THE UNIVERSITY OF UTAH GRADUATE SCHOOL

SUPERVISORY COMMITTEE APPROVAL

of a thesis submitted by

Monica Cecilia Sanchez-Campos

This thesis has been read by each member of the following supervisory committee and by majority vote has been found to be satisfactory.

Chair: Patricia H. Berry

[Signatures]
To the Graduate Council of the University of Utah:

I have read the thesis of Monica Cecilia Sanchez-Campos in its final form and have found that (1) its format, citations, and bibliographic style are consistent and acceptable; (2) its illustrative materials including figures, tables, and charts are in place; and (3) the final manuscript is satisfactory to the supervisory committee and is ready for submission to The Graduate School.

Date

Patricia H. Berry
Chair, Supervisory Committee

Approved for the Major Department

Chair/Dean

Approved for the Graduate Council

David S. Chapman
Dean of The Graduate School
ABSTRACT

As the Hispanic community becomes the largest minority in the United States, it is important for health-care providers to explore ways to enhance communication with their Spanish-speaking patients. Research is abundant in this field but scarce in one of the most vulnerable populations, postpartum women.

This work focused on describing the thoughts, feelings, and ideas from nurses and patients regarding language barriers in the health-care setting. Towards this aim, I took two approaches. First, 15 registered nurses’ and 11 patients’ responses were obtained and analyzed from four focus group discussions in order to answer research questions. Frustration and fear were among the major themes extracted from analyzing responses and were the common denominators for all groups. Interestingly, all participants were embarrassed to use their limited foreign language skills. A series of misunderstanding situations were identified in all participants’ groups, as it was a concern for confidentiality issues and the belief that it was not their sole responsibility to learn a foreign language. “Assumptions” was a topic for the nurse groups and “quality of interpreters” was a topic for the patient groups. Among the possible solutions to language barriers were that patients would like nurses to learn Spanish and nurses would like patients to speak English. Most groups also contemplated the possibility of a pocket-size translator as a solution.
Second, the demographic questionnaires revealed that short-term nurse employees are more prepared with Spanish classes than long-term nurse employees. In addition, most of the nurses did not feel comfortable taking care of Spanish-speaking patients. For patients, their answers revealed that most of them were in their early 20s, their level of education was below ninth grade, and their family income was below the poverty level. Patients had been residing in the United States for less than 9 years, and none of them had medical insurance.

Understanding participants’ perspectives about language barriers and practicing solutions addressed by the affected parties are vital in order to make modifications accurate and valuable to those involved. When these improvements are applied to the health-care setting, their implementation achieves significance as misdiagnosis, misinterpretation, dissatisfaction, and negative health outcomes are reduced.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th></th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td></td>
<td>iv</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td></td>
<td>viii</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td></td>
<td>ix</td>
</tr>
<tr>
<td>1. INTRODUCTION</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Purpose</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Research Questions</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>2. REVIEW OF LITERATURE</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Introduction</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Demographics of the Hispanic Population</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Legal Concerns</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Translation Methods</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Cost Issues</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Facts</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Perspectives</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>3. METHODS</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>Introduction</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>Design</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>Population</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>Sampling</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Procedure</td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>Data Analysis</td>
<td></td>
<td>21</td>
</tr>
<tr>
<td>Summary</td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>Chapter</td>
<td>Page</td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>4. RESULTS</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Introduction</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Findings</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Results of Research Questions</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>Summary</td>
<td>55</td>
<td></td>
</tr>
<tr>
<td>5. DISCUSSION</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>Introduction</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>Discussion of Findings</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>Implications for Registered Nurses and Other Health-care Providers</td>
<td>69</td>
<td></td>
</tr>
<tr>
<td>Limitations of the Study</td>
<td>71</td>
<td></td>
</tr>
<tr>
<td>Recommendations for Further Research</td>
<td>72</td>
<td></td>
</tr>
<tr>
<td>Conclusions</td>
<td>72</td>
<td></td>
</tr>
</tbody>
</table>

Appendixes

| A. OPERATIONAL DEFINITIONS | 74 |
| B. INTRODUCTORY AND DEBRIEFING OUTLINES FOR FOCUS GROUP SESSIONS | 77 |
| C. PARTICIPANTS’ CONSENT FORMS | 79 |
| D. FOCUS GROUP QUESTIONS FOR PATIENTS | 92 |
| E. FOCUS GROUP QUESTIONS FOR NURSES | 94 |
| F. DISCUSSION GROUP QUESTIONNAIRES FOR PARTICIPANTS | 96 |
| G. ANALYSIS OF MAJOR THEMES | 102 |
| H. POSSIBLE SOLUTIONS TO OVERCOME LANGUAGE BARRIERS | 105 |
| REFERENCES | 107 |
LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demographic Characteristics of Nurses</td>
<td>27</td>
</tr>
<tr>
<td>2. Demographic Characteristics of Patients</td>
<td>30</td>
</tr>
<tr>
<td>3. Day-shift Nurses’ Comments</td>
<td>103</td>
</tr>
<tr>
<td>4. Night-shift Nurses’ Comments</td>
<td>103</td>
</tr>
<tr>
<td>5. Primiparous Patients’ Comments</td>
<td>104</td>
</tr>
<tr>
<td>6. Multiparous Patients’ Comments</td>
<td>104</td>
</tr>
</tbody>
</table>
ACKNOWLEDGMENTS

I would like to thank my thesis committee (Patricia H. Berry, Jackie A. Smith, and Jane M. Dyer) for their guidance, ceaseless encouragement, understanding, and assistance throughout the process of this research study.

I would also like to thank the nursing staff in the maternity unit at the University of Utah Hospital for their interaction with Spanish-speaking patients and for inspiring me to begin this research.

This work is dedicated to my family in Peru.
CHAPTER 1

INTRODUCTION

This study examined language barriers between Spanish-speaking women and their non-Spanish-speaking nurses in a maternity unit at a university hospital in the western United States. Focus group methodology was utilized to identify language barriers for both patients and nurses. In addition, suggestions were sought on ways to improve care and satisfaction levels of this population.

The United States, already one of the most diverse societies in the world, is becoming increasingly multicultural and multilingual. Health services are mainly directed to the English-speaking population in this country (Timmins, 2002). Literature reveals that the Hispanic population will become the nation's largest minority by 2005 and that they are often unable to express even their basic needs. This growing number of Spanish-speaking people in the United States makes it necessary for health-care providers to find ways to increase the level of communication between themselves and their Spanish-speaking patients. Some research studies have described the impact that the language barrier has on patients' access to care and on their quality of care (Carrasquillo, Orav, Brennan, & Burstin, 1999; Foltz-Gray, 1998; Timmins, 2002). This study was conducted to gain an in-depth understanding of the interaction between the Hispanic and Caucasian populations, particularly in the context of health care.
Purpose

The purpose of this study was to explore language barriers that exist during nurse-patient interaction between Spanish-speaking patients and non-Spanish-speaking nurses in a maternity unit at a Level III hospital in a western city. The goal was to describe language barriers in detail and to explore ways to overcome these barriers.

Research Questions

Focus group methodology was employed to answer the following research questions. For nurses who do not speak Spanish, the research questions were:

1. What perceptions do nurses have regarding care for Spanish-speaking patients?
2. What barriers do nurses experience in providing care to Spanish-speaking patients?
3. What strategies are helpful in providing care to Spanish-speaking patients and their families?

For Spanish-speaking patients, the research questions were:

1. What perceptions do Spanish-speaking patients have when receiving care from a non-Spanish-speaking nurse?
2. What barriers do Spanish-speaking patients perceive when receiving maternity care from a non-Spanish-speaking nurse?
3. In what ways do Spanish-speaking patients feel the care received from non-Spanish-speaking nurses could be improved?
4. How do Spanish-speaking patients think their communication with non-Spanish-speaking nurses could be improved?

This exploratory study will add to the existing literature regarding language barriers and attempted to identify methods of overcoming them. Specifically, the study examined perceptions of care and communication between Spanish-speaking patients and non-Spanish-speaking nurses.
CHAPTER 2

REVIEW OF LITERATURE

Introduction

In this era of worldwide communications, current scientific publications recognize English as the established universal language in many aspects of life (Flory, 2001; U.S. Census Bureau, 2000a). Of course, non-English-speaking countries also use their own languages when publishing their works and particularly when delivering health care to their populations. It is imperative to acknowledge the need for understanding between health-care providers and their patients.

In the Middle Ages, Arabic was used in all countries with an Islamic culture. In Europe, Latin was used for communication in science and education until the 17th century. Between 1700 and 1800, Latin lost its popularity, and instead scientific communication took place in French, German, Italian, and English in their respective countries. The use of French declined dramatically after World War I, and the use of German declined after World War II. After this period, especially in the past 30 years, English has progressively become the primary language in scientific health communication as America came to dominate both basic research and technology ("Breaking the Language Barrier," 2001; Pei, 1976). As English becomes a universal way to communicate, nonnative English
speakers can be at a disadvantage compared to native English speakers. This fact is
accentuated when these people speak little or no English. Therefore, non-English-
speaking people are at a great learning disadvantage or are at increased risk for
missing important health-care information.

Demographics of the Hispanic Population

Between 1970 and 1990, the number of Hispanics in the United States
increased by almost 60% (Flory, 2001; Foltz-Gray, 1998; McCloskey & Grace,
1997; Timmins, 2002). According to the U.S. Census Bureau (2000b), Hispanics
will become the nation’s largest minority group by 2005. The census indicates that
8.3 million Spanish-speaking residents knew little or no English in 2000.
Currently, there are 37.4 million Hispanics in the United States, representing
13.3% of the population (U.S. Census Bureau, 2002).

The U.S. Hispanic population is made up of people from Mexico (66.9%),
Puerto Rico (8.6%), Cuba (3.7%), Central and South America (14.3%), and other
Hispanic populations (6.5%). Their gender distribution shows similar percentages
of Hispanic men (13.9%) and women (12.7%) in the United States. Hispanic
children represent 17.7% of all children in this country. The educational levels of
this population in 2002 showed that 27% have less than a 9th-grade education,
16% between a 9th- and 12th-grade education, almost 28% high school graduates,
18% some college, and only 11.1% a bachelor’s degree. In addition, 40.2% (15
million) of Hispanics were born in a foreign Hispanic country. Fifty-two percent of
them entered the United States between 1990 and 2002 compared to 25.6%
entering in the 1980s and 22.3% before the 1980s. The unemployment rate for Hispanics 16 years old and older is 8.1%. Hispanics constitute 21.4% of the population living below the poverty level, and Hispanic children constitute 30.4% of the population of children living in the same conditions. In 22.6% of families, the female is the householder with no spousal economic support; coincidentally, this group showed the highest percentage (37%) of families living below the poverty level (U.S. Census Bureau, 2002).

According to the U.S. Census Bureau (2002), a large percentage of the Hispanic population in the United States are women of childbearing age who are not well educated, do not have support from a partner, and are living below the poverty level. Therefore, they are at risk for compromising their health care. The size and demographics of this segment of the U.S. population indicate a need to provide Spanish-speaking consumers with relevant health information for improving health maintenance and quality of life (Barlow, 2001; Timmins, 2002).

**Legal Concerns**

Title VI of the Civil Rights Act of 1964 (1964) forbids discrimination on the basis of race, color, religion, sex, or national origin. In other words, residents who do not speak English must still receive the same quality of care as English-speaking residents. Health-care facility managers who do not strive to give them the same quality of care by hiring bilingual staff or interpreters risk severe sanctions. Facilities often have institutional policies and monitor language services using translators or bilingual staff. Language policies require that when employees
are providing direct care to patients, they speak in the language the patient understands or find an alternative method of communication (Foltz-Gray, 1998).

The government has responded to the language barrier issue by increasing the number of regulations requiring that accommodations be made for people who are not proficient in English (Timmins, 2002). Former President William Jefferson Clinton issued an executive order in 1996 requiring all federally financed programs to make accommodations for people with limited proficiency in English. The Joint Committee on Accreditation of Health Care Organizations, American Hospital Association, Henry J. Kaiser Family Foundation, and National Health Law Program generated research policies, standards, recommendations, guidelines, and funding toward bridging the language barrier problem and required that accommodations be made for these patients ("Notices," 2000; Sullivan & Mattera, 1997). In addition, some states have passed laws requiring health-care facilities to provide interpreters for non-English-speaking patients (Sullivan & Mattera, 1997; Timmins, 2002).

**Translation Methods**

There are many ways to respond to the need of communication for non-English-speaking patients. Family members can interpret for patients, but their involvement may cause a new set of problems. They may misrepresent their family situation out of embarrassment or they may leave out cultural details that could, if known, allow for better care at a health-care institution. For example, the father eats crocodile soup when he has a cold: perhaps the soup has chemicals that could
interact with current medications. Omissions may interfere with the provider's sense of what is really happening in the patient's medical history, and it may also cause role confusion if children are translating and violate patient confidentiality (Foltz-Gray, 1998; Timmins, 2002).

Another method of communication is the use of language line services. By using these services, the patient and health-care provider can talk on the telephone with a bilingual operator. Due to the unwillingness of patients to confide private information to a stranger at the other end of the phone line, this form of communication may not be the best option. There may be a lack of sensitivity while translating due to the translator's inability to see the patient directly. Even so, language line services may be the only alternative in an emergency. There are also Spanish-language medical handbooks that health-care providers can study to be prepared when interacting with Spanish-speaking patients. By considering these options, more can be done to accommodate Spanish-speaking patients. Spanish educational materials are also available to patients that can assist providers in their teaching process but not in the information-gathering process. Patients, however, are often too tired or stressed to read these materials in a hospital setting, or they may be illiterate (Gravely & Boyd, 2001; Timmins, 2002).

According to Timmins (2002) and Foltz-Gray (1998), using well-trained bilingual staff is the best way to bridge communication gaps. Usually knowledgeable staff members can address cultural issues as well. Nonhealth-care staff should not be used to interpret. For example, they may not be able to
interpret accurately, thus causing misinterpretation that can lead to misdiagnosis (Timmins, 2002). Confidentiality is also an issue. A patient may not want to confide his or her medical problems to a stranger who is not involved in the medical field. Patient satisfaction may be compromised when patients’ health targets are not met due to language barriers (Carrasquillo et al., 1999; Foltz-Gray, 1998).

Cost Issues

Even though there are translators, their numbers are insufficient to meet the demands of the growing Spanish-speaking population (Russell & McCammon, 1995). Facilities are also hiring bilingual staff. However, their numbers are so few that frequently they feel overloaded, not only with their own assignment but with the responsibility to be a translator for other colleagues. Pulling them from their duties may cause loss of productivity in their areas of practice (Timmins, 2002; Villarruel, Portillo, & Kane, 1999). Spanish educational materials are available for patients at no cost other than making copies of an original (Russell & McCammon, 1995; Timmins, 2002). A professional interpreter needs specific training in medical interpretation, patient confidentiality, and cultural sensitivity. Professional interpreter services usually range from $50 to more than $100 an hour; however, the University of Utah Hospital (hereafter referred to as University Hospital) pays $33 per hour to on-site interpreters. Telephone language lines via AT&T are available 7 days a week, 24 hours a day. In 2001, the cost ranged from $2.25 to $4.50 per minute, depending on the time of day and type of account package.
Facts

When caretakers do not share the language of those they care for or work with, misunderstanding can build (Foltz-Gray, 1998). Patients may feel frightened and uninformed about their care and isolated socially and psychologically. Studies based on patient understanding of the encounter, patient recall, patient satisfaction, follow-up, and compliance found solid evidence that language barriers can produce a significant detrimental quality of care (Timmins, 2002). For example, patients may be unable to express basic needs like hunger, fatigue, or thirst, and they may feel helpless and withdrawn because of fear or shame. Non-English-speaking patients, already in an unfamiliar setting, may find it impossible to acclimate socially or psychologically, and they may feel isolated (Derose, 2000; Foltz-Gray, 1998).

The value of cultural competency as part of the communication process cannot be overstated. Leininger (2002) stated the importance of learning about diverse cultures and of understanding different cultures’ views of stages of life and their milestones (e.g., maternity). For example, if someone seems to agree during conversation, it could mean “maybe” or “I will consider it.” The patient’s culture might prompt him or her to regard disagreement as something to be ashamed of or avoided; consequently, the patient might agree to something not wanted or not understood. A customer satisfaction survey implied that patients were very satisfied with obstetrical services received. However, when the Spanish interpreter spoke to
several of them regarding the survey, they learned that the patients feared they might be subject to retribution “by the government” by filling out a written survey (Smith, Stanley, & Scott, 2001, p. 5). A decision-making process is also likely to be influenced by external fears and cultural beliefs, as in a patient’s willingness to divulge personal information to a stranger (Axner & Dupraw, 1997; Hayes, 1995; Smith et al., 2001).

Nurses working in all parts of the country encounter patients whose primary language is Spanish. At best, an inability to communicate with these patients is inconvenient and frustrating. At worst, an inability to communicate with these patients compromises care and makes it inappropriate or inaccessible (Gravely & Boyd, 2001; Hayes, 1995). For example, communicating feelings of comfort is important for a patient who has had a cesarean section delivery. If the patient is not accurately educated about early ambulation and the importance of pain medication, healing may be compromised and complications may develop. If she is feeling pain, she may not want to take medications, believing that if she does not move pain will not increase. If the patient does not ambulate early, gas accumulation can result in severe shoulder/upper back/incision pain. A vicious cycle develops that can be broken only when the patient understands the nurses’ instructions and the importance of them. A patient is benefited and health outcomes are not compromised when the patient can communicate what is wrong (Foltz-Gray, 1998). Timmins (2002) recognized the negative impact of language barriers on health outcomes such as misdiagnosing, prescribing inappropriate medications,
or having an inaccurate perception of education by the patient. Timmins also emphasized the need for further research to clarify negative health outcomes' causal versus associative relationship. Her findings included studies in which Spanish monolingualism is not a health risk factor but an indicator of other risk factors such as diminished education, poverty, and diminished access to care. Other studies reviewed by Timmins indicated that language disparity can result in negative health-care consequences.

The language barrier continues to be a major obstacle for Hispanic women and their health-care providers. Because interpersonal relationships are critical to Hispanic patients, there is a need to improve providers' Spanish skills in order to improve care and to promote healthy obstetrical outcomes (Smith et al., 2001).

**Perspectives**

The patient-centered orientation of nursing makes it imperative for nurses to be able to respond to the unique cultural and language needs of patients (Ratner, 2001). Nurses who work in the maternity unit are encouraged to deliver early and to provide comprehensive and specialized teaching to prepare patients and families for appropriate quality home care (Jones, Clark, Merker, & Palau, 1995).

There are many literature resources about language barriers; however, limitations regarding this topic in a hospital setting exist. I found only one study on language barriers related to provider-patient interaction in a vulnerable population (e.g., postpartum women) (Smith et al., 2001). I have been in close contact with this population, and I have observed their needs to be understood and accepted
within the English-speaking community. It is also necessary for learning needs to be satisfied in the patients’ own language. The education required by these patients is not limited to postpartum care; it also includes newborn care. I have also been in close contact with non-Spanish-speaking nurses who feel overwhelmed and frustrated when assigned to a Spanish-speaking patient.

This study was proposed due to a need for an understanding of both non-English-speaking patients’ and non-Spanish-speaking nurses’ perspectives in order to gather information about their thoughts, feelings, and possible solutions.
CHAPTER 3

METHODS

Introduction

This chapter describes the methodology used for the research study. The methodology includes the study design, population, and sampling methods. The data collection process is introduced, and the procedures that were implemented for conducting the study are described. (Refer to Appendix A for operational definitions.)

Design

This study was exploratory and descriptive in nature and was designed to elicit qualitative data from patients and nurses regarding language barriers. Focus group discussions were used as a method to obtain data. Standardized focus group methodology was followed (Stewart & Shamdasani, 1990).

Population

The population consisted of 15 registered nurses and 11 postpartum patients. The nurses’ group was divided into two groups: (a) those who worked day shifts (10 nurses) and (b) those who worked night shifts (5 nurses). The patients’ group was also divided into two groups: (a) primiparous patients (7 patients) and (b) multiparous patients (4 patients).
Sampling

Sample

This study utilized four focus groups:

1. Group 1 included non-Spanish-speaking nurses who worked day shifts and who were assigned to Spanish-speaking patients at the University Hospital.

2. Group 2 included non-Spanish-speaking nurses who worked night shifts and who were assigned to Spanish-speaking patients at the University Hospital.

3. Group 3 included Spanish-speaking-only primiparous maternity patients who delivered at the University Hospital.

4. Group 4 included Spanish-speaking-only multiparous maternity patients who delivered at the University Hospital.

Sampling Criteria

The selection criteria used for all Spanish-speaking patients included patients (a) who had recently delivered a baby, (b) who were under the care of a nonbilingual English-speaking nurse, and (c) who were 18 years old or older. The selection criteria used for all nonbilingual-English-speaking nurses included nurses (a) who took care of Spanish-speaking patients, (b) who worked during the day shift when most teaching is usually done, and (c) who worked during the night shift when very few or no interpreters are available unless it is an emergency.
Procedure

Human Subjects’ Review

The project was submitted to and approved by the University of Utah Institutional Review Board prior to the start of recruitment efforts and data collection.

Recruitment

A list of potential participants was developed in consultation with the maternity nurse manager. Fourteen nurses (Group 1) and 19 nurses (Group 2) who met the criteria were contacted and asked to participate. Nineteen patients (Group 3) and 21 patients (Group 4) who met the criteria were also asked to participate. It was anticipated that approximately half of those contacted would participate. Thus, there were 10 nurses in Group 1 and 5 nurses in Group 2, and there were 7 patients in Group 3 and 4 patients in Group 4.

Participation was promoted by directly contacting nurses on the maternity unit at the University Hospital and by making phone calls to recently discharged patients whose names were on the list. Each participant was told that (a) her participation was to be a single 2-hour discussion group regarding health-care issues, (b) the discussion group would be led by a master’s student/registered nurse at the University Hospital who was trained in leading focus groups, (c) the purpose of the study was to elicit the patients’ thoughts and feelings about past health-care experiences and the patients’ opinions on how to provide optimal health care, and (d) each participant’s responses would be held in strict confidence. Participation
was motivated by emphasizing the opportunity participants had to express their thoughts and feelings in a setting where their voices were valued and could make a difference. Each potential participant was told that (a) the setting would be casual and comfortable, (b) refreshments would be served, and (c) she would receive a small gift to thank her for her participation. She was also given the date, time, and location of her specific group session. A letter of confirmation, with all information given at the initial contact, was sent to each participant immediately after the first contact. A follow-up letter was sent to each participant 1 week prior to the session, and a follow-up phone call was made 1 or 2 days prior to the session (underlining the purpose of the group; the importance of their attendance; and confirming the date, time, and location). The location of the focus groups for patients was at a convenient and familiar community building, the Centro de la Familia. The nurses’ groups were held in the pediatric conference room at the University Hospital for the day-shift nurses and at a College of Nursing conference room for the night-shift nurses. The follow-up letter contained a map and specific directions to the exact meeting room. Appropriate signs and information were available near the main entrance to facilitate participants easily locating the meeting area.

Data Collection

The sessions were held in comfortable rooms to create a relaxed atmosphere. Each participant was greeted and given a name tag. Refreshments were available. The moderator welcomed the participants, introduced herself and
her assistant, briefly discussed the purpose of the group, and gave an overview of the role of the moderator and the participants (see Appendix B).

Consent and Confidentiality

Participants were asked to sign a participant consent form prior to the start of each focus group (see Appendix C). I was available to clarify the informed consent for Spanish-speaking participants. Participants were informed of the nature of the interview prior to the event but were not provided with the exact questions to be asked.

Participation

I, as the moderator, directed the discussion, asked questions designed to answer the research questions, and asked more specific questions as needed in order to clearly understand the participants' comments. The focus group questions were as open as possible to assure that the contents in the discussion addressed the study group's perspective rather than mine (see Appendixes D and E).

Focus Group 1 (day-shift nurses) was held at 3:30 p.m. at the designated location. Most of these nurses were coming from working their shifts; 4 of them arrived 8 minutes before the scheduled time. Small talk was initiated, then 3 more nurses arrived near the starting time. The session started with 7 participants, and they began to answer the first question; 2 more participants arrived late, and 1 participant arrived significantly late. All of them gave their opinions; however, 3 of the participants had more to say than all of the others. One of the participants
often made negative comments. Because of these comments, there were moments when the group’s comments departed from the topic of discussion, but they were promptly refocused. There were differing points of view, and probing was used as necessary. One of the participants left during the last question; later she was asked to fill out the participant’s survey. The moderator and assistant moderator debriefed the participant.

Focus Group 2 (night-shift nurses) was held at 7:30 a.m. at the designated location. Of the 6 nurses who planned to attend, 1 called late the night before asking to be excused. The nurses were coming after working a night shift, and only 1 of them arrived on time. Ten to 15 minutes later 4 more nurses arrived. The questions were answered in an orderly manner, but the nurses often expressed answers to questions that were not yet asked, presumably due to remembering their experiences at that moment. However, they were specific for the remaining questions. All of the participants were alert and enthusiastic during the first four questions, but 2 of them became quieter for the last questions, presumably due to fatigue from working the night shift. Nonetheless, all of them were given the opportunity to express their opinions. The last questions needed more probing; some answers were interesting and innovative. Participants were asked to restrain from sharing their comments with other colleagues. They were reminded to take credit for their time in order to be reimbursed. The moderator and assistant moderator debriefed for 10 minutes.
Focus Group 3 (primiparous patients) was held at 7:00 p.m. at the designated location. Only 3 participants arrived on time; the rest arrived within 15 minutes. After signing the consent form, the participants listened to a brief introduction to the session. The questioning started with only 7 of the 10 participants who were expected. These participants’ comments also wandered between Research Questions 1 and 3 but to a lesser degree. There were different points of view among the participants, and they shared many of their positive and negative health-care experiences. They were enthusiastic, and their responses were interesting. Probing was used when necessary throughout the discussion.

Focus Group 4 (multiparous patients) began at 7:00 p.m. at the designated location. Of the 10 participants who agreed to come, only 4 arrived. One of the participants called later and admitted she got lost and never made it to the location. The participants arrived within 10 to 15 minutes past the starting time. These women also answered the questions out of order. Participants needed to be refocused to the central topic when they wandered from it. They also needed a greater amount of probing to obtain their answers at the beginning and end of the session. One of the participants had a moderately different point of view, which gave variety and flavor to the discussion. Small talk was sustained and refreshments were served while waiting for the participants’ rides.

All discussions were tape recorded for further analysis and interpretation, and the tapes were sent to a reliable source for transcription. I kept the discussion within the established time frame (75 to 90 minutes) and ensured that all questions
were addressed. At the end of each discussion, the participants were debriefed and refreshments were served.

**Data Analysis**

**Content Analysis**

Written and verbal communications are often subjected to content analysis as a way of quantitatively measuring research findings (Polit & Hungler, 1991; Seaman, 1987). The tapes were transcribed in English for the nurse groups and in Spanish for the patient groups. Specific themes and patterns of responses were examined and summarized, and recommendations were made. Content analysis was utilized to convert original conversations into usable reports based on established focus group research methodology (Krueger, 1997; Stewart & Shamdasani, 1990).

Each group was analyzed individually according to objective and subjective descriptors and results to determine the key conclusions. Vertical analysis was used to analyze nurse and patient groups separately. Horizontal analysis was used to analyze the two groups of nurses, and the same approach was applied to the two groups of patients.

Analysis considered internal consistency of the comments, their frequency and extensiveness, and their intensity at the moment of verbalization (see Appendix A). The groups' responses were compared to findings related to the research questions until central themes emerged, emphasizing the predominant topic voiced in most of the groups.
Specific topics were highlighted by annotating key findings and potential quotes. A list of themes was prepared with sample comments.

Demographic Data Analysis

Demographic data were collected from the participants in order to enlighten, clarify, or confirm the answers to focus group questions regarding participants’ perceptions about language barriers. I was also interested in whether or not certain demographic variables influenced a participant’s comments. Demographic questionnaires are presented in Appendix F.

Rigor

Because I was the only person reviewing the transcribed focus group discussion and assigning content to categories, the results of this study would not be justifiable or credible if issues surrounding rigor of the study were not addressed. Guba and Lincoln (1981) stated, “Problems of rigor arise from the inquirer’s need to persuade other inquirers or audiences of the authenticity of the information provided and the interpretations that are drawn from it” (p. 87). These criteria are the (a) credibility of the information obtained through these discussions, (b) fittingness of the data or the ability to generalize findings from this study to the larger world, (c) auditability or the ability of another individual to come to the same or similar conclusions in data analysis, and (d) confirmability (Guba & Lincoln, 1981).
Credibility can be improved by the moderator's close and careful listening to the participants' responses and gathering more detailed information through probing questions (Guba & Lincoln, 1981). I carefully monitored the participants' responses in this study by taping the conversations, making field notes (nurse focus groups), and using probing questions. Probing was necessary to clarify some of the answers and in exceptional cases was necessary to uncover additional information. Participants were willing to provide extensive, in-depth data. Credibility can also be established by prolonged involvement with study participants (Guba & Lincoln, 1981). Participants in this study were provided with my phone numbers. All of the participants were interested in the study results at the end of each session. Nurses were informed of the study results in an executive summary, and patients received a simplified summary of the study results in a letter mailed to their home addresses. The credibility of findings is improved through similarities found when comparing study findings with reviewed literature (Guba & Lincoln, 1981). These findings are covered in the discussion section.

The results of this study cannot be generalized to a greater extent other than to be used for planning improvements in the area studied. The nature of the study and the small sample are not qualities of generalizability; thus, even though participants were selected carefully and according to meticulous criteria, rigor cannot be ensured through fittingness. However, these findings could be compared by individual research consumers in different parts of the United States. Research consumers might identify similar situations and decide to use these results as part
of their way to overcome language barriers.

Ensuring rigor through auditability involved asking one objective observer to audit the study’s methodology and results (Krueger, 1997). Rigor was not entirely possible due to time restrictions; however, there was a debriefing period with a focus group expert and subjective observer. I also reviewed each transcribed focus group discussion copy four times in an attempt to place content into appropriate categories while eliminating redundancy.

Confirmability of the study results implied the need to look at written sources to gather further support for study results in addition to seeking the professional opinion of others. Confirmability also required me to assess my own biases before and during data collection and analysis. For instance, I made sure that my opinions about language barriers did not influence how I asked questions. When probing answers, I was careful to avoid leading participants inadvertently in a direction that would validate literature findings. I also refrained from sharing my opinions when asked for them by the participants.

Summary

Purposive sampling (see Appendix A) was used in this qualitative descriptive study to recruit 26 participants. After written consent was obtained, four audiotaped focus group sessions were conducted at appropriate locations. Six to seven questions were asked of each nurse and patient group. These questions were designed to gather information regarding each participant’s perception of language barriers within a group. In addition to gathering data through focus group
sessions, I collected demographic data through a written survey-type questionnaire and then included this information in the analysis and discussion of the results.
CHAPTER 4

RESULTS

Introduction

The purpose of the study was to (a) explore and describe language barriers that exist during nurse-patient interactions between Spanish-speaking patients and non-Spanish-speaking nurses in a maternity unit and (b) explore ways to overcome these barriers. Data were collected using four focus group sessions and demographic questionnaires (see Appendix F). Content analysis and descriptive statistics were used for data analysis. Results of the data analysis are presented in this chapter.

Findings

Description of the Sample

The sample consisted of four focus groups, two groups of nurses with 5 and 10 members and two groups of patients with 4 and 7 members (N = 26 participants). All of the participants were female.

Demographics of the Sample

Nurses’ demographic characteristics are described in Table 1. In Group 1, 40% of the day-shift nurses who had worked for less than 1 year in the maternity unit had an average of 0.7 years (8 months) as obstetric/gynecologic nurses. Sixty
Table 1

Demographic Characteristics of Nurses

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Day shift</th>
<th></th>
<th>Night shift</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Time working in maternity unit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than up to 1 year</td>
<td>3</td>
<td>30.0</td>
<td>3</td>
<td>60.0</td>
<td>6</td>
<td>40.0</td>
</tr>
<tr>
<td>2 to 5 years</td>
<td>1</td>
<td>10.0</td>
<td>1</td>
<td>20.0</td>
<td>2</td>
<td>13.3</td>
</tr>
<tr>
<td>6 to 9 years</td>
<td>1</td>
<td>10.0</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td>More than 10 years</td>
<td>5</td>
<td>50.0</td>
<td>1</td>
<td>20.0</td>
<td>6</td>
<td>40.0</td>
</tr>
</tbody>
</table>

| Spanish classes                         |           |          |             |          |       |          |
| Yes                                      | 5         | 50.0     | 4           | 80.0     | 9     | 60.0     |
| No                                       | 5         | 50.0     | 1           | 20.0     | 6     | 40.0     |

| Level of comfort                         |           |          |             |          |       |          |
| Uncomfortable                            | 1         | 10.0     | 1           | 20.0     | 2     | 13.3     |
| Not comfortable/uncomfortable            | 7         | 70.0     | 3           | 60.0     | 10    | 66.7     |

| Comfortable                              | 2         | 20.0     | 1           | 20.0     | 3     | 20.0     |

| Shift worked                             |           |          |             |          |       |          |
| Day shift                                | 9         | 90.0     | 0           | 0.0      | 9     | 60.0     |
| Night shift                              | 0         | 0.0      | 5           | 100.0    | 5     | 33.3     |
| Both                                     | 1         | 10.0     | 0           | 0.0      | 1     | 6.7      |

| Total                                    | 10        | 66.7     | 5           | 33.3     | 15    | 100.0    |
percent of the nurses who had worked between 9 and 25 years had an average of 16.8 years as obstetric/gynecologic nurses. In comparison to the night-shift nurses (Group 2), 80% (n = 4) were newer employees for an average of 3.7 years; 20% (n = 1) had worked in obstetric/gynecologic for 10.5 years.

Fifty percent of the day-shift nurses had never attended Spanish classes; 80% (n = 5) of this group had worked more than 11 years and 20% (n = 1) had worked for a few months. The other 50% of day-shift nurses had taken Spanish classes; 60% of them had worked for less than 1 year and 40% had worked for more than 9 years. Eighty percent of these nurses attended hospital survival classes and 20% took a class at the University of Utah. In comparison with the night-shift nurses (of whom 80% had taken Spanish classes), half of this group had studied Spanish at junior high school and the other half at other sources such as hospital classes and traveling. Only the remaining 20% (n = 1) had never taken a Spanish class; coincidentally, she was the nurse who had been working for the longest time from among the nurses in the group.

When exploring the nurses' degree of comfort on a 1 to 5 scale as they interacted with Spanish-speaking patients, 10% of the day-shift nurses felt uncomfortable, 20% felt comfortable, and 70% felt neither comfortable nor uncomfortable. Among the night-shift nurses, 20% felt uncomfortable, 20% felt comfortable, and 60% felt neither comfortable nor uncomfortable. From these results, it is concluded that most of the nurses felt neither comfortable nor uncomfortable when interacting with Spanish-speaking patients. The results differed
somewhat from what was said in the focus groups.

Most of the nurses in Group 1 worked a day shift (80%), 10% worked afternoons, and 10% worked alternating day and night shifts. Group 2 worked night shifts only (100%).

Patients' demographic characteristics are described in Table 2. The average age for the primiparous patients in Group 3 was 22 years, and the average age for multiparous patients in Group 4 was 26 years.

The average number of children for multiparous patients was 2.5. Sixty percent of these children were born at the University Hospital. For primiparous patients, this was their first experience in the maternity unit at the hospital.

Among the primiparous patients, 43% had family members who spoke English, and 57% had no family members who spoke English. Among multiparous patients, 75% had English-speaking husbands who helped them. Due to a lack of resources, a majority of the primiparous patients who needed postpartum education because of their lack of experience were more vulnerable to language barriers than the multiparous patients.

Among the primiparous patients, 28.6% had less than a 6th-grade education, 14.2% had a 6th- to 8th-grade education, 14.2% had a 9th- to 12th-grade education, and 43% had an associate's degree. By comparison, 25% of the multiparous patients had less than a 6th-grade education, 25% had an associate's degree, and 50% had a 6th- to 8th-grade education. A high percentage of primiparous patients had an associate's degree when compared to Group 4;
Table 2

Demographic Characteristics of Patients

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Multiparous</th>
<th></th>
<th>Primiparous</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 to 24</td>
<td>2</td>
<td>50.0</td>
<td>6</td>
<td>85.7</td>
<td>8</td>
<td>72.7</td>
</tr>
<tr>
<td>25 to 30</td>
<td>2</td>
<td>50.0</td>
<td>1</td>
<td>14.3</td>
<td>3</td>
<td>27.3</td>
</tr>
<tr>
<td><strong>Number of children</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>0</td>
<td>0.0</td>
<td>7</td>
<td>100.0</td>
<td>7</td>
<td>63.6</td>
</tr>
<tr>
<td>2 to 3</td>
<td>3</td>
<td>75.0</td>
<td>0</td>
<td>0.0</td>
<td>3</td>
<td>27.3</td>
</tr>
<tr>
<td>4 or more</td>
<td>1</td>
<td>25.0</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
<td>9.1</td>
</tr>
<tr>
<td><strong>Number of children born at hospital</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>50.0</td>
<td>7</td>
<td>100.0</td>
<td>9</td>
<td>81.8</td>
</tr>
<tr>
<td>More than 1</td>
<td>2</td>
<td>50.0</td>
<td>0</td>
<td>0.0</td>
<td>2</td>
<td>18.2</td>
</tr>
<tr>
<td><strong>Family member speaks English</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
<td>75.0</td>
<td>3</td>
<td>42.9</td>
<td>6</td>
<td>54.6</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>25.0</td>
<td>4</td>
<td>57.1</td>
<td>5</td>
<td>45.4</td>
</tr>
<tr>
<td><strong>Level of education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No school</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Less than 6th grade</td>
<td>1</td>
<td>25.0</td>
<td>2</td>
<td>28.5</td>
<td>3</td>
<td>27.2</td>
</tr>
<tr>
<td>6th to 8th grade</td>
<td>2</td>
<td>50.0</td>
<td>1</td>
<td>14.3</td>
<td>3</td>
<td>27.3</td>
</tr>
<tr>
<td>9th to 12 grade</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
<td>14.3</td>
<td>1</td>
<td>9.1</td>
</tr>
<tr>
<td>Associate’s degree</td>
<td>1</td>
<td>25.0</td>
<td>3</td>
<td>42.9</td>
<td>4</td>
<td>36.4</td>
</tr>
<tr>
<td>Upper degrees</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Family members at home</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>0</td>
<td>0.0</td>
<td>5</td>
<td>71.4</td>
<td>5</td>
<td>45.4</td>
</tr>
<tr>
<td>4 to 5</td>
<td>2</td>
<td>50.0</td>
<td>1</td>
<td>14.3</td>
<td>3</td>
<td>27.3</td>
</tr>
<tr>
<td>6 or more</td>
<td>2</td>
<td>50.0</td>
<td>1</td>
<td>14.3</td>
<td>3</td>
<td>27.3</td>
</tr>
<tr>
<td>Characteristics</td>
<td>Multiparous</td>
<td>Primiparous</td>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-------------</td>
<td>-------------</td>
<td>-------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Family income</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than $15,000/year</td>
<td>0</td>
<td>0.0</td>
<td>2</td>
<td>28.5</td>
<td>2</td>
<td>18.2</td>
</tr>
<tr>
<td>$15,000 to less than $20,000/year</td>
<td>2</td>
<td>50.0</td>
<td>3</td>
<td>42.9</td>
<td>5</td>
<td>45.4</td>
</tr>
<tr>
<td>$20,000 to $30,000/year</td>
<td>1</td>
<td>25.0</td>
<td>2</td>
<td>14.3</td>
<td>2</td>
<td>18.2</td>
</tr>
<tr>
<td>More than $30,000/year</td>
<td>1</td>
<td>25.0</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
<td>9.1</td>
</tr>
<tr>
<td>No information</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
<td>14.3</td>
<td>1</td>
<td>9.1</td>
</tr>
<tr>
<td>Medical insurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>No</td>
<td>4</td>
<td>100.0</td>
<td>7</td>
<td>100.0</td>
<td>11</td>
<td>100.0</td>
</tr>
<tr>
<td>Time residing in the United States</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 2 years</td>
<td>1</td>
<td>25.0</td>
<td>4</td>
<td>57.1</td>
<td>5</td>
<td>45.4</td>
</tr>
<tr>
<td>2 to 8 years</td>
<td>3</td>
<td>75.0</td>
<td>3</td>
<td>42.9</td>
<td>6</td>
<td>54.6</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>36.4</td>
<td>7</td>
<td>63.6</td>
<td>11</td>
<td>100.0</td>
</tr>
</tbody>
</table>
however, a lower percentage of multiparous patients had less than a 6th-grade education when compared to Group 3.

For primiparous patients, the number of family members who lived at home, including children and extended family who were supported by the main family provider, averaged 3.7 members. Of these members, 71% \((n = 5)\) lived separately from extended family members. For Group 4, an average of 4.8 family members was calculated. Only 29% of the primiparous patients \((n = 2)\) and 25% of the multiparous patients \((n = 1)\) lived with extended family members.

The average family income for the 5 primiparous patients who disclosed this information was $342 per week ($17,784 per year). One of these patients had a weekly income of $500 ($26,000 per year). The average family income for 75% of the multiparous patients was $367 per week ($19,084 per year) and for the remaining 25% \((n = 1)\) $950 per week ($49,900 per year). From these findings, it is concluded that 70% of the primiparous patients and 50% of the multiparous patients live below the established level of poverty for the United States ($20,000 per year).

All patients in both patient groups had no health insurance. Paradoxically, this finding also applies to patients whose family income was over the poverty level.

Primiparous patients who had been in the United States for less than 2 years constituted 57.1% of the group; 42.9% of them had been living in the country between 2 and 8 years. The average time of residence in the United States for all
primiparous patients was 2.4 years. The same average for all multiparous patients was 3 years, but this average (75%) for this group was 2 years and for the remaining 25% was 8 years. Partitioned percentages in the multiparous group were calculated due to the skewed samples. A large percentage of primiparous patients had been in the United States for less than 1 year, and a low percentage of both groups had been living in the country for more than 5 years. From these findings, it is concluded that most patients are at a disadvantage when trying to communicate due to the short length of time they had to adjust to a new country, climate, food, culture, and language.

Results of Research Questions

Major Themes in Each Focus Group

All comments are illustrated according to their frequency, extensiveness, intensity, and internal consistency (see Appendix G). For nurses in Groups 1 and 2, the research questions were:

1. What perceptions do nurses have regarding care for Spanish-speaking patients?

2. What barriers do nurses experience in providing care to Spanish-speaking patients?

3. What strategies are helpful in providing care to Spanish-speaking patients and their families?

Major themes evolved as focus group questions were asked that directly or indirectly answered the research questions.
Groups 1 and 2: Nurses

Strong feelings when dealing with Spanish-speaking patients. Most day-shift and night-shift nurses felt helpless and described their experiences as very difficult when having to care for a Spanish-speaking patient. They attributed this difficulty to the uncertainty of translator availability. Both Groups 1 and 2 had feelings of embarrassment and inadequacy when speaking to patients in their limited Spanish. They were afraid of using their limited Spanish skills because Spanish-speaking patients talked back to them at a rapid speed and beyond the range of their vocabulary.

The nurses felt helpless when patients had emotional problems that could not be addressed with the nurses' limited Spanish. They also felt intimidated when deciding what to do when no one was available to interpret. They felt frustrated and hoped that nothing would go wrong or exceed the normal postpartum care. “You . . . just survive your shift and hour by hour explain each thing that happens instead of giving them the bigger picture.” “I try my hardest and hope that somebody can fix and do better and clear up the muddy water.” Nurses also felt uncomfortable not knowing if patients could read, how much they understood English, the level of their education, or if they had any experience.

The most common feeling was frustration but for different reasons (e.g., not being able to provide good admission/discharge planning and teaching or being frustrated having to call a translator for simple matters like a patient needing to void). They were frustrated when patients felt aggravated due to a lack of
understanding. Nurses described their experiences as terrible and difficult, which was often due to the unavailability of a Spanish-speaking person in the unit—especially in emergency situations when patients could not express themselves and nurses could not ask questions. “I am frustrated. . . . I feel better if I have resources around. . . . I rely a lot on demonstrations more than anything, . . . but I agree, it is hard, admissions and discharges, . . . it is hard.”

Another strong feeling was the fear of patients assuming that nurses who speak some Spanish could understand everything they said at their normal and rapid rate of speaking. When these circumstances occurred, nurses opted to leave the room and returned only for necessary assessments.

The thing that I fear is . . . when you attempt to communicate, . . . then they just bombard me with everything, and it just goes over my head, and I can’t help them with questions or things like that because I just don’t have a mastery of the language.

On the other hand, some nurses also felt irritated and frustrated when patients who knew some English did not use it. “That’s what I sometimes find frustrating is when they don’t try a little harder to use the English they do know.”

Some nurses worried that they provided inadequate care for their patients when they relied on Spanish-speaking providers or on nurses in the next shift to do the teaching. “I don’t do hardly any teaching at all and just wait until the next nurse does it.” Some nurses felt sorry for patients because of their own inability to help them at their highest level of capacity. They also felt it was difficult because it took longer to accomplish simple tasks. “It took me 45 minutes. . . . Something so simple took me 45 minutes to accomplish, . . . that was 45 minutes of my time.
over something that wasn’t even that big of a deal.”

Nature of service. Some nurses thought these patients were at a deficit because they probably did not receive the care at the same level as did English-speaking patients.

When I get an English-speaking admit, I am in there for 45 minutes just going over everything, . . . and the Spanish-speaking patient, it’s like 5 minutes because you can’t. . . . That’s an obvious lack of education going on because of the language barrier. And I try my best Spanish, but it’s not very good.

Some nurses felt that this care was generic and impersonal and with only a basic number of questions to develop a plan of care. One nurse stated that patients received good care and that the only problem was that questions and concerns could not be expressed or addressed.

I feel like it’s pretty generic care. All of us know basically a handful of questions, and it’s not personalized. . . . Let’s do group discharge teaching. . . . It’s not the way we communicate with our English-speaking patients. You know, “How are you today?” “Is your family coming?” “You know, you get more one-on-one. You know more where they are coming from, and it’s not just me reading it.

Most night-shift and some day-shift nurses hoped patients felt as comfortable and welcome as English-speaking patients felt knowing that the nurses did their best and used available resources to communicate with them. “I hope that they would have the feeling that we tried.”

Misunderstandings due to language barrier. Day-shift nurses described situations that made them panic, misinterpret what patients were requesting, and waste time (e.g., detection of chest pain in a patient who was recovering from
magnesium infusion occurring 6 hours after the fact; babies being bottle-fed during the night when the mother wanted to breast-feed only; and thinking a patient had a serious problem such as bleeding, dizziness, and pain when she was only signing and asking for permission to walk around).

I had an experience last week where my patient was actually having chest pains, and she was in magnesium recovery, and she came to communicate that 6 hours after the fact that this had been going on . . . to one of the aides who spoke to her in Spanish. And so I felt terrible because she had been experiencing chest pain and trouble breathing and all of these things, but she didn’t even try to communicate that to me because she didn’t feel like she could because she doesn’t know enough English. I don’t know, I just think it’s a big issue. It’s really hard for me to be in that boat because I did the best I could do given the circumstance.

One night-shift nurse described a situation in which her time was wasted and panic developed after a simple problem (e.g., preference in temperature of fluid intake versus sore throat or heartburn).

She was saying “dolor” in her throat, so I was thinking okay. . . . I almost called the doctor for . . . Maalox because I thought she was having heartburn, and I went on the computer and went to a Web site and did Spanish words because nobody spoke Spanish, and you know, something so simple, . . . just to not put ice in her water. . . . I was thinking, oh no, has she got a sore throat? Has she got heartburn? What’s going on?

Patient’s responsibility. Most nurses agreed that if patients choose to immigrate to an English-speaking country, it is the patient’s responsibility to learn basic English. “They don’t have to speak perfect English, it just really makes a difference if they know a few phrases, a few words.” A few nurses felt the need for patients to learn English. Some day-shift nurses emphasized this idea and based their opinions on the fact that they were already helping the patients to pay for
their hospital stay by paying their taxes.

I feel like I am already paying for their hospital stay in the taxes that I pay in my check every other week. And they’re getting free money from our government to have babies here. And then on top of that I’m also kind of expected to be a good nurse to learn their language. Not only am I giving them their hospital stay so to speak but then I’m also expected to learn their language to take good care of them. It’s like they’re not even expected to learn English so to speak, even though they’re getting in exchange the free care that they’re getting, so I kind of am torn.

“I would like to see those people who immigrate to this country . . . learn English. . . . They chose to come to America and the language in America is English.”

“We are attempting to learn more Spanish, and they should be trying to learn English, too.”

Few nurses were condescending and recognized that it is difficult for patients to learn English as it was for pioneers who came to America many years ago. They believe patients are in the process of taking responsibility to become bilingual.

You want people to be compassionate . . . caring. . . . Somewhere along the line my ancestors came here and didn’t know the language, but they learned and took responsibility. . . . I think that some of our patients are in that process of taking responsibility in the process of learning. . . . You know, it is just a hard thing.

One nurse wondered if she would be required to learn the language if she were in the patient’s country. She did not believe she would be expected to learn Spanish. Others were also opposed to this idea and did not understand why Hispanic patients do not learn English. “Maybe they are ignorant. . . . I don’t know. . . . I can speculate.” “I don’t understand how they can live here in
America and not know a little English, . . . how they function.”

Confidentiality. Nurses used friends, family members, significant others, and generally anyone available who spoke Spanish to translate. They also used children, depending on their age, but did not feel comfortable making them translate certain topics.

Nurses recognized that housekeepers and children were not appropriate and would not be a first choice. They acknowledged that family dynamics could make a patient uncomfortable when family members were translators. Nurses also believed that for simple issues, such as asking for a blanket or water, they would use anyone to translate.

A few nurses stated that they would rather have a family member answer questions than have no answers. One nurse contacted her husband by phone to get Spanish phrases from him to speak with patients. “Their roommate. . . .” “Even when you don’t ask, they just seem to pipe in.” “I’ve even used the housekeepers. Oh yes, some of them speak really good Spanish, and I’ve had to in a pinch.” “I think we all have.” “I’ll use anyone I can find basically.” “I’ve used my husband actually. He is a Spanish translator for a living, and so I’ve actually called him at home and said, ‘I need to know this, right this minute.’”

Some nurses tend to be cautious about the age or gender of the translator (e.g., using a brother for some topics and, if possible, a significant other for everything else). Other nurses make no distinction between the nature of conversation and the gender or age of an occasional translator. However, some
nurses would still ask their patients if they are comfortable with the translator and vice versa. “Ask if they [others] are comfortable in translating, [and] if the patient is comfortable having them ask her personal questions and having her tell them about personal things.” Phone translators are so impersonal and can make a patient feel embarrassed that nurses rarely use this resource. “You talk to the interpreter and then you hand the phone to the patient. . . . It’s not as good as having someone in person at all. It’s just a last resort.” “I’d feel embarrassed if I were in the position. I am [a] very shy modest person. I’d hate it. I’d have a really hard time with it.”

It’s just so impersonal. And here you are asking these personal questions, and this patient has got to talk to somebody they don’t even see about their perineum, their vagina, . . . their breasts, . . . their nipples, and things like that. . . . They don’t want to tell some strange man on the telephone that they need breast cream because their nipples are sore.

Assumptions. Both day- and night-shift nurses made assumptions about their patients’ behaviors and then acted according to their assumptions. Day-shift nurses assumed that if mothers wanted their babies in the nursery, they wanted nurses to bottle-feed them. “Concerning breast-feeding, . . . on occasion the mother has not wanted the baby to go to the nursery and be fed, . . . but it is just assumed that’s what she wanted.”

Nurses assumed that Hispanic patients who were in pain denied it for cultural reasons and brought pain medications anyway. “I kind of get the feeling sometimes that they are not allowed . . . to feel pain or to have pain treated, . . . but it’s something . . . you are supposed to endure.” “I make sure they get the
right dosage every 8 hours. . . . I just take it to them because . . . they will always say no.”

Hispanic patients are assumed to be literate when nurses, in their inability to communicate, give patients Spanish handouts. “On the medications, . . . they have those little Spanish instructions. . . . I guess you are assuming and hoping that they can read.”

Because Hispanic patients have had other kids, it is assumed they know how to breast-feed. Patients thought that nurses could miss the facts that perhaps their children were adopted or that they did not breast-feed before for private reasons. “You can tell the way mama holds the babe, . . . she’s done this before.”

One nurse relied on Spanish-speaking providers to perform discharge education. “I frequently rely on the care providers . . . that speak Spanish are doing some of the teaching in Spanish and then I’m not as anxious. . . . I don’t know if it really is.”

Night-shift nurses thought that if the patients live in Hispanic communities where everything is in English and Spanish, then perhaps they did not feel the need to use English to communicate. Nurses also made assumptions that patients might feel intimidated or embarrassed to use their English. “I don’t know if they are embarrassed themselves to use English like we are embarrassed to use Spanish.”

Another assumption is that patients agree with everything if they don’t understand. “They agree with everything if they don’t know what to do.” “I’ve had patients say yes to everything, . . . except for pain, which might be bad.”
Possible solutions to language barriers: Differences in non-Spanish-speaking nurse group discussions. Both groups felt frustrated for different reasons. The day-shift nurses felt incapable of giving good admission/discharge planning and teaching. They were calling interpreters for minimal translations, and they also felt frustrated when, after great effort on their part, these patients did not understand. Night-shift nurses were frustrated when patients who could speak some English refused to do so and when there were complications that could not be resolved with their limited Spanish.

Night-shift nurses feared the unknown and wondered about their patients' level of fluency in English, their education, and their experience as mothers. Day-shift nurses felt that their care of Spanish-speaking patients was generic and impersonal. In contrast, night-shift nurses empathized with patients and hoped they knew they did their best.

Both groups also felt that their time management was affected when assisting these patients. However, day-shift nurses acknowledged the lack of education provided to these patients when comparing the amount of time spent with English-speaking patients versus time spent with Spanish-speaking patients. For night-shift nurses, it took a great amount of their time to accomplish a small task with Spanish-speaking patients when compared to the same task for English-speaking patients.

Some night-shift nurses stressed the fact that if no teaching occurred during the night, they would not sign the education record. When night-shift nurses were
asked about their feelings if they had worked day shifts, some of them said that they would feel worse because teaching occurs more frequently during the day when patients are 90% more perceptive. Other nurses had no problem since there were more resources available.

Groups 3 and 4: Spanish-speaking Patients

For the Spanish-speaking patients in Groups 3 and 4, the research questions were:

1. What perceptions do Spanish-speaking patients have when receiving care from a non-Spanish-speaking nurse?

2. What barriers do Spanish-speaking patients perceive when receiving maternity care from a non-Spanish-speaking nurse?

3. In what ways do Spanish-speaking patients feel the care received from non-Spanish-speaking nurses could be improved?

4. How do Spanish-speaking patients think their communication with non-Spanish-speaking nurses could be improved?

Strong feelings when facing non-Spanish-speaking nurses. Both primiparous and multiparous patients agreed that the experience of being under the care of non-Spanish-speaking nurses was a stressful and desperate situation for most of them. They felt abandoned when their family members were not around and everyone around them spoke English.

Patients stated that when they were transferred to their rooms after delivery, this became more difficult and frustrating, as the nurses did not speak Spanish.
Thus, it was moderately difficult for them to express what they wanted to tell the nurses and difficult to understand what the nurses were telling them. For some patients, it was even more difficult during the night when providers were non-Spanish-speaking nurses. “It is difficult, we do not know what is being said, we do not understand very well.”

Patients felt isolated when significant others were not allowed to remain with them during surgical procedures, especially one who remained hospitalized for more than 4 days due to complications. “For me, it was a difficult experience because I felt alone in my room, with no one to talk to . . . surrounded by strangers. . . . I was afraid.” “When friends and family are supporting you, you can momentarily forget about your problems; but during the night when they are gone, you feel alone and sad.”

Some patients felt desperate and somewhat irritated when nurses did not pay attention to their requests and gave no explanation. “And they would say ‘breast-feed him,’ but he was not satisfied, and they always replied the same, to wait for an hour and try again. This went on for a whole day.”

Patients were grateful that these experiences were over and now a part of their past. Some of them had memories of times during which they were so desperate that they were ready to cry, and they had haunting thoughts and uncertainties. “There were moments in which I wanted to cry because I didn’t understand nor say a word in English. And I thought ‘now who is going to help me?’”
Both groups were so afraid of making mistakes when using their limited English that they did not have the courage to use it. They were also afraid of forgetting their English if they tried to speak it. They felt ashamed of their accent. There were some patients in both groups, however, that neither understood nor spoke English. Patients recognized that their providers wanted to communicate and felt limited as they did. It was not difficult for 2 patients because they either had Spanish-speaking providers or they understood and spoke some English; however, they had to pay close attention and make a great effort to understand English. “I also think it is the fear of speaking it wrong. One maybe knows how to ask for basic things, but there is the fear of not being understood.” “One thinks that others are going to mock the way we talk.”

Patients were afraid due to negative past experiences of interacting with non-Spanish-speaking providers. They also felt desperate when an emergency situation arose. Patients were unable to explain what was happening, and the providers could not explain the situation to them.

My last night was very stressing; along with my roommate, we were trying to figure it out and commenting, “And now, how are we going to tell her this or that?” “Do you know how to say this?” We were trying to think how we were going to communicate our needs.

Some of them had no understanding of what the provider was saying and even described their experiences as traumatic. They could not sleep, they worried, and they wondered if the person entering the room was able to speak Spanish.

If I had, . . . this was a very traumatic situation. I thought, now, what do I do? And because no one can stay during the night, . . . we didn’t know how to explain or ask for things we needed. During
the day, I was more comfortable because my husband was there. . . . He understands English.

When asked about their feelings if they could better understand what nurses were telling them, patients acknowledged that they would enjoy interpersonal relationships with their providers rather than the few minutes visit they get with a non-Spanish-speaking provider. “It would be more enjoyable. Sometimes they come and want to talk to you to cheer you up, but they can’t. . . . Conversations would be possible and our stay more enjoyable.”

Nature of service. Both of these groups agreed that the type of service they received was good and they were satisfied with it. Patients were impressed by the nurses’ care for them.

Patients felt their providers’ emotional support when they were afraid. Some patients felt that the basic phrases providers said in Spanish were understandable. Others felt care was adequate, since they did not require intensive care. “I was satisfied with the service I got.” “Nurses and doctors are of great support.”

Patients appreciated that providers did not leave them alone and always asked if they needed anything. They perceived the services as superb and different from those of their home countries. Patients believed that providers were doing their best to learn Spanish and were trying to make themselves understandable.

We could have received an excellent care from most of them. Maybe for others it was the opposite, maybe they had a lot to do or and were tired. . . . We are not the only patients they have. . . . For me, it was an excellent service. I felt good. I did not want to go home. The way they treated me was great.
Misunderstanding due to the language barrier. Both groups reported situations of misunderstanding that brought negative feelings to patients and providers. Primiparous patients described situations that caused them dissatisfaction, confusion, and long periods of time waiting to have their basic needs or simple requests satisfied. For example, after 3 days of the baby failing to latch on to the breast, the nurse denied a request for formula feeding. “I was trying to tell the nurse my baby was not satisfied and to go ahead and formula-feed him. And they . . . always replied the same, . . . to wait for an hour and try again.” The nurses brought pain pills when patients denied having pain. “I was in the hospital for 2 days, and they . . . brought me pain pills. I didn’t understand why because I was not in pain.” An unexplained diagnosis of insufficient amniotic fluid caused patients to worry too much.

My only worry was my baby. Before he was born, they said I did not have enough amniotic fluid. I was worried for my baby. Some of the nurses tried to explain to me, but I was still worried.

A patient who simply wanted to walk, after explaining, signing, and pointing, had to wait for someone else to come and translate that simple request.

One time I was tired to be in bed, and after getting up to the bathroom, I . . . asked my nurse if I could. So I gave a few steps over and over to show her, but she said “no understand” in Spanish. And after a while, she brought someone who spoke Spanish and she explained to my nurse that I wanted to walk.

Multiparous patients described situations that were alarming and caused distress and anxiety. These situations could have caused nurses’ incapability to get subjective data from patients during an emergency situation. The patient may also
feel powerless to explain what is happening to her or to obtain an explanation about it.

I had a cesarean section, . . . and when I went to the bathroom, I had some kind of tissue coming out of my vagina. They panicked, thinking . . . that could be my uterus or ovaries protruding. The doctor determined that it was a piece of placenta. I was really freaked out. I didn’t know how to explain what was going on, and initially they couldn’t explain what it was.

Some patients also described hostile situations with some nurses and felt discriminated against. Some of them did not feel safe due to a previous misdiagnosis. They also recognized that Americans sometimes misuse Spanish words.

One nurse brought ice water when the patient had previously refused it. Then the patient was afraid to ask for pain pills. The patient felt hostility in the nurse’s tone of voice and thought that the nurse would be the same even if she spoke Spanish. “She asked me if I wanted ice water. . . . I said ‘no thanks.’ Then . . . she put ice water on my table. I told her, ‘I’m not going to drink it,’ and she said, ‘I don’t care, do as you want.’”

When trying to explain the pain when a baby descends into the pelvic cavity during the last weeks, the patient heard a wrong message and thought there was a problem.

I had a doctor that spoke some Spanish, and I was complaining of some pain in the bottom. And he told me that my bottom was opening. I had a dozen images in my mind on how my bottom could be opening. He used a Spanish word that I didn’t understand, but later I knew it was hips and tissue surrounding it. He had to sign and point where it was opening for me to kind of understand and calm down.
A multiparous patient was sent home even though she felt she was in labor. Her husband made her return an hour later in time for a precipitous delivery.

The nurse told me to go home because those weren’t laboring contractions. . . . My husband . . . took me back to the hospital. The same nurse . . . told me, “I told you to go home.” I told her, “This is laboring pain, . . . this is not my first baby.” My doctor . . . said that the nurse who sent me home was crazy and these were real contractions. It’s bad that some nurses take advantage of us because we don’t speak the language very well.

One pregnant woman went to a clinic with a Spanish-speaking provider. She was diagnosed with preterm labor and was medicated for that after having previously been misdiagnosed at the hospital.

I went to a Spanish-speaking doctor, and he explained to me why I had preterm labor. And he was the one who gave me the medication, and I could have my baby. . . . He asked me if I was ever told this in the hospital.

For Spanish-speaking people, the word partera (midwife) denotes the concept of a lay midwife, someone who helps with delivery only and someone with no prenatal care included in the service. It was confusing when the mothers were trying to choose who was going to assist with their delivery.

Patient’s responsibility. Their limitations notwithstanding, most participants in both groups recognized that the responsibility for understanding is not only with the provider but also with themselves. “That they [could] learn more Spanish but also that we learn more English as well.”

Some patients wished they could speak English and felt guilty for not learning it. They thought they should do their best to learn English as providers do with Spanish—at least the basic words. They recognized that it is as difficult for
them to learn another language as it probably is for providers and wondered if providers' expectations included patients speaking English. One of the patient participants felt strongly that patients who had resided in the United States for more than 10 years should speak at least basic English. "I think that in the same way they do their best to learn Spanish, we as well could do our best to learn English." "But it is in us as well to do our part to learn basic words to try to better communicate with them."

Some patient participants presented reasons for not learning English. For example, their only purpose for coming to the United States was to work, and they did not feel the need to learn English, as they were going back to their country. "Not all people came here to learn. Some of us come here only to work. . . . Why should I learn if I am going back to Mexico?" Years passed and procrastination on these thoughts stopped them from learning English. They also decided to remain in the United States for various reasons.

Now I will not go back to Mexico because all my children were born here. . . . They don't want them in the hospitals because they are Americans. . . . It is not a good place for raising children. . . . School year could be lost if changes are made.

**Need for more professional interpreters.** Both patient groups agreed that there is a need for more professional interpreters. Since they would like more detailed information about their health care and they felt interpreters summarized what the providers were trying to say, patients would appreciate formal training for health-care translators. Patients believed that translators did not always give them the exact meaning of what was said. They felt the translators did not translate the
words as they came from the doctors’ or nurses’ mouths; it was thought that translators narrated only the main points and that no details came through the translation. “It is not easy to translate all the words as they really are. The real meaning could be lost in the process of translation.” “They usually don’t explain as the doctors or nurses are speaking as we want them to explain us. I think the interpreter has to explain as it is supposed to be, not summarizing.”

I think that interpreters beyond their ability to be bilingual should be a trained person in the area they are supposed to be interpreting—someone more professional. It is not just the fact of translating a simple conversation, but if they are not familiar with medical terms or maybe they don’t even understand what doctors and nurses are talking about, then how they would attempt to tell us. They wouldn’t explain what we need to know. Those will probably be their own opinion[s] on what the medical professional want[s] to tell us.

Confidentiality. Patients felt embarrassed if providers used their children for translating confidential and personal topics. They felt confident with partners as translators, and they preferred no other family member unless it was an adult female. “I think the only family member would be my partner. I would feel confident and comfortable with him as a translator.”

Only 1 participant felt comfortable with her brother translating. One patient emphasized that even when she was forced by circumstances to use children as translators, she believed this practice was prohibited by law.

Possible solutions to the language barriers. All groups agreed that nurses as well as patients needed to learn Spanish and English as part of the solution to a language barrier. In addition to the methods that nurses were using (e.g.,
educational materials and videos), Spanish forms were also mentioned by patients and nurses. Only a few participants in all groups mentioned these forms, and the remaining participants thought these educational materials would be a good resource to help patients. The primiparous patient group and both nurse groups mentioned the electronic translator as a possibility (see Appendix H).

**Differences in Spanish-speaking patient group discussions.** For primiparous patients, this was their first experience as a mother and their first experience in a hospital. They felt this experience was very difficult and were afraid. They almost cried because they did not understand or speak English, they had haunting thoughts, and they wondered who was going to help them.

On the other hand, multiparous patients were afraid because of their own or their friends’ negative past experiences when interacting with non-Spanish-speaking providers. One of the patients reported being aware of a misdiagnosis when she went to a Spanish-speaking provider. Another felt hostility from one of the nurses caring for her.

Multiparous patients described the type of care they received as being superior to the care available in their own countries. Multiparous patients, however, would like to see formal hospital preparation of nurses by offering Spanish classes. Multiparous patients also like interpreters who are trained in the area in which they are to interpret to ensure that they are familiar with medical terms and to keep their opinions to themselves. Multiparous patients, when talking about using their children as translators, believed that it is illegal to do so.
The primiparous patients’ solution to the language barrier was somewhat different from the multiparous patients’ solution. They suggested hiring more bilingual nurses, using an English-Spanish dictionary, or using an electronic translator.

Common themes between Spanish-speaking patients and non-Spanish-speaking nurses. Both nurses and patients expressed having strong negative feelings when giving or receiving care in a different language. Feelings of helplessness and difficulty were described by nurses. Stress, desperation, and loneliness were described by patients.

Frustration was the common denominator for the four groups. Frustration came about because of not understanding and not being understood. The nurses felt frustrated at not being able to accomplish simple tasks in a normal period of time and at not being able to teach as thoroughly as they would teach an English-speaking patient. The patients’ frustration came from the providers’ inability to offer detailed information they wanted to receive about their condition and also from the amount of time they had to wait for answers to their questions and requests.

Ironically, both nurse and patient groups felt embarrassed about using their limited foreign vocabulary with each other. They were afraid of making mistakes and of being mocked. Both nurse and patient groups agreed that nurses as well as patients bear the responsibility for learning the predominant foreign language: Spanish for nurses and English for patients.
Both nurse and patient groups suggested strategies that included signs as a way to explain what they needed when a translator was not available. They also used family members as translators. Both felt most comfortable with the husband or significant other providing translation. Most of the nurses and all of the patients thought that using children as translators was inappropriate. All groups acknowledged situations of misunderstanding that caused confusion, dissatisfaction, and panic among patients as well as loss of productivity for nurses.

Different words were used to describe the nurses’ and patients’ feelings about the possibility of being better understood (e.g., safer, easier, more adequate, more comfortable, less stressed, and more confident). Patients indicated that their stay would have been more pleasant because conversations would have been possible. A common thought was that patients would feel better knowing nurses could do a better job and that they would feel safer.

Both nurses and patients agreed that patient-nurse interaction would be better if nurses learned Spanish and patients learned English. Neither the patients nor the nurses supported the idea that it was an imposition for nurses or patients to learn a different language. Three of the four groups agreed that an electronic translator would be an ideal solution. All of the groups expressed different ideas about the features of this translator. Some thought that a pocket-sized device would be very helpful; some preferred the type that when one enters or says a word in English, it automatically translates into Spanish. Some participants even went so far as to suggest that a computer expert enable the pocket translator for voice
recognition (see Appendix H).

Summary

Participants’ answers to demographic questionnaires were considered. Their answers were presented using descriptive analysis. The participants’ responses to the focus group discussions were analyzed according to their content considering their frequency, extensiveness, intensity, and internal consistency.

Responses were analyzed looking for similar patterns and differences. Major themes were identified through vertical and horizontal vertical analysis. First, each focus group was analyzed by itself. Then both nurse groups and both patient groups were analyzed separately. Finally, analysis across all focus groups was performed. Sample comments were cited for each major theme.

Findings of the study pointed to frustration and fear as the prevalent feelings when participants were facing health care in a different language. Both nurse and patient groups were embarrassed to use their limited foreign language skills. All participants narrated many misunderstanding situations due to language barriers and brought up confidentiality issues. “Assumptions” and “quality of interpreters” were isolated topics for nurse and patient groups, respectively.

Findings also revealed the need for participants to learn a foreign language and the possibility of using a pocket-size translator as possible solutions mentioned by the majority of participants. Demographic data were useful in making participants’ responses clearer for analysis and discussion of the findings.
CHAPTER 5

DISCUSSION

Introduction

This study focused on (a) examining thoughts, feelings, and perceptions of care and communication between Spanish-speaking patients and non-Spanish-speaking nurses and (b) identifying and exploring ways for nurses and health-care providers to overcome communication barriers. In this chapter, a discussion of the findings and conclusions are presented. The results are related to previous research on the language barrier with the Hispanic community in other parts of the United States. Recommendations for future research and implications for health-care providers are presented.

Discussion of Findings

Groups 1 and 2: Nurses

Research Question 1

Research Question 1 asked: What perceptions do nurses have regarding care for Spanish-speaking patients? It was found that nurses had predominantly negative perceptions of their interactions with Spanish-speaking patients. According to the survey, only 20% of both day- and night-shift nurses felt comfortable in interacting with them. Smith and colleagues (2001) conducted the only study that explored
health-care providers' perceptions of their interactions with Spanish-speaking patients. The similarities found among the providers' negative experiences with Spanish-speaking patients were frustration with language and continuity of care concerns. According to most of the nurses, a different language is perceived as a major barrier to giving the health care intended. "There is an obvious lack of education due to language barriers." Night-shift nurses felt compassion and empathy, and they hoped patients received the care they needed.

False assumptions can easily be made when language and culture represent a barrier for nurse-patient interaction. Day-shift nurses made many assumptions, most of which were not scientifically based. Night-shift nurses made assumptions only about trying to understand their patients' lack of English proficiency. Axner and Dupraw (1997) affirmed that some of the assumptions, when interrelated with knowledge of the patient's culture, could be appropriate; however, nurses must be cautious when generalizing and making an assumption a part of their assessment, especially when a translator is available.

Research Question 2

Research Question 2 asked: What barriers do nurses experience in providing care to Spanish-speaking patients? According to the survey and the focus groups, most of the nurses did not feel comfortable interacting with Spanish-speaking patients because of the language barrier. This fact could be due to a lack of adequate Spanish instruction. Survey results suggested that 50% of the day-shift nurses and 80% of the night-shift nurses had taken Spanish classes. The short-term
employees in the maternity unit had a higher percentage who were prepared with Spanish classes, which is excellent for these employees but worrisome for the long-term employees who remain at a disadvantage. This fact was corroborated by Smith and colleagues (2001). They recognized that language barriers are a major obstacle for patients and for their health-care providers as well.

Another way to measure the serious impact of language barriers is the evolution of misunderstanding or misinterpretation. A series of misunderstandings came up for the day-shift nurses, probably because most patients are awake and alert during the day. According to the described experiences, it can be concluded that a serious health problem could be missed due to the inability of the patient to express what she is feeling in a foreign language. Simple issues could also be misinterpreted as hazardous situations. For example, a simple request could be mistaken for a serious issue and take a significant portion of the provider's time to investigate. This last conclusion was also true for the only misinterpretation occurrence that the night-shift nurses reported.

These circumstances can, as Hayes (1995) and Gravely and Boyd (2001) reported, compromise care and make it inappropriate. This study's findings are consistent with Timmins's (2002) and Ratner's (2001) conclusions in which negative health outcomes such as making a misdiagnosis, prescribing inappropriate medications, and having an inaccurate perception of education were part of the impact of language barriers on provider-patient interaction. They indicated that language disparity can result in negative health-care consequences. Fortunately, in
this study, the misunderstanding situations did not completely compromise patients' health outcomes.

Research Question 3

Research Question 3 asked: What strategies are helpful in providing care to Spanish-speaking patients and their families? Day-shift and night-shift nurses shared many ideas on different strategies from short-term ideas to long-term and ambitious ideas. The present study's findings about the nurses' perceptions of what should be done are similar to those of Jones and colleagues' (1995) perceptions of the need for maternal-child nurses to deliver early, that is, to provide comprehensive and specialized teaching to prepare patients and families for appropriate quality home care. Some of the strategies were already in use and others needed implementation. Based on these ideas, one of the more prominent strategies was to have patients learn English and to make nurses learn better Spanish. Gravely and Boyd (2001) stressed the need for nurses to learn Spanish and also discussed encouraging nurses to direct patients to Spanish-speaking health-care providers as the most effective ways to reduce language barriers. The goal of learning Spanish is not difficult to achieve if it could be considered part of basic nursing training; after all, it is required by law to make accommodations for people who are not proficient in English ("Notices," 2000; Sullivan & Mattera, 1997; Timmins, 2002). This law is especially true for all federally financed institutions such as the University Hospital. In agreement with Timmins (2002), a summarized list of policies ("Notices," 2000) for providers caring for non-English-speaking
patients includes but is not limited to the following: Recipients of federal funds have an obligation to offer translation services at no cost to limited English proficiency (LEP) individuals. Recipients of federal funds need to have written policies for and staff awareness of the existence of such policies. Recipients need to provide written notices to clients in their primary language informing them of their right to receive interpreter services. Family and friends of LEP individuals should be asked to provide interpretive services only after alternative, no cost methods have been offered and the patients still choose family/friend interpretation. Minors should not be used to translate. Recipients need to ensure the availability of a sufficient number of qualified interpreters on a 24-hour basis. Interpreters need to be qualified and trained with demonstrated proficiency in both English and the other language, knowledge of specialized terms and concepts in both languages, and the ethics of interpreting.

Some of the translating resources used are questionable, and some nurses acknowledged it. Their answers were similar to comments about confidentiality and law (Carrasquillo et al., 1999; Foltz-Gray, 1998; Timmins, 2002). They agreed that nonhealth-care staff should not be used to interpret since they may not be able to interpret accurately, thus causing misinterpretation that can lead to misdiagnosis.

Gravely and Boyd (2001) and Timmins (2002) agreed with the perceptions of nurses in the present study about language line service operator's use. They believed that it is too impersonal and that there is a lack of sensitivity due to a lack of close interface interaction. In addition, Villarruel and colleagues (1999)
discussed the expense of this method and its inappropriateness when trying to exchange vital information in the absence of body language and facial expression. The nurses and the referenced authors agreed on language line service alternative use in case of emergency.

Foltz-Gray (1998) and Timmins (2002) inferred that family involvement in translation may cause a new set of problems from embarrassment at translating cultural details to omissions that may interfere with the provider’s accurate understanding of the patient’s medical history. Using child translators could violate patient confidentiality and cause role confusion. The findings of these studies concerning minimal use of family members as translators agreed with the perceptions of the authors about the omission of numerous health details needed and confidentiality issues.

Hiring more bilingual staff was one strategy nurses suggested. According to Hayes (1995), the presence of someone who speaks the same language may make an enormous difference during the encounter with the health-care professional and with the history that is subsequently obtained. Villarruel and colleagues (1999) and Timmins (2002) recommended, however, that bilingual staff should be sufficient in number to avoid overloading them with their assignments and translation responsibilities.

Another aspect mentioned by the nurses, Gravely and Boyd (2001), and Timmins (2002) was the use of educational materials. The authors implied that these materials can assist providers in the teaching process but not in the
information-gathering process. The authors suggested delivering educational materials at the appropriate time in order to avoid patient fatigue or stress due to inherent postdelivery status. They also mentioned the inability of use with illiterate patients.

The pocket translator or voice recognition translator mentioned by both nurse groups are probably not financially feasible. These instruments remain as a possibility for future use, however, as technology becomes more commonplace and reasonably priced according to the law of supply and demand. Villarruel and colleagues (1999) discussed the use of specialized computer software as most useful as an adjunct to patient teaching and as least useful in situations requiring open-ended questions. Timmins (2002) recognized that executing a strategy to overcome language barriers could present financial challenges. Some costs may be counteracted by the reduced expense of having an adequate language access system, thus eliminating the increased use of diagnostic tests and decreasing the loss of productivity when staff are pulled away from their usual job requirements to interpret.

Groups 3 and 4: Patients

Research Question 1

Research Question 1 asked: What perceptions do Spanish-speaking patients have when receiving care from a non-Spanish-speaking nurse? As this study’s results demonstrated, patients had predominantly suspicious and fearful opinions about their interactions with non-Spanish-speaking nurses. According to the
questionnaire, multiparous patients apparently would have less reason than primiparous patients to be apprehensive due to previous experience in a hospital setting since 60% of their previous offspring were born at the University Hospital. In addition, 75% of the multiparous patients had a family member who spoke English compared to only 43% of the primiparous patients’ family members. Foltz-Gray (1998) and Derose (2000) did not make a distinction between previous experiences at the hospital and the presence of English-speaking family members. However, they stated that because of the language barrier, patients may be unable to express basic needs such as hunger, fatigue, or thirst. Consequently, they may feel helpless and withdraw because of fear or shame. Timmins (2002), Hayes (1995), Foltz-Gray (1998), and Derose (2000) agreed and added that non-English-speaking patients already in an unfamiliar setting can feel frightened and uninformed about their care and also feel isolated socially and psychologically, which was the case for some of the participants who had never been in a hospital. They felt isolated, as significant others were not allowed to remain during surgical procedures or as they remained hospitalized for many days due to complications.

As for the literature reviewed, patients’ embarrassment at speaking English was a new finding. However, whether or not the patients were multiparous or primiparous, both groups felt embarrassment when speaking their limited English and also felt strong negative feelings when facing an English-speaking provider. This circumstance puts Spanish-speaking patients at a disadvantage when compared to English-speaking patients. Timmins (2002) reviewed studies in which solid
evidence was found that language barriers can produce a significantly detrimental quality of care.

I concur with Smith and colleagues (2001) and recognize that because interpersonal relationships are critical to Hispanic patients, as patients stated in this study, a need exists to better providers' Spanish skills that in turn will improve care and promote patients' healthy obstetrical outcomes.

Research Question 2

Research Question 2 asked: What barriers do Spanish-speaking patients perceive when receiving maternity care from a non-Spanish-speaking nurse? Barlow (2001) stated that the demographics of the Hispanic population make it a vulnerable group. The multiparous women's average number of children was not very high (2.5), but the average number of family members living at home and supported by the same income was 4.75 for multiparous patients and 3.7 for primiparous patients. When the family income was considered, it was found that 63.6% of all patients were living below the poverty level. There were 27.3% of patients \((n = 3)\) who were living above the poverty level, and 9.1% \((n = 1)\) did not give this information. Notwithstanding patients' financial status, none of them had medical insurance. This finding coincides with results ("Language Barriers Inhibit Care," 2003) that approximately 61% of Spanish-speaking Hispanics were medically uninsured during all or part of the year. The U.S. Census Bureau (2002) revealed somewhat similar percentages for the level of education among Hispanics. As the current study showed, 27% completed less than a 6th-grade education, and
the other 27% completed only a 6th- to 8th-grade education. Nationally 27%
completed less than a 9th-grade education. Nine percent completed between a 9th-
and 12th-grade education compared to 16% nationwide. Of the 36% of associate
degree graduates, the majority were primiparous patients; nationally this percentage
is 18%. No higher degrees of education were revealed.

The U.S. Census Bureau (2002) also revealed that the unemployment rate
for Hispanics is 8.1%. In the present study, there was only 1 case of
unemployment among the patients’ families. In 22.6% of Hispanic homes in the
United States, the female is the household provider; in the present study, this was
ture in only 1 case. Nationally Hispanics constitute 21.4% of the total population
living under the poverty level. As discussed earlier, 63.6% of the patients who
participated in this study are part of that national percentage provided by the U.S.
Census Bureau (2002).

Another disadvantage is the number of years of residency in the United
States. The U.S. Census Bureau (2002) determined that from the 15 million
(40.2%) Hispanics who were born in a foreign country, 52% entered the United
States between 1990 and 2002. In the present study, 57% of primiparous and 25%
of multiparous patients had resided in the country for less than 2 years. According
to Spector (2000), it usually takes three generations to be assimilated and to speak
English fluently and without an accent.

Foltz-Gray (1998) stated that when caretakers do not share the language of
those for whom they provide care, misunderstandings can occur. Patients in this
study reported a series of misunderstandings. The described experiences suggest that dissatisfaction builds when a nurse's actions conflict with a patient's request. Imposing a treatment when the patient has denied the need for it can be frustrating and could generate mistrust of the provider's care. In addition, an insufficient explanation of the patient's health condition can cause the patient confusion. It has been observed that simple tasks can take longer to accomplish. It has also been noted that both patients and nurses can panic in a critical situation if insufficient data are gathered from the patient. Patients can perceive nurses as being rude if after patients decline services, the nurses provide them anyway. Those same patients could later feel intimidated and anxious about asking for a needed service if they perceive a negative attitude on the part of nurses. Patients sometimes feel that nurses take advantage of their position of power and discriminate against Spanish-speaking patients by providing inadequate or improper treatment. When providers attempt to speak Spanish, a literal translation of Spanish and English words can cause confusion for patients. Complications can arise when problems are underdiagnosed or misdiagnosed due to the language barrier.

Research Question 3

Research Question 3 asked: In what ways do Spanish-speaking patients feel the care received from non-Spanish-speaking nurses could be improved? The quality of service patients received in the hospital was exceptional, excluding a few situations mentioned previously. Patients affirmed this finding when comparing the type of previous service they had received in their countries of origin. This finding
conflicts with those of Timmins (2002) and Carrasquillo and colleagues (1999). Their findings suggested that language barriers caused decreased patient satisfaction when the patients’ health goals were not met. These findings also conflict with those of Smith and colleagues (2001). They supported this conclusion with a poststudy survey of the same patients that utilized the assistance of a Spanish-speaking interviewer.

Foltz-Gray (1998) and Carrasquillo and colleagues (1999) affirmed that a patient may not want to confide his or her medical problems to a stranger who is not involved in the medical field, thus supporting the present study’s findings on patients’ negative responses to occasional translators. They also disagreed on having patients’ children translate personal topics as Timmins (2002) had recommended.

Research Question 4

Research Question 4 asked: How do Spanish-speaking patients think their communication with non-Spanish-speaking nurses could be improved? According to Timmins (2002) and Russell and McCammon (1995), Spanish educational materials are available for patients at no cost other than making copies of the original documents. The possession of these materials is what some of the patients recalled as the strategies used by nurses in this study. Other patients acted and verbalized as if they never heard of these educational materials. I have encountered patients who had a quantity of written materials but who had no idea what they were for. Even though this was not mentioned in the patient group discussions, Jones and
colleagues (1995) indicated that most Spanish materials are written in the Mexican Spanish dialect, which has considerable differences from the Spanish dialects used in other Latin countries. The forms should be adapted for use by patients speaking any Spanish dialect.

It was affirmed that a professional interpreter needs specific training in medical interpretation, patient confidentiality, and cultural sensitivity ("Notices," 2002; Timmins, 2002). This concept is congruent with the patients' opinions about interpreters in the current study. Timmins (2002) identified five common errors committed by untrained interpreters: (a) omission (partial or complete deletion of the message), (b) addition (information not expressed by the clinician), (c) condensation (simplifying and summarizing), (d) substitution (replacing contents), and (e) assuming the role of the interviewer (interpreter takes over and replaces the provider's questions with his or her own questions). The patients in this study complained about most of these behaviors and knew they occurred because family members or roommates who spoke English told them so.

According to Timmins (2002) and Foltz-Gray (1998), well-trained bilingual health-care professionals and trained interpreters are the two major strategies used across the United States to bridge communication gaps. These strategies are also desirable from the patients' point of view.

Among the possible solutions to language barriers, patients also suggested, as if money were not an obstacle, the pocket translator as a tool to bridge language barriers in the hospital setting. They agreed with 1 participant's comment. "One
feels good when someone else speaks your own language and you can better understand.”

One of the solutions agreed upon by most patients was to learn English. No literature reviewed commented on this topic except a study on a Latino mental health group that had a strong commitment to and placed a high value on their group goal of learning English as a second language (Carpinello, 1995).

Implications for Registered Nurses and Other Health-care Providers

Timmins (2002) and Smith and colleagues (2001) indicated that language disparity can result in health-care consequences. Smith and colleagues emphasized the importance of improving the providers’ Spanish skill to enhance care and to promote healthy obstetrical outcomes. Nurses can incorporate the approaches found in this work if they want to promote greater satisfaction and healthier outcomes. Understanding the backgrounds, opinions, feelings, and thoughts of Spanish-speaking patients can lessen nurses’ prejudgment about their patients’ inability to understand or speak English. In the same way, if patients understand how nurses feel and what they do to make patients feel better, they would feel more comfortable. The negative feelings mentioned in this study would likely ease, and cooperation would increase. Appendix G illustrates the patients’ and nurses’ opinions that must interrelate in order to effectively implement interpersonal and innovative strategies that will affect existing language barriers between patients and their providers.
Educative and supportive roles are essential parts of nursing. Language barriers tend to frustrate efforts to comply with these roles. The patients' and nurses' common responses suggest some ideas to overcome the obstacles (see Appendix G). Those aspects of overcoming language barriers that patients have identified as helpful in an effort to gain a better understanding and, consequently, better health care are also outlined in Appendix G.

The findings of this study suggest that Spanish-speaking patients and nurses value interactive communication. A majority of participants in all groups are willing to actively engage in improving their foreign language skills. This study provides needed reinforcement of their efforts. The overall goal for nurses would be to participate with patients regarding their care, to provide patients with the necessary information about nurses' capabilities and expectations in the patients' language, and, as much as possible, to comply with suggestions offered by patients. These goals are compatible with patients' desires, which should ease the burden and lessen the misunderstandings created in this interaction process.

Nurses can implement supportive and educative tasks to facilitate the aspiration of patients to have a positive health-care experience and positive health outcomes. One way to help Spanish-speaking patients could be to identify a low-cost local school at which they can learn English as a second language and then encourage them to attend. Another way to help them could be to make changes in hospital policies to accommodate family members remaining with patients when they must remain in the hospital for a longer than expected time.
Evenly shifting work schedules could be encouraged so that interpreters and bilingual staff would be available over a 24-hour period. Educational material and videos could be updated for patients’ current needs, as nurses and patients requested in the present study. Community clinics could consider organizing preparation for parenthood classes that include culturally appropriate health education programs for ethnic minority groups of women.

**Limitations of the Study**

Limitations of the study include a small sample size and homogeneity pertinent to a purposive sample that prohibits generalization to other settings; however, this type of sample was necessary according to the qualitative nature and purpose of the study. Another limitation was that 2 participants in the nurse groups knew the assistant moderator in the role of a teacher; their responses may have been influenced by this previous relationship. Both of these participants, however, were strongly engaged in the topic when expressing their opinions. For some of the night-shift nurses, having to share their perspectives after their night-shift work may have prevented an enthusiastic expression of their opinions.

This study was limited to the Hispanic population and, therefore, could not be generalized to other ethnic groups. Although other ethnic groups likely face similar difficulties as the population in the present study, these results could not be applied to them.
Recommendations for Further Research

Based on these and other research findings, there is a need for quantitative research to examine the role of language barriers in health outcomes and health-care costs. One recommendation, the pocket translator, could be used to plan and implement strategies needed for some of the idealistic and optimistic suggestions from nurses and patients in defeating language barriers.

Participants in this study identified various resources available in their unit such as Spanish forms, Spanish medication labels, videos, language line services, off-site interpreters, and Spanish packets of information (which were not in use). Differences were found in the patients' and nurses' groups regarding their knowledge of these resources. Therefore, a quantitative study could be conducted to determine the resources available, to identify resources that are preferred, and if resources are not used, to identify the reasons for nonuse.

This study retrieved data showing that patients' health care was or was almost compromised due to language barriers. A retrospective meta-analysis and a prospective study on the rate of complications that could be avoided if the language barrier was overcome would be interesting and useful in obtaining better patient health outcomes.

Conclusions

This study is important for nurses and health-care providers when patients and nurses are able to express their sincere opinions about their feelings and possible solutions. The more the choices come from those affected, the more
accurate and genuine the perceptions and solutions become.

Despite the fact that literature on language barriers was available, the literature was limited in the postpartum setting. The present study contributes to the research body with qualitative data elicited through focus groups’ discussions.

This research study is unique in the effectiveness of data collection inherent to focus groups. The similarity of participants’ experiences and a familiar group setting made them feel free to share their opinions in a way in which discussion was fomented and a variety of equivalent and opposing points of view were debated. Such data were rich enough to bring forward conclusions and recommendations that, if implemented, could change the way English-speaking nurses and Spanish-speaking patients feel at their mutual interaction and assure healthy outcomes for patients.

This study will be a positive addition to the existing literature and a suitable part for building up more knowledge-related research. The development of quantitative research that would generalize to other settings could be considered.
APPENDIX A

OPERATIONAL DEFINITIONS
**Competent interpreter** is a medically trained interpreter who can provide a higher level of accuracy and confidentiality and who is aware of the patient’s cultural differences.

**Content analysis** is the process of organizing and integrating narrative, qualitative information according to emerging themes and concepts. It is also a procedure for analyzing written or verbal communication in a systematic fashion with the goal of quantitatively measuring variables.

**Descriptor** is a descriptive summary of each section of the focus groups’ responses.

**Extensiveness of comments** reveals how many people gave the same or similar comment.

**Frequency of comments** reveals how often the comment was shared.

**Horizontal analysis** occurs when common issues from among the focus groups are reported.

**Intensity of comments** reveals the strength of the opinion.

**Internal consistency** occurs when participants keep their position on the comments they share.

**Monolingualism** is the ability to speak and understand only one language.

**Multiparous** is any woman who has more than one child and who has past experiences taking care of newborns.

**Nurse** is a registered nurse or licensed practical nurse who is in contact with patients and who has the unique responsibility of his or her health education.
Primiparous is any woman who has delivered only one child and who has never had previous experiences with newborns.

Purposive sampling is a sampling strategy in which the researcher selects subjects who are considered to be typical of the population.

Vertical analysis occurs when issues voiced by each group are discussed separately.
Introductory Text

Welcome, my name is Monica (a graduate student at the University of Utah), and I will be conducting the discussion group. This is my assistant ________. I will be asking you for your opinions on an important health-care issue. The group discussion is informal and anyone may speak with anyone else, including me (the moderator). There are no right or wrong answers; I would like to hear your honest thoughts and opinions.

The group itself will take 1 hour 15 minutes. The tape recording is to help me remember what was said. Your name will not be used in association with any of your responses.

I would like to start with the first question, and I would like to hear from everyone.

Debriefing Text

Thank you for your participation. This study will be used to identify language barriers and suggest ways to improve patient care.

Again, your name will not be used in association with your responses. Your ideas along with responses from three other discussion groups will be analyzed together to make recommendations. If there is a related topic or question you believe may have been worthwhile to discuss, please let me know now.

To thank you for your time, I have a small gift. Thanks again for your help.
APPENDIX C

PARTICIPANTS’ CONSENT FORMS
Consent Form: Nurse

Background

The purpose of this study is to get a sense of what Spanish-speaking patients and their nurses experience during the communication process while hospitalized in the maternity unit at the University of Utah Hospital. You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with your friends and relatives if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you volunteer to take part in this research study.

Study Procedure

This study explores your experiences giving health care in a different language in order to understand this process and to try to improve our services in the future. Your participation will consist of attending one 2-hour discussion group in which you will be asked to voice your opinions, perceptions, and expectations regarding patient care services at 2 North, University of Utah Hospital’s in-patient maternity care unit.

The purpose of the group discussion is to obtain your viewpoints, and there are no right or wrong answers. The role of the moderator is to manage the group interaction so that everyone feels free to voice their opinions openly without feeling intimidated or feels free to withhold their responses.

This session is being audiotaped for use in analyzing the responses. The data collected for the discussion may be used for evaluation of services by the University of Utah Hospital and possibly as part of a published article.

Risks

The only foreseeable risk to you is feeling uncomfortable voicing opinions during the session. Even though the moderator may call upon you for a response, it is perfectly acceptable to choose not to respond.
Benefits

A perceived benefit from you taking part in this study is that your thoughts and feelings as a caregiver in a different language will be understood. We hope that the information we get from it may help us in developing new or better ways to overcome language barriers.

Alternative Procedures

You may choose to participate in the research study or you may choose to remain as a backup participant—in case we need you due to late cancellations. The other alternative is to choose not to participate in the study.

Confidentiality

We will keep all research records that identify you private to the extent allowed by law. Results of the study may be shared with the maternity unit staff at the University of Utah Hospital or they may be published; however, your name and other identifying information along with individual responses will be held strictly confidential.

Person To Contact

If you wish to discuss anything related to this study, you may call Monica Sanchez, RN, BSN, the investigator, at 582-1241 at any time.

Institutional Review Board

If you have questions regarding your rights as a research subject, or if problems arise that you do not feel you can discuss with the investigator, please contact the Institutional Review Board office at (801)581-3655.

Voluntary Participation

You understand that participation in this study is entirely voluntary and that you may withdraw from participation prior to or at any time during this session. If you do decide to take part, you will be asked to sign a consent form. Withdrawal will not cause any future adverse effects on you or your family receiving care or in your job as a caregiver at the University of Utah Hospital nor will it affect the
relationship you have with the investigator. You may withdraw from the study at any time without penalty and without giving any reason.

**Unforeseeable Risks**

The focus group session may involve risks to participants that are currently unforeseeable, but researchers will do their best to overcome them if any.

**Right of Investigator To Withdraw**

The researchers can withdraw you without your approval; if so, you will be informed. The only possible reason to withdraw would be overrecruitment.

**Costs to Subjects and Compensation**

There is no cost to you for participating in this study other than your time for staying after your scheduled work shift or coming earlier than your scheduled work shift. No funds have been set aside for any health problem event while participating in the sessions; if you think it is necessary, you may want to check with your health insurance. Nonetheless, we anticipate a positive uneventful afternoon. At the opening of this group discussion, refreshments will be served. As a token of our gratitude, your time spent in this session will be compensated and paid as part of your hourly salary by your employer.

**Number of Subjects**

We expect to enroll approximately 8 to 10 people for each one of the four discussion groups. Each one of you will be placed in a group with similar backgrounds/experiences in giving health care at the University of Utah Hospital.

**Consent**

I confirm that I have read and understand this consent document and have had the opportunity to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time and without giving any reason, without employment or legal rights being affected. I will be given a signed copy of the consent form to keep.
I agree to participate in this research study as you have explained in this document.

Participant’s Name

---------------------------------------------------------
Participant’s Signature  Date

---------------------------------------------------------
Name of Person Obtaining Consent

---------------------------------------------------------
Signature of Person Obtaining Consent  Date
Consent Form: Patient

Background

The purpose of this study is to get a sense of what Spanish-speaking patients and their nurses experience during the communication process while hospitalized in the maternity unit at the University of Utah Hospital. You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with your friends and relatives if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you volunteer to take part in this research study.

Study Procedure

This study explores your experiences receiving health care in a different language in order to understand this process and to try to improve our services in the future. Your participation will consist of attending one 2-hour discussion group in which you will be asked to voice your opinions, perceptions, and expectations regarding patient care services at 2 North, University of Utah Hospital’s in-patient maternity care unit.

The purpose of the group discussion is to obtain your viewpoints, and there are no right or wrong answers. The role of the moderator is to manage the group interaction so that everyone feels free to voice their opinions openly without feeling intimidated or feels free to withhold their responses.

This session will be audiotaped for use in analyzing the responses. The data collected for the discussion may be used for evaluation of services by the University of Utah Hospital and possibly as part of a published article.

Risks

The only foreseeable risk to you is feeling uncomfortable voicing opinions during the session. Even though the moderator may call upon you for a response, it is perfectly acceptable to choose not to respond.
Benefits

A perceived benefit from you taking part in this study is that your thoughts and feelings as a care receiver in a different language will be understood. We hope that the information we get from it may help us in developing new or better ways to overcome language barriers.

Alternative Procedures

You may choose to participate in the research study or choose to remain as a backup participant—in case we need you due to late cancellations. The other alternative is to choose not to participate in the study.

Confidentiality

We will keep all research records that identify you private to the extent allowed by law. Results of the study may be shared with the maternity unit staff at the University of Utah Hospital or they may be published; however, your name and other identifying information along with individual responses will be held strictly confidential.

Person To Contact

If you wish to discuss anything related to this study, you may call Monica Sanchez, RN, BSN, the investigator, at 582-1241 at any time.

Institutional Review Board

If you have questions regarding your rights as a research subject, or if problems arise that you do not feel you can discuss with the investigator, please contact the Institutional Review Board office at (801)581-3655.

Voluntary Participation

You understand that participation in this study is entirely voluntary and that you may withdraw from participation prior to or at any time during this session. If you do decide to take part, you will be asked to sign a consent form. Withdrawal will not cause any future adverse effects on you or your family receiving care at the University of Utah Hospital nor will it affect the relationship you have with the
investigator (if applicable). You may withdraw from the study at any time without penalty and without giving any reason.

**Unforeseeable Risks**

The focus group session may involve risks to the participants that are currently unforeseeable, but researchers will do their best to overcome them if any.

**Right of Investigator To Withdraw**

The investigators can withdraw you without your approval; if so, you will be informed. The only possible reason for withdrawal would be overrecruitment.

**Costs to Subjects and Compensation**

There is no cost to you for participating in this study, with the exception of transportation to the location where groups will be held. Child care will not be provided, and we ask you to make the necessary arrangements in advance for your 2-hour participation. No funds have been set aside for the health problem event while participating in the sessions; if you think it is necessary, you may want to check with your health insurance. Nonetheless, we anticipate a positively uneventful evening. At the opening of this group discussion, refreshments will be served, and at the conclusion of it, you will receive a $10 gift certificate to a local grocery store.

**Number of Subjects**

We expect to enroll approximately 8 to 10 people for each of the four discussion groups. Each of you will be placed in a group with similar backgrounds/experiences in giving/receiving care at the University of Utah Hospital.

**Consent**

1. I confirm that I have read and understand this consent document and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my medical care or legal rights being affected.

3. I agree to participate in this research study, and I understand I will be given a signed copy of the consent and authorization form to keep.

Participant’s Name

Participant’s Signature Date

Name of Person Obtaining Consent (Researcher/Assistant)

Signature of Person Obtaining Consent Date
Formulario De Consentimiento

Antecedentes

El propósito de este estudio es tener una idea de lo que las pacientes que hablan Español y sus enfermeras experimentan durante el proceso de comunicación. Se le invita a tomar parte en un estudio de investigación. Antes de que usted decida, es importante que comprenda la razón por qué se está llevando a cabo esta investigación, y lo que consiste. Haga el favor de leer detenidamente la siguiente información y de discuítirla con amigos y los familiares si así desea. Pregúntenos si hay algo que no esté claro o si es que desea más información. Sirvase hacer su decisión con calma de ofrecerse como voluntario o no a fin de tomar parte en este estudio de investigación.

Procedimiento Del Estudio

Este estudio explora sus experiencias al recibir cuidados de salud en un idioma diferente al suyo para poder entender este proceso y tratar de mejorar nuestros servicios en el futuro. Su participación consistirá en atender a una reunión grupal por 2 horas. En esta, se le pedirá expresar sus opiniones, percepciones y expectativas acerca del cuidado de las pacientes en la unidad de maternidad de la Universidad de Utah.

El propósito de esta reunión de grupo es obtener sus puntos de vista; no hay respuestas correctas o incorrectas. El rol del moderador es manejar los comentarios de las participantes de manera que todos se sientan libres de expresar abiertamente sus opiniones sin sentirse intimidadas o que se sientan libres de no expresar sus respuestas si les parece pertinente.

Esta reunión será grabada en cintas de audio para analizar sus respuestas en el futuro. La información obtenida en los grupos podría ser utilizada para evaluar los servicios dados por el Hospital de la Universidad y posiblemente como parte de un artículo de publicación.

Riesgos

El único riesgo que se puede percibir es que usted se sienta incomoda dando a conocer sus opiniones durante la reunión de grupo. Entienda que aun cuando el moderador o jefe de grupo le pida que responda a una pregunta, es perfectamente aceptable no responder si así lo decide.
Beneficios

El beneficio que se percibe al tomar parte de este estudio, como persona que recibe cuidados de salud en un idioma diferente al suyo, es que otras personas comprenderán sus pensamientos y sentimientos. Por lo que esperamos que la información que obtendremos de estas sesiones grupales puedan ayudarnos a desarrollar nuevas o mejores formas de sobrellevar barreras de idioma.

Procedimientos Alternativos

Usted puede escoger participar en el estudio o de lo contrario mantenerse como posible participante—en caso de que hayan cancelaciones de ultimo minuto. La otra alternativa es escoger no participar en el estudio.

Confidencialidad

Mantendremos confidenciales y privados todos los registros que le identifican. Es posible que se publiquen los resultados de este estudio o se presenten al personal de enfermería de la unidad de Maternidad del Hospital de la Universidad de Utah; sin embargo, se mantendrán privados su nombre y cualquier otra información que le pudiese identificar

Persona A Quien Se Puede Contactar

Si usted desea conversar sobre cualquier asunto relacionado con este estudio, usted puede llamar en cualquier momento a Monica Sanchez RN BSN, la investigadora, al teléfono 582-1241.

Institutional Review Board (Consejo De Revisión Institucional)

En caso de que usted tenga preguntas en cuanto a sus derechos como sujeto de investigación o que surjan problemas de los cuales usted no siente que puede discutir con los investigadores, sírvase contactar con el Institutional Review Board (Consejo de Revisión Institucional) de la Universidad de Utah al (801)581-3655.
Participación Voluntaria

La decisión de tomar parte o no en este estudio es suya. Si usted decide tomar parte se le pedirá que firme un formulario de consentimiento. Aunque decide tomar parte, usted es libre de dejar de participar en cualquier momento sin dar una razón. Esto no causará ningún efecto adverso ni afectará la relación que tiene con el investigador, el personal, ni el cuidado habitual que usted y su familia ya reciben.

Riesgos Imprevisibles

La reunión en sí, podría envolver riesgos para los participantes que actualmente no se pueden percibir. Sin embargo los investigadores harán lo mejor para sobrellevarlos si es que ocurrieran.

Derecho Del Investigador A Retirar Al Sujeto

Usted puede dejar de tomar parte en el estudio en cualquier momento sin penalidad alguna. El equipo de investigación puede retirarla del estudio sin que usted lo haya aprobado previamente. La única razón posible por la que podría ser retirada del estudio es que se sobrepase el número de participantes necesarios.

Compensaciones Y Costos Para Los Sujetos

No hay costo alguno por participar en este estudio con la excepción del transporte hacia el lugar donde los grupos se llevaran acabo. Además, el cuidado de los niños no se proveerá por lo que les pedimos que hagan los arreglos necesarios con anticipación a fin de que puedan participar por las 2 horas requeridas en el grupo. No se han apartado fondos para problemas de salud que pudieran surgir durante su participación, talvez querrían consultar con su seguro medico o aseguranza. Sin embargo, anticipamos positivamente una noche sin dificultades. Al principio de esta reunión se servirán bocaditos y al término de la discusión grupal, usted recibirá una un certificado de regalo de 10 dólares para obtener productos en una tienda de abarrotes cercana a su domicilio.

Numero De Sujetos

El equipo de investigación espera reunir de 8 a 10 participantes por cada uno de los 4 grupos. Usted será ubicada en un grupo que tenga similares experiencias a las de usted en cuanto al cuidado recibido en el Hospital de la
Universidad.

Consentimiento

Sírvase marcar la casilla con sus iniciales

1. Yo confirme que he leído y comprendido este formulario de consentimiento y que he tenido la oportunidad de hacer preguntas.

2. Yo entiendo que la participación mía es voluntaria y que tengo la libertad de retirarme en cualquier momento, sin dar razón alguna, sin que mi cuidado médico o mis derechos legales se vean afectados.

3. Estoy de acuerdo en tomar parte en el estudio antemencionado y que se me dará una copia firmada del formulario de consentimiento para guardar.

Nombre del Participante

__________________________  ____________________
Firma del Participante       Fecha

Nombre del Investigador o Personal Asistente

__________________________  ____________________
Firma del Investigador o persona asistente  Fecha
APPENDIX D

FOCUS GROUP QUESTIONS FOR PATIENTS
1. When you think about receiving care after delivery at the hospital, what type of things come to mind?
2. What was it like to be under the care of a non-Spanish-speaking nurse?
3. How did you feel when nurses and doctors did not speak Spanish? What were your concerns?
4. What type of things do you do when you do not understand nurses and doctors?
5. What things did nurses and doctors do to help you understand what they are saying?
6. How would you feel if you could better understand what your nurses and doctors are telling you?
7. What could nurses and doctors who do not speak Spanish do to improve their communication with you?
8. Do you have any other thoughts and feelings?
APPENDIX E

FOCUS GROUP QUESTIONS FOR NURSES
1. When you think about caring for Spanish-speaking patients, what things come to mind?

2. What is it like to take care of Spanish-speaking patients when there is no translator available?

3. How do you feel when interacting with Spanish-speaking patients?

4. What do you do to overcome your concerns?

5. What are the strategies you use to overcome the language barrier?

6. How would you feel if you were better understood by your Spanish-speaking patients?

7. What type of things could be done to improve communication with these patients?

8. Do you have any other thoughts or feelings?
APPENDIX F

DISCUSSION GROUP QUESTIONNAIRES

FOR PARTICIPANTS
Discussion Group Questionnaire: Nurses

Please answer the following questions to help us understand the discussion group participants as a whole. No names please.

1. How long have you been working as a maternity (obstetric/gynecologic) nurse?
   _____ Years _____ Months

2. Have you had any Spanish classes to help you communicate with Spanish-speaking patients?
   _____ Yes (specify): ____________________________
   _____ No

3. On a scale of 1 to 5, how comfortable are you caring for Spanish-speaking patients? (circle one number)
   1 Very uncomfortable
   2 Uncomfortable
   3 Neither
   4 Comfortable
   5 Very comfortable

4. Which shift would you primarily work? (check one)
   _____ Day shift
   _____ Night shift
   _____ Other (specify): ____________________________

5. Other comments:
   _______________________________________________________
   _______________________________________________________
   _______________________________________________________

Thank you for your time. Please hand the completed survey to the discussion leader or assistant.
Discussion Group Questionnaire: Patients

Please answer the following questions to help us understand the discussion group participants as a whole. No names please.

1. What was your age at your last birthday?
   ____ years old

2. How many living children do you have?
   ____ # of children

3. How many children have you delivered at the University of Utah Hospital?
   ____ # of children

4. At your most recent delivery, did you have an English-speaking family member helping you during your hospital stay?
   ____ Yes (relationship to you): ________________________________
   ____ No

5. Check the highest level of school you have completed.
   ____ No formal schooling
   ____ Less than 6th grade
   ____ 6th to 8th grades
   ____ 9th to 12th grades
   ____ Technical trade school
   ____ Some college
   ____ Graduate college
   ____ Postgraduate

6. How many family members live in your household (including children)?
   ____ # of family members

7. What was your total weekly household income (for your family) last year before taxes? If unsure, estimate the amount.
   $ _________ (dollars)

8. Do you have medical insurance?
   ____ Yes (indicate type): ________________________________
   ____ No

9. How long have you lived in the United States?
   ____ # of years   ____ # of months
10. Other comments:

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Thank you for your time. Please hand the completed survey to the discussion leader or assistant.
Questionario Para Participantes Del Estudio

Por favor responda las siguientes preguntas, las que nos ayudaran a entender a los participantes de este estudio. No escriba su nombre por favor.

1. Cuantos años tenia en su último cumpleaños?
   _____ años de edad

2. Cuantos hijos vivos tiene Ud?
   _____ # de hijos

3. De cuantos niños se alivio en el Hospital de la Universidad?
   _____ # de niños

4. En su mas reciente alumbramiento (alivio), tuvo Ud. algún miembro de la familia que hablara Ingles a su lado para ayudarle?
   _____ Si (como esta relacionado a Ud?) ________________________
   _____ No

5. Marque el mas alto nivel de Educacion que Ud. ha completado.
   _____ No fue al colegio
   _____ Menos que 6to grado
   _____ 6to a 8vo grado
   _____ 9no a 12avo grado
   _____ Escuela Técnica
   _____ Parte de la Universidad
   _____ Graduada de la Universidad
   _____ Postgraduado

6. Cuantos miembros de la familia viven en casa? (incluya a los niños)
   _____ # de miembros de la familia

7. Cuanto fue la entrada de dinero aproximada para toda su familia el ano pasado antes de descontar los impuestos. Si no esta segura, podría estimar la cantidad o poner la cantidad semanal. (opcional, pero ayudaria mucho saberlo)
   $ __________ (dólares)

8. Tiene Ud. aseguranza medica?
   _____ Si (indique cual): _______________________________
   _____ No
9. Hace cuanto tiempo vive en los Estados Unidos?
   _____ # de años
   _____ # de meses

10. Otros comentarios:

    ______________________________________
    ______________________________________
    ______________________________________
    ______________________________________
APPENDIX G

ANALYSIS OF MAJOR THEMES
Table 3

Day-shift Nurses’ Comments

<table>
<thead>
<tr>
<th>Major themes</th>
<th>Frequency</th>
<th>Extensiveness</th>
<th>Intensity</th>
<th>Internal consistency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong feelings</td>
<td>30</td>
<td>10/10</td>
<td>Moderate → intense</td>
<td>High</td>
</tr>
<tr>
<td>Nature of service</td>
<td>5</td>
<td>3/10</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Misunderstandings</td>
<td>3</td>
<td>3/10</td>
<td>Moderate → intense</td>
<td>High</td>
</tr>
<tr>
<td>Patient’s responsibility</td>
<td>8</td>
<td>6/10</td>
<td>Moderate → intense</td>
<td>High</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>13</td>
<td>9/10</td>
<td>Moderate → intense</td>
<td>Medium</td>
</tr>
<tr>
<td>Assumptions</td>
<td>8</td>
<td>5/10</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>

Table 4

Night-shift Nurses’ Comments

<table>
<thead>
<tr>
<th>Major themes</th>
<th>Frequency</th>
<th>Extensiveness</th>
<th>Intensity</th>
<th>Internal consistency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong feelings</td>
<td>40</td>
<td>5/5</td>
<td>Moderate → intense</td>
<td>High</td>
</tr>
<tr>
<td>Nature of service</td>
<td>3</td>
<td>2/5</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Misunderstandings</td>
<td>1</td>
<td>1/5</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Patient’s responsibility</td>
<td>3</td>
<td>2/5</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>6</td>
<td>4/5</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Assumptions</td>
<td>7</td>
<td>3/5</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>
Table 5

**Primiparous Patients’ Comments**

<table>
<thead>
<tr>
<th>Major themes</th>
<th>Frequency</th>
<th>Extensiveness</th>
<th>Intensity</th>
<th>Internal consistency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong feelings</td>
<td>33</td>
<td>7/7</td>
<td>Moderate → intense</td>
<td>High</td>
</tr>
<tr>
<td>Nature of service</td>
<td>12</td>
<td>5/7</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Misunderstandings</td>
<td>4</td>
<td>4/7</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Patient’s responsibility</td>
<td>3</td>
<td>3/7</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Quality of interpreters</td>
<td>3</td>
<td>3/7</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>

Table 6

**Multiparous Patients’ Comments**

<table>
<thead>
<tr>
<th>Major themes</th>
<th>Frequency</th>
<th>Extensiveness</th>
<th>Intensity</th>
<th>Internal consistency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong feelings</td>
<td>23</td>
<td>4/4</td>
<td>Moderate → intense</td>
<td>High</td>
</tr>
<tr>
<td>Nature of service</td>
<td>10</td>
<td>4/4</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Misunderstandings</td>
<td>6</td>
<td>4/4</td>
<td>Moderate → intense</td>
<td>High</td>
</tr>
<tr>
<td>Patient’s responsibility</td>
<td>7</td>
<td>2/4</td>
<td>Moderate → intense</td>
<td>High</td>
</tr>
<tr>
<td>Quality of interpreters</td>
<td>5</td>
<td>4/4</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>5</td>
<td>4/4</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>
APPENDIX H

POSSIBLE SOLUTIONS TO OVERCOME

LANGUAGE BARRIERS
Patients’ and nurses’ opinions on possible solutions to overcome language barriers.
REFERENCES


