an outline of the strengths and limitations of the research are discussed, and finally, recommendations for future research.

Summary of Thesis Manuscript

This thesis is focused on exploring SA patients' experiences in primary care and is submitted in partial fulfilment of the requirements for Master of Applied Health Services Research degree at the University of New Brunswick (UNB). I, Simal Qureshi, have led this research project with the aid and supervision of my supervisors: Dr. Shelley Doucet, Dr. Alison Luke, and Dr. Julie Easley. This research study was approved by the Horizon Health Research Ethics Board in March 2020 and by the UNB Research Ethics Board in April 2020, with the recruitment for the study officially starting in May 2020. This manuscript is written in an article-based format to prepare for publication after completing the defense. The publishable article in this manuscript is titled: South Asian Patients' Experiences with Cultural Sensitivity in Primary Care.

Several months before conducting this research study, a literature review was conducted to gain a better understanding of SAs' healthcare needs, as well as cultural sensitivity and the current research relating to this topic within Atlantic Canada. Upon completion of the review, it was determined that there was a gap in the literature regarding SAs' experiences accessing primary care within a particular Atlantic Canadian city. However, there were two studies that related to the focus of study and helped shed

light on ethnic minority patients' when accessing the Atlantic Canadian healthcare system. One of these studies was written by Baker and Daigle (2009) and looked at cultural sensitivity through Mi'kmaq peoples' perspectives. Their findings demonstrated that healthcare providers should possess qualities such as compassion and have non-discriminatory attitudes to reduce cross-cultural communication barriers and foster healthy patient-provider relationships. The second study was conducted by Reitmanova and Gustafson (2009) in which they interviewed visible minority immigrants in Atlantic Canada to discover gaps in accessing healthcare services. The authors found that factors like language issues, and cultural differences, and insensitivity negatively contributed to immigrants' accessibility and health care experiences. The studies included in the literature review lent insight to the current research study, which was focused on exploring the question: "what are the lived experiences of SA patients when accessing and receiving primary care services, including their experiences related to the cultural sensitivity practices of their PCPs?".

For this study, phenomenology was employed in order to best understand participants' lived experiences. Additionally, semi-structured interviews were conducted with a sample pool of 19 SA individuals, all of whom had accessed primary care services in this city at least once within the past five years. Based on the participants' responses, two apparent themes emerged: 1) barriers and challenges and 2) recommendations for future healthcare practices, and within each theme, there were four subthemes. For barriers and challenges, the subthemes were: communication barriers; lack of representation; racist attitudes, stereotypes, and cultural assumptions; and lack of awareness of SA cultural customs, norms, and traditions. For participant's suggestions for

improvement, the subthemes were: cultural sensitivity training; learning about and gaining exposure to SA culture; taking time to talk to patients; and navigational support.

In short, the results of this study demonstrated the difficulties participants commonly encountered when talking to their PCP. Many participants endured communication barriers and felt their provider spoke to them in condescending tones and possessed a lack of patience when there were translators present. This led to some participants feeling anxious and like their voice was not being heard. Lack of representation in the healthcare workforce also posed as a barrier as many participants shared that having a PCP who was from the same cultural community would better understand their cultural and medical needs. Additionally, racist attitudes, stereotypes, and cultural assumptions on the part of the PCP during their appointment led to some participants' perception that their health concerns were not taken seriously, and consequently negatively impacted their experience. Lastly, PCPs' lack of awareness of SA cultural customs, norms, and traditions sometimes hindered participants from receiving primary care services they felt comfortable with. However, some participants shared that when PCPs asked them about their mental health, this was a positive experience for them as mental health is not seen as a serious aspect of one's health in some SA countries.

In terms of participants' recommendations for solutions, the overwhelming majority of participants expressed the need for PCPs to undergo additional cultural sensitivity training on top of what they already receive in school, as well as encouraged PCPs post-licensure to engage in expanding their knowledge of other cultures through doing background readings and attending multicultural events to engage with members of

SA communities. In addition to this, participants shared their desire for PCPs to take time to listen, speak slowly if their patient's first language is not English, and allow time for patients to ask questions and express any concerns they have. It was also suggested that PCPs ask their patients culturally relevant and appropriate questions to form a healthy cross-cultural relationship between patient and provider. Being open-minded to patients' thoughts and concerns was important to the participants, with a few international student participants adding it would be helpful for PCPs to aid newcomers in navigating the Canadian healthcare system through holding short educational presentations at local institutions or community centres.

Ethical Considerations

Ensuring all participants feel comfortable and safe during the research process is a key aspect of any research study. In this study, written consent from each participant was obtained and participants were assured that they were able to withdraw at any point without any consequences if they did not feel comfortable. As well, all collected information regarding participants' experiences with PCPs was stored on a secure database to ensure confidentiality and comfort for the participants in knowing that their personal stories were stored securely and used solely for the purpose of this study. Additionally, participants' personal stories were not shared with the care team.

Data Trustworthiness

Trustworthiness, also known as the truth value, contributes to the transparency of the research and study at hand; it is imperative for the practicality and integrity of the findings (Cope, 2014). To achieve data trustworthiness, there are four criteria qualitative researchers must demonstrate in their study: credibility, transferability, dependability, and

confirmability (Guba, 1981; Shenton, 2004). Part of this also means reporting how data was collected, results were created, and having data that is accurate, acceptable, and valid to ensure that participants' experiences are being documented in detail (Schreier, 2012; Rivaz, Shokrollahi, & Ebadi, 2019).

Credibility

To begin, credibility complements trustworthiness, as it is the proposed criterion against which the truth value of the study is judged (Beck, 1993). It refers to the researcher's confidence in how well the data is representative of the findings (Anney, 2014; Cope, 2014; Graneheim & Lundman, 2004), as well as how vivid and accurate the description of the phenomenon is (Beck, 1993). Credibility can be achieved by the researcher describing their experiences through reflexivity (Anney, 2014; Cope, 2014). Hayre and Muller (2019) state that reflexivity allows researchers to understand, define, and theorize the research they are writing and conducting. It involves the researcher's awareness regarding how their values, background, and previous experience with the phenomenon at hand can affect the research process (Cope, 2014). From a healthcare perspective, it is important that the research is not solely about obtaining disclosures and confessions, but instead researcher's biases and personal experiences are clearly and succinctly addressed to ensure mindful, appropriate research is taking place (Hayre & Muller, 2019; Dodgson, 2019). For this reason, I employed reflexivity to allow for a greater understanding of participants' experiences to be inferred and drawn upon in a concise and applicable manner to the research (Creswell & Poth, 2018). Reflexivity was accomplished by keeping a journal to write notes, thoughts, and experiences for reflection

to bracket subjectivity (Mantzoukas, 2005). Additionally, to ensure credibility, participants have been sent a summary sheet of the study following its completion.

Transferability

The next measure of trustworthiness is transferability. Transferability is defined as the extent to which research findings can be transferred to different groups, settings, or contexts (Graneheim, & Lundman, 2004). Such a measure involves giving a clear description of the characteristics of the participants, the context of the study, and the data collection/analysis processes (Graneheim, & Lundman, 2004). In this case, transferability was ensured through providing a thick description of the study, which included a detailed description of the context of the study and its participants (Bitsch, 2005). Thick description allows researchers to make judgements and better understand how well this research study can fit other contexts (Li, 2004). In this case, participants' demographic characteristics are collected through a sociodemographic questionnaire (please see Appendix V), asking participants questions such as their gender, age, where they were born, and languages they speak. By providing a clear description of the participants' characteristics and the context of this study, I am able to help other researchers potentially replicate this study with similar conditions in the future, thereby achieving transferability (Abazari et al., 2016; Anney, 2014).

Dependability

Lincoln and Guba (1990) define dependability as the extent to which data can change over time; more specifically, the changes in a researcher's decisions during the analysis process of the study, and what means of action will be considered to account for such factors attributing to change. For this study, an audit trail was kept ensuring

dependability. An audit trail is when a record of the study is maintained, including its raw data and the completed results, allowing readers to follow a researcher's steps and decide whether the study's findings may be relied upon for future studies (Carcary, 2009; Wolf, 2003). In this case, I documented the key stages of the study, including methodology choices, transcripts of participants' stories, and notes made during the interviews. By keeping this audit trail, the dependability of this study was enhanced as it emphasized the transparency of key decisions made throughout the research process (Carcary, 2009).

Confirmability

Confirmability refers to the extent to which results of a question can be corroborated by other researchers (Baxter, & Eyles, 1997). It focuses on ensuring that the data and its interpretations has transpired from the data itself, and not the researcher's personal views or imagination. For this study, confirmability was achieved through a couple of techniques - the first being bracketing, also known as epoche. This is where I, as much as possible, put aside any assumptions, biases, and personal experiences before beginning data collection (Creswell & Poth, 2018; Isfahani et al., 2015; Hopkins, Regehr, & Pratt, 2017). This allowed me to understand what participants shared without bringing in any preconceived beliefs and notions (Chan, Fung, & Chien, 2013). To achieve confirmability and carry out bracketing, I included several participants' quotes to ensure it was their narrative and experiences being shared and not my personal stories or perspectives. Additionally, confirmability entails describing the research steps taken in a transparent manner, outlining the steps taken from the start of this research project to its development, and finally its findings (Korstjens & Moser, 2018). For this reason, an audit trail was also kept to ensure confirmability.

Discussion and Recommendations

This qualitative study demonstrated common barriers SAs may face when accessing primary care services but also shed light on potential solutions to such barriers, as noted by recommendations for future healthcare practices. When conducting this research, there were certain limitations and strengths that factored into the success of the study, as well as recommendations that were made for future studies.

Limitations of the Research

This Master's is a two-year degree and operates on a tight timeline. For this reason and due to COVID-19 restrictions, the participant pool did not have as much variation as planned, as advertising for the study could only be conducted virtually and mostly students reached out to participate for the study. As well, in this study, there were not any participants who practiced Sikhism- one of the major religions practiced in South Asia, and two SA countries, Maldives and Afghanistan, were not represented. Having both an extended timeline and greater representation of religions and countries would allow for more participants to be recruited and the sample pool to become larger and more diversified. This could result in potentially learning about new experiences that have, otherwise, not been mentioned in this study. Finally, one of the Research Ethics Board applications for this study was submitted shortly before restrictions for the COVID-19 pandemic were implemented. This caused the application approval time to be delayed as it was sent back for edits to account for proper social distancing safety measures, such as only virtual recruitment and interviews taking place as opposed to any in-person. This further contributed to rushing to meet the deadline for this degree.

Strengths and of the Research

The supervisors overseeing this project included Dr. Shelley Doucet, Dr. Alison Luke, and Dr. Julie Easley - all of whom have extensive experience in research and in healthcare, which complemented the goal of this research study. Their insight and skills allowed me to learn from them and ask questions related to the research process that I, as an inexperienced researcher, knew hardly anything about. Specifically, Dr. Easley's experience in conducting qualitative studies lent great insight into the appropriate methods for this study, and Dr. Doucet and Dr. Luke's significant experience in supervising students conducting research and writing their theses, helped guide me in the research process and enhance the success of this study. Pertaining to the study, participant representation and background experience were fairly diverse. For example, the study included male and female participants, with the majority having accessed primary care from at least two different locations in this city. Additionally, this study included participants who represented most major SA countries and religions and included participants both born in and outside of Canada. Lastly, as far as I am aware, no research study with a similar goal and target population same as this project has been carried out in Atlantic Canada.

Recommendations

This qualitative study elucidated many barriers SAs have commonly encountered when accessing primary care in an Atlantic Canadian city. Although this study has provided relevant information to inform future PCPs of ways they can improve their practice, there are still some recommendations that can be made to further enhance understandings of SA patients' experiences. Firstly, seeing this study focused solely on

primary care within this particular city in Atlantic Canada, it would be beneficial for the study to broaden its geographical scope to all of Atlantic Canada and determine whether different themes emerge that are specific to a province or region. As well, seeing that the sample pool for this study was primarily comprised students ranging from 20-23 years old, a study with participants across the lifespan is recommended. This may bring forward different experiences that are specific to other age groups, such as older adults, when accessing primary care services.

Conclusion

Minorities from racial and ethnic backgrounds are often subject to systemic barriers and challenges (Van Wormer, 2005) in many aspects of their life, including when accessing healthcare. These barriers can sometimes be attributed to lack of cultural sensitivity, on part of the PCP. In Canada, as one of the largest visible minority groups (Quay et al., 2017), SAs can be susceptible to culturally insensitive practices. Findings indicated that there were significant barriers commonly encountered by SA patients when accessing and receiving primary care services in an Atlantic Canadian city. These barriers included a lack of SA representation in the healthcare workforce and PCPs' general lack of awareness of SA cultural customs which in turn, would sometimes perpetuate assumptions and stereotypes. Additionally, these barriers indicated that many PCPs, though not all intentionally culturally insensitive, may engage in behaviour that created communication barriers and led to patients feeling anxious and discouraged from seeking primary care. Solutions to these barriers included additional cultural sensitivity training for those both in school studying primary care and post-license, gaining exposure to SA culture, helping newcomers navigate the Canadian health care system, and ensuring PCPs

take time to listen and engage with their patients. This study contributes to a deeper understanding of SA patients' experiences in primary care and the factors that influence those experiences, and, as a result, can advise PCPs of certain steps they can take to become more culturally aware and sensitive.

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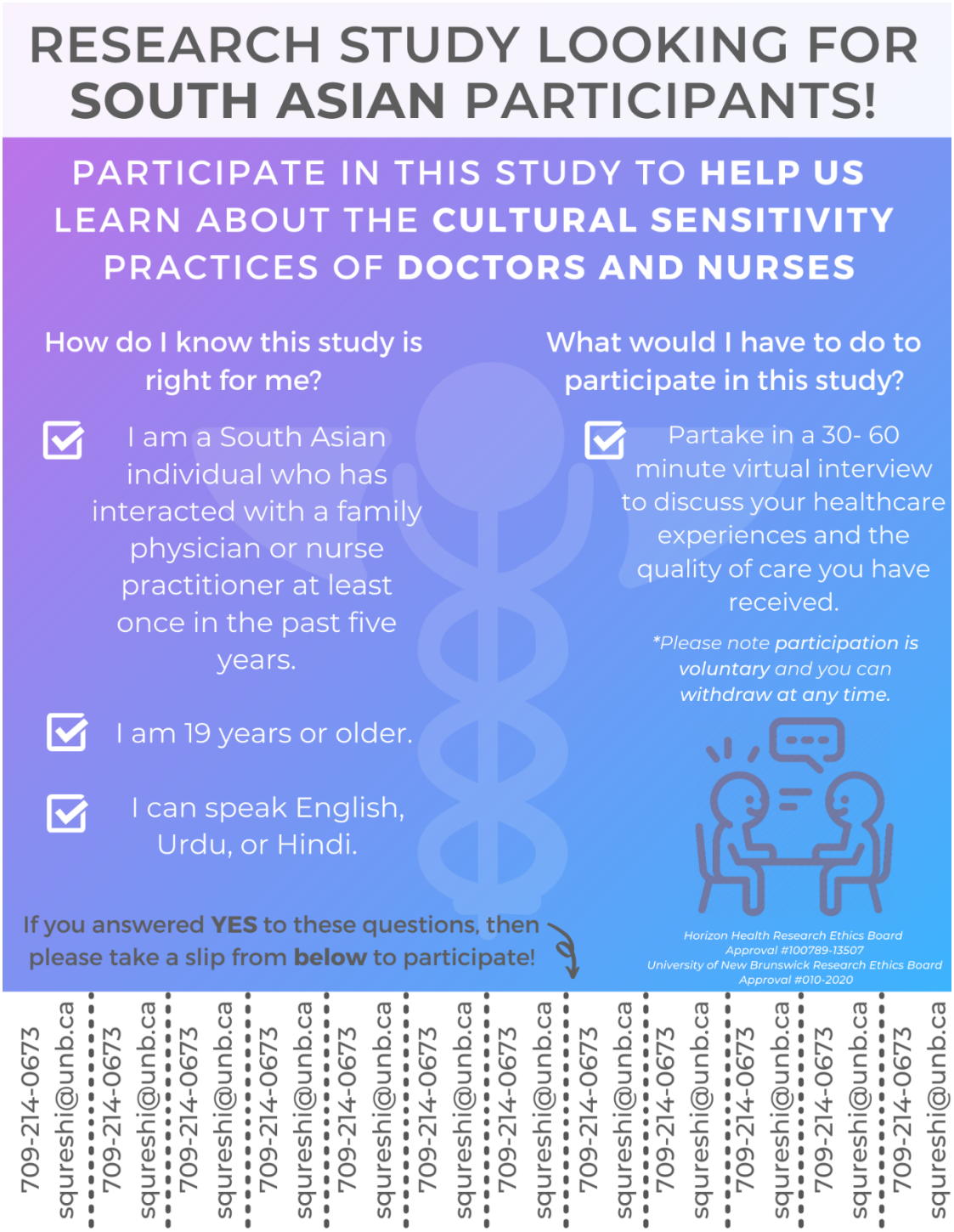
Appendix I: Recruitment Poster



Appendix II: Informed Consent Form

South Asian patients' experiences with accessing and receiving primary care Consent Form

TITLE OF STUDY/PROTOCOL

South asian patients' experiences with cultural sensitivity in primary care

PRINCIPAL INVESTIGATORS

Simal Qureshi, Master's in Applied Health Services Research Student, University of New Brunswick

SUPERVISORY TEAM

Dr. Shelley Doucet, Nursing and Health Sciences, University of New Brunswick Saint John
Dr. Alison Luke, Nursing and Health Sciences, University of New Brunswick Saint John
Dr. Julie Easley, Research Director, Dalhousie University, Family Medicine Teaching Unit, Dr. Everett Chalmers Hospital

PROTOCOL NAME/NUMBER _____

FILE NUMBER _____

INTRODUCTION

My name is Simal Qureshi and I am a graduate student studying at the University of New Brunswick. I would like to invite you to participate in this research study on the experiences of SAs when accessing and receiving primary care services here in this city. This study also focuses on how the cultural sensitivity practices of family physicians or nurse practitioners, also known as primary care providers, may affect SAs' health care experiences. The research study and its details are described below. This description outlines what you will be asked to do and the potential discomfort you may experience. Participating in the study may not benefit you, but we hope to learn things that will benefit others. Participation is completely voluntary, and you may withdraw at any point. Please let me know if you have any questions or concerns. This consent form may contain words that you do not understand. Please ask the researcher to explain any words or information that you do not clearly understand.

PURPOSE OF THE STUDY
The purpose of this study is to explore and describe the lived experiences of South Asian patients when accessing and receiving primary care services here, including how the cultural sensitivity practices of primary care providers may affect South Asians' health care experiences.

WHAT YOU WILL BE ASKED TO DO:
You will first be asked to read this consent form and give either your written or oral consent. Upon agreeing to participate in this study, you will be asked to participate in a 30 to 60-minute interview where you will be asked questions about your experiences with your family physician and/or nurse practitioner. The interview will consist of approximately ten open-ended questions.

Unidentifiable Quotes:
I would like to be able to use unidentifiable pieces of your interview to support the findings of the project. For publication purposes, all identifying information will be removed from the data. I will ask if you consent to the use of unidentifiable pieces before beginning the interview.
Consent given for use of interview quotes? Yes__ No___ Interviewer Initials: _____

STUDY PROCEDURES
Interviews will be arranged with the research lead in person at a location convenient for you, or virtually (i.e. over the phone, Skype, Zoom video-conference platform) at a time that works well for you. The sessions will be recorded using a digital recorder and transcribed. Audio files will only be heard by the lead researcher and her supervisors and they will be deleted once the research is completed.

Your participation is voluntary. This means that you do not have to participate if you do not want to. If you do participate, it is okay to refuse to answer any questions you do not want to answer. You can agree to participate now, and then change your mind at any time, and have your information removed from the study. There will be no consequences. If you choose to withdraw from the study, you are encouraged to tell the principal investigator, Simal Qureshi at (709) 214-0673 or squreshi@unb.ca.

POTENTIAL RISKS/DISCOMFORTS
This study is of minimal risk to you. If at any time during the interview you would like to skip a question you do not wish to answer, you may do so. If you also wish to end your participation in the interview at any time, simply advise the researcher of your decision, and you can withdraw without penalty.

POTENTIAL BENEFITS

There may not be direct benefits to you from participating in this study; however, learning about your experiences will provide great insight into the cultural sensitivity skills of primary care providers and how that impacts a South Asian patient's health care experience in an Atlantic Canadian city.

PRIVACY AND CONFIDENTIALITY

Information gathered in this research study may be published or presented in public forums; however, your name and other identifying information will not be used or revealed. Only the researchers will be aware of your identity and have access to the interview data. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law. All recording and transcripts of the interviews will be stored as computer files on a secure database. This computer will be password protected and only accessible to the researchers. After the study is completed, the data will be stored for a period of 5years after which all data will be appropriately deleted or destroyed.

QUESTIONS OR CONCERNS

You are free to ask any questions that you may have about the interview or your rights as a research participant. If any questions come up during or after the study, contact the principal investigator (contact information listed at the top of the form).
This study has been reviewed by the Horizon Health Network Research Ethics Board (#100798-13507) and the University of New Brunswick Research Ethics Board (#010-2020). For questions specifically about your rights as a research participant or the conduct of this study, you may contact the Horizon Health Research Ethics Board at reboffice@HorizonNB.ca or University of New Brunswick at ETHICS@unb.ca.

PARTICIPANT'S RESPONSIBILITIES

If you choose to participate in this study, you will be expected to:

- Complete a 30-60 minute interview in person or virtually (i.e., i.e. over the phone, Skype, Zoom video-conference platform), at a time and location that work best for you.

STATEMENT OF CONSENT

By giving consent, you understand and agree with the following statements:

- You have read this consent form and have had the opportunity to discuss this research study with the lead researcher, Simal Qureshi, and all questions have been answered.
- You have had your questions answered by the researcher in language that you understand.
- You understand that you will be given a copy of this consent form after signing.
- The risks and benefits have been explained to you and you understand that your participation in this study is voluntary.
- You understand that you may choose to refuse answering any questions and can withdraw from the research study at any time without consequence.
- You freely agree to participate in this study.
- You understand that information regarding your personal identity will be kept confidential and that confidentiality will be guaranteed within limits of the law.
- You understand that you have not waived any of your legal rights upon agreeing to participate in this research study.

PARTICIPANTS STATEMENT

I have read the above information and understand the purpose of the research. I hereby give my informed consent to be a participant in this study.

_____	_____
Name of participant	Phone Number
_____	_____
Signature of participant	Date

STUDY SUMMARY

If you would like to receive a summary of the study results, please provide your name, phone number, and e-mail below.

Name: _____

E-mail: _____

Phone: _____

STATEMENT BY PERSON PROVIDING INFORMATION ON STUDY

I have explained to the above participant the nature, requirements and the purpose of the study, potential benefits, and possible risks associated with participation in this study. I have answered any questions that have been raised by the participant. I believe that the participant understands the implications and the voluntary nature of the study.

Researcher Signature: _____ Date: _____

Appendix III: Script for Oral Consent

South Asian patients' experiences with accessing and receiving primary care

1. Have you had the opportunity to review the consent form that I sent to you?

   If NO – participant will be given the opportunity to review or to have the consent form sent to them to review. If neither of these conditions can be met, the researcher will read the consent form over the telephone before asking for consent.

   If YES – proceed to next question.

2. Do you have any questions about the study or your rights as a research participant?

   IF NO – proceed to next question.

   IF YES – Questions from the participant will be answered before proceeding to the next question.

3. Do you give consent to participate in this interview?

   IF NO – Thank you for your time and interest. Terminate interview.

   IF YES – proceed to next question.

4. In the consent form, it was specified that I would like to use sections from your interview to support the findings of our research. I will not identify you in any way in those sections. Do you consent to having such sections from your interview being published?

   IF NO – Alright, I will not use unidentifiable quotes from your interview.

That's the end of the consent process, are you ready to begin the interview?

IF YES – Alright, that is the end of the consent process, are you ready to begin the interview?

Date: _____

Interviewer:_____

Appendix IV: Semi-structured Interview Guide

Semi-Structured Interview Guide

South Asian patients' experiences with accessing and receiving primary care

Date: _____ Code: _____ Location: _____

Introduction

Hello! Thank you for participating in this study. My name is Simal Qureshi and I am a student at the University of New Brunswick. I am the primary researcher for this study and will be exploring the experiences of South Asian individuals when accessing and receiving primary care services in this city, including how the cultural sensitivity practices of primary care providers may affect SAs' health care experiences. Primary care providers are health care professionals that include general practitioners, family physicians, and nurse practitioners. From here on out, general practitioners, family physicians, and nurse practitioners will be referred to as primary care providers. If you are still unsure what primary care providers, please do not hesitate to ask me. I can help you better understand by providing examples of primary care providers, what their roles are, and where they work.

Before we officially begin, I would like to review the consent form with you. If you have any questions or concerns, please do not hesitate to ask me anything.

As a gentle reminder, your participation in this interview is voluntary. You do not have to answer any questions you do not feel comfortable answering. Just let me know and we can proceed to a different question. As well, please remember that there are no right and wrong answers- simply share whatever you are comfortable sharing. Finally, you are free to withdraw from this study at any time and there will be no consequences and if you do choose to participate in this study, all information will be confidential.

Any final questions? If not, we can begin. I am turning on the recording device now.

Interview Questions

1. I'd like to begin with a general question. In your opinion, are there any specific challenges for SAs when accessing and receiving primary care*?*

2. How do you think primary care providers show OR could show that they are sensitive to your needs and are respectful of your ethnicity?

3. Can you describe your experiences with a primary care providers(s)? *How would you describe your interactions with a primary care provider(s)?*

4. Based on your past experiences of talking to a primary care provider, has there been a time when you had trouble sharing your thoughts and/or concerns with them during your visit(s)? *Did you find they were understanding of your concerns?*

5. Has there been a time or an experience you had where you found there to be a barrier between you and a primary care provider when seeking help? *If yes, what types of barriers have you encountered in terms language barriers and differences in attitude with a primary care provider?*

6. What does clear communication from a primary care provider look like to you? *How can primary care providers do a better job of communicating with their patients OR how do they do a good job?*

7. What kind of experiences have you had when asking your primary care provider questions or sharing your concerns with them? *How have you found they take time to listen to you and answer any questions or address any concerns you have?*

8. Please describe your level of comfort with a primary care provider during your past health care experiences. *What did a primary care provider do that made you feel that way? What do you do when a primary care provider does X?*

9. Reflecting on your health care experiences can you describe a time where you felt you could talk openly and comfortably with a primary care provider? *What are the things a primary care provider has done to allow you to feel that way?*

10. How do you think primary care providers can better address the needs of South Asian patients and how is this being done already? W*hat do you see missing in the health care system that would allow people like me and you to receive better and fair care?*

This brings us to the end of the interview. Once again, thank you for your time and participation in this study to gain insight on exploring the experiences of South Asian patients with cultural sensitivity skills of primary care providers.

Appendix V: Sociodemographic Questionnaire

Title of Study: South Asian patients' experiences with accessing and receiving primary care

Participant I.D.: _____ Date: _____

1. **What is your age?**

   a. 19-24 years old
   b. 25-34 years old
   c. 35-44 years old
   d. 45-54 years old
   e. 55-64 years old
   f. 65-74 years old
   g. 75 years old or above

2. **Gender identity**: _____

3. **Were you born in Canada?** Yes _____ No _____

   a. If no, how long have you resided in Canada? _____

4. **What South Asian country do you identify as originating from?**

   a. Pakistan
   b. Sri Lanka
   c. India
   d. Afghanistan
   e. Bangladesh
   f. Nepal
   g. Bhutan
   h. Maldives
   i. Other: _____

5. **I) Which language(s) do you speak?** Circle all that apply.

a. Bengali
b. English
c. French
d. Hindi
e. Nepali
f. Pali
g. Panjabi
h. Prakrit
i. Sanskrit
j. Sinhala
k. Tamil
l. Urdu
m. Other: _____

II) What is your primary language: _____

6. **What religion do you practice?**
a. Islam
b. Hinduism
c. Sikhism
d. Christianity
e. Judaism
f. Buddhism
g. Jainism
h. Zoroastrianism
i. Not applicable
j. Other: _____

7. **What is your marital status?**

a. Single (never married)
b. Married, or live common law
c. Widowed
d. Divorced
e. Separated

8. **Do you have any children?** Yes _____ No _____

a. If yes, how many? _____

9. **Do you have a primary care provider (i.e. family physician or nurse practitioner)?**

Yes _____ No _____

10. **Approximately, how often do you see a primary care provider per year?**
    a. Once a year
    b. 2-5 times a year
    c. More than 5 times a year

11. **Where do you access primary care?** Circle all that apply.
    a. Family Doctor or Nurse Practitioner office
    b. Walk-in clinic
    c. Student health centre
    d. Long-term care facility
    e. Community health centre
    f. Other: _____

12. **What is the highest degree or level of school you have completed? (If you're currently enrolled in school, please indicate the highest degree you have *received*.)**

    a. Less than grade 10
    b. Secondary School Certificate (SSC)
    c. High school degree or equivalent (e.g. GED)
    d. Some college, no degree
    e. Associate degree (e.g. AA, AS)
    f. Bachelor's degree (e.g. BA, BS)
    g. Master's degree (e.g. MA, MS, MEd)
    h. Professional degree (e.g. MD, DDS, DVM)
    i. Doctorate (e.g. PhD, EdD)

13. **What is your current employment status? Please circle all that apply.**

    a. Unemployed, currently looking for work
    b. Unemployed, not currently looking for work
    c. Employed full-time (30 or more hours per week)
    d. Employed part-time (up to 30 hours per week)

e. Self-employed
f. Student
g. Homemaker
h. Unable to work
i. On paid sick leave
j. On unpaid sick leave (plan to return to previous job)
k. On Social/Government Assistance
l. Retired
m. Other: _____

14. **What is your occupation?** _____

Curriculum Vitae

Candidate's full name: Simal Amer Qureshi

Universities attended:

University of New Brunswick, Master in Applied Health Services Research, in-progress, 2018-2020

University of New Brunswick, B. PHIL in Interdisciplinary Leadership, 2015-2018

Publications: N/A

Conference Presentations:

Qureshi, S. (March 2019). *Allyship- In the Context of Mental Health.* Jack.org Mental Health Summit. Fredericton, NB.

Academic Awards:

NBIF STEM & Social Innovation Award, 2019

Alumni Merit Award, 2019

Provincial Graduate Scholarship, 2018