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Experiences and Perceptions of Physicians Utilizing the Irish Language

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Abstract

Aim

To elucidate perceptions held by physicians with Irish language skills or in Gaeltacht practice of the practicality and level of importance of healthcare provision through Irish.

Methods

We completed semi-structured virtual interviews with five physicians recruited through Acadamh na Lianna, all of whom spoke Irish and/or practiced in the Gaeltacht. Interviews were conducted in both Irish and English and analyzed using reflexive thematic analysis.

Results

Four major themes were identified across the interviews. 100% of the 5 doctors interviewed spoke to strong English dominance in healthcare, all 4 of the 4 Irish speaking doctors interviewed identified problems in the identification of Irish speaking patients and/or providers, 3 (75%) of the Irish speaking doctors described past situations that truly necessitated Irish language healthcare services, and both of the junior doctors interviewed expressed a desire for specific opportunities to use Irish throughout medical education.

Discussion

Better health records or registries of the language skills of patients and physicians would likely decrease language discordance in healthcare interactions. Galway's Teanga an Leighis curriculum could be revived, and Gaeltacht rotations should be preferentially assigned to those with Irish language skills.

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Introduction

The Irish Language enjoys strong legal status in the Republic of Ireland and, recently, Northern Ireland[1, 2]. Like many minoritized languages, practical implementation of the Irish Language faces challenges and its use in healthcare is not well described.

While there is no exact analog to the Irish linguistic landscape, similarities may be found abroad in research highlighting the significance of language in healthcare. Anglophone and Francophone populations in Canada suffer different rates of harm depending on the linguistic policy of the hospital visited[3]. In a bilingual region of Finland, Swedish speakers have significantly decreased rates of healthcare visits despite similar socioeconomic status and strong Finnish proficiency, which the authors suspect was due to language discordance between patients and physicians[4]. In Wales, the most culturally similar landscape, the health service has specific plans for language implementation and, importantly, completes regular systematic reviews of their effectiveness[5].

Irish-language policy in healthcare lags behind that of other domains. Limited progress has been acknowledged by the HSE, which became especially apparent during the COVID-19 pandemic[6, 7]. An Comisinéir Teanga was likewise quoted as unsure as to whether live Irish language healthcare services were required if requested[8]. Positively, healthcare-specific language planning has existed since at least 2003[9], and there are specific efforts to hire Irish-speaking providers[10] and recruit Irish speakers via scholarship schemes[11].

The Gaeltacht regions already face many healthcare disparities due to their rural nature, lower socioeconomic status, and older population[12, 13]. This is reaffirmed by journalistic accounts from Gaeltacht GPs[14]. There does exist a documented desire for Irish-language services within the Gaeltacht. In 2007, government-sponsored surveys found that 40% of respondents had used HSE services in Irish, and the vast majority of those were pleased with the quality of Irish[15]. Yet, only 22% had the option to use Irish in their last healthcare encounter, and half were unhappy with the quantity of Irish services available. Similar government surveys have since been conducted, but HSE representatives would not provide them on request. A private 2022 study conducted by Tuismitheorí na Gaeltachta agrees that the current structure of the HSE is inadequate to ensure availability of healthcare services in Irish to Gaeltacht families[16]. Recent surveys reveal that Speech and Language Therapists often fail to assess their pediatric bilingual Irish-English patients' Irish-language skills comprehensively,[10] which may lead to either missed diagnoses or false positives and unnecessary treatment. SLTs are aware that all languages should be assessed in multilingual patients, but Irish is consistently overlooked. Finally, psychiatry and psychology represent other obvious fields where a lack of Irish-language services could, at least hypothetically, lead to patient harm[17].

Methods

The study involved one-time, semi-structured interviews with physicians offering services through the Irish Language or practicing in Gaeltacht areas. Participants were recruited through Acadamh na Lianna, the organization for Irish-speaking physicians, and then snowball sampling. Six participants was the desired sample size, as that was expected to obtain data saturation[18]. Consent procedures included informed consent forms and information leaflets distributed at least two weeks before interviews. Participants were informed that they could stop the interview at any time and that they could not opt-out after transcript finalization due to anonymization. The study posed minimal physical risks to participants as it was virtual, and confidentiality was the chief ethical concern.

Semi-structured interviews assessed providers' attitudes towards Irish-language healthcare services and the needs of their patients. Interviews began in Irish and transitioned to English, and were conducted via institutional Zoom. Each interview lasted 30 to 45 minutes.

Videos were deleted after transcript auto-generation by Zoom and audio-only recordings were retained. Transcripts were refined and PII was redacted before sending to participants for final approval. All data was stored in the University of Galway OneDrive cloud with password protection. Audio transcripts were deleted after final transcript approval. After finalization, transcripts were analyzed using Nvivo 12 software, employing reflexive thematic analysis in an inductive and semantic style[19, 20].

Results

Seven interviews were conducted, and five physicians approved their final transcripts for analysis. Interviews typically lasted 30 to 45 minutes, began in Irish and shifted to English as the interviewer's technical Irish was limited. Four of the five physicians were highly proficient in Irish, with varying sources of exposure. Two were General Practitioners in Gaeltacht regions, and the other three practiced in Internal Medicine, Geriatrics, and Pediatrics. Two physicians were still in training; the other three had been practicing for decades. Four main themes were identified and expanded upon below: the level of English dominance in healthcare, problems with the identification of Irish speakers, situations that necessitate the use of Irish, and potential educational opportunities to improve Irish language healthcare training for doctors.

Theme One: English Dominance in Healthcare

Interviews confirmed English as dominant in the healthcare domain in Ireland, which was the expected outcome based on prior literature. Patients cannot reliably expect to communicate in Irish with healthcare providers, even in Gaeltacht areas. All five physicians spoke to this theme. One physician shared that patients "often don't have a firm choice [between Irish and

English] because they may have never been asked before." This English dominance is especially apparent in non-GP settings. Thus, initiating Irish interactions in healthcare largely falls on the providers.

Subtheme: An Avenue for Normalization?

Interestingly, the youngest providers interviewed recognized potential change through pediatrics. One doctor noted that encouraging Irish use in healthcare can show kids that "you can live your life *as Gaeilge*." Another suggested that children don't have the same “hang-ups” regarding language use, making it easier to normalize Irish in this population.

Theme Two: Problems in the Identification of Irish Speakers

All four Irish-speaking physicians discussed challenges in identifying fellow Irish speakers, whether patients or colleagues. The multifaceted nature of this issue broke down into three aspects: healthcare providers identifying Irish-speaking patients, identifying Irish-speaking physicians for patients, and identifying Irish-speaking physicians to other physicians.

Subtheme: Identifying Patients to Providers

The primary challenge discussed across interviews was identifying Irish-speaking patients. Physicians typically relied on informal cues, such as hearing patients speak Irish, seeing Irish names, or recognizing addresses from Gaeltacht regions. However, this method was prone to both false positives and false negatives. Some providers actively created a welcoming atmosphere with Irish signage and used verbal cues to “dangle it... for all people who have grown up in Ireland,” i.e. to indicate that Irish-language services were available via active offer. “*Tar isteach,* come in” was one example cited.

Documenting patients’ languages in charts differed based on the health records system in use. At least one system did not offer Irish as an option, despite having many non-autochthonous languages available. Similarly, it seems that some clinics historically anglicized Irish names within patient charts. This practice led to lost histories and potentially worse outcomes; this was not an issue with names of foreign origin.

Subtheme: Identifying Providers to Patients

Four doctors noted the importance of ensuring that patients are aware that they can speak Irish. Standard bilingual language signage doesn't necessarily imply that Irish-speaking providers are available, requiring the need for more visible cues. One junior doctor suggested adopting a Welsh system of lanyards in hospital that portray the language proficiency of providers, while another proffered using the Gardaí system of rings. Different levels, i.e. a *cúpla focal* through to *cainteoir líofa* may be desirable. This visual cue could help patients identify providers who can speak Irish, fostering a more inclusive atmosphere.

Subtheme: Identifying Providers to Providers

All four Irish speakers interviewed also identified a lack of means to identify other Irish-speaking doctors. More experienced doctors had informally established contacts with specialists in their areas who spoke Irish. However, recently trained doctors, despite being eager to refer Irish-speaking patients to Irish-speaking colleagues, often struggled. A centralized registry or list of Irish-speaking practitioners was proposed to streamline the process. The younger generation of physicians also saw a registry being beneficial for their personal development via Irish-language training opportunities, discussed in theme four. One doctor noted that a similar registry exists in Australia for all of the languages that physicians speak, which may be an ideal model to follow.

Theme Three: Situations Necessitating Irish Language Services

Three physicians interviewed commented on the necessity for Irish-language services in specific situations. Individuals with developmental disabilities were highlighted as a crucial group for Irish language services. In a situation involving invasive medical procedures for an adult with intellectual disabilities, one doctor emphasized the necessity of communicating through Irish "so that he could fully consent and understand." Another doctor stated, "The biggest cohort, for which I absolutely need to use Irish now is with... Alzheimer's... and advanced dementia," which they recognized being due to a "first language in, last language out" phenomenon. Multiple physicians were also aware that the Mini-Mental Status Exam had been translated and validated in Irish,[21] which is specifically useful in this population.

Theme Four: Irish Language Medical Education

Three of the physicians interviewed commented on this theme. One established physician who actively taught junior doctors saw their Irish-language skills as strictly for "rapport building" and "not transferable," similar to an interest in GAA. Meanwhile, both junior doctors ardently desired more. One stated that their Irish-specific medical education was limited to "West Kerry for a weekend." They also relayed how they had been passed up for a Gaeltacht clinic training rotation for a trainee with little to no Irish skills, despite "hav[ing] Irish as [their] first language, " and making clear they "have great interest in practicing medicine through Irish." The other was lucky enough to participate in University of Galway's *Teanga an Leighis* curriculum, which taught them how to take a full history in Irish, but likewise had not been able to take advantage of any further Irish language training opportunities. They further opined a desire for the system to learn more from the Welsh model, which they had seen firsthand as involving "keeping up their Welsh and adding to their clinical vocabulary in Welsh.. to be able to provide care in both Welsh and English." This was noted to occur in the Basque country as well. Both doctors desired this capability for themselves in Irish.

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Discussion

This study, though limited in sample size, bolsters the argument for the necessity of Irish-language healthcare services, particularly for the elderly and developmentally disabled. This agrees with previous findings that patients with dementia may suffer asymmetric language loss with preferential preservation of the first acquired language[22]. Younger physicians also recognized the significance of opportunities to speak Irish with the pediatric population, taking advantage of Grosjean's complementarity principle[23]. The study may indicate divisions in attitudes among healthcare providers at different stages in their careers, but future research should aim to validate these findings with larger sample sizes, and also solicit input from patients to cross-reference the experiences.

Regarding theme 2, there are many avenues for systemic improvement. First, updating software to be capable of accommodating both Irish and anglicized names as well as noting patient Irish language proficiency within electronic health records may solve headaches and improve patient-provider interactions. Second, providing cultural awareness training on Irish names and spellings for healthcare professionals with foreign training may be beneficial. Third, establishing a publicly available registry for the language skills of physicians practicing in Ireland could improve language concordance between patients and providers, even beyond Irish. Finally, implementing a physical identification system for Irish-speaking providers, as is done with Welsh and by the Garda, might increase interactions, particularly in hospital.

While not necessary when physicians' level of Irish is sufficient, Irish-language interpreter usage may augment care and help address theme three, where the Irish Language is necessary for high-quality care. Additionally, active offer, used in Canada[24] and by some of the providers interviewed, could help address all of the themes. Regarding theme four, it was highly desired by the younger doctors studied to develop better training pathways for those physicians interested in practicing through Irish. Preferentially allocating Gaeltacht training rotations to accommodate this demand and reimplementing the *Teanga an Leighis* curriculum developed by the University of Galway[25] across all medical schools in Ireland would constitute relatively simple changes with great potential benefit, however it appears *Teanga an Leighis* was a victim of the pandemic and would need to be renewed. Ultimately, if Irish is used to a greater extent within healthcare, patients may benefit from higher quality care.

Declarations of Conflicts of Interest:
None declared.

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