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The Effects of Language Barriers with Hispanic Patients in the Nashville

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Senior Honors Thesis: The Effects of Language Barriers with Hispanic Patients in the Nashville Area

Rachel Poston

Belmont University

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Abstract

The existence of language barriers in the health care setting is a vital topic of study. This study assesses language barriers from the perspective of nurse-patient relationships, focusing on the Hispanic patient population in the Nashville, Tennessee area. A survey was designed using the *Theory of Bureaucratic Caring* by Marilyn Ray (2006) to investigate the current success, according to nursing perspectives, of healthcare facilities support of Hispanic patients to ensure quality outcomes and comprehension of care. The research design for this study was a non-experimental, descriptive study using a cross-sectional survey. The researcher used themes from the *Theory of Bureaucratic Caring* as a framework to construct the survey questionnaire. The results demonstrated that this study sample of nurses believe their facility successfully ensures quality outcomes for their patients with language barriers but does not ensure the comprehension of care for their Hispanic patients. The results demonstrate a need for further support of cultural competency of health care personnel and support for increased health literacy among the patient population.

Introduction

As a nursing student, the investigator has extensively studied the dynamic nature of the relationship between nurse and patient. There are a multitude of factors that contribute to the holistic care of a patient. In the clinical setting, the investigator has experienced first-hand the struggle when difficulties impede fully holistic care. The investigator recalls the care of a patient that spoke hardly any English who was relying heavily on younger family members to translate information from the doctors and nurses. The investigator understood enough Spanish to communicate on a very basic level, but it was difficult to complete a task as simple as explaining the medications being administered or assessing pain level and quality. The nurse overseeing the investigator shared her concern that this patient was not fully aware of the extent of the health situation. The family's decisions about treatment plans moving forward were completely dependent on their knowledge of the situation, so lack of understanding changed the family's perceptions and choices. The thought that a patient may not comprehend the severity or extent of any health concern they have, simply because they cannot communicate effectively with their medical team, shocked the investigator and has driven an interest in this topic.

The issue of language barriers in healthcare settings has been identified and examined for years. Researchers David & Rhee (1998), Timmins (2002), Thompson, Parrot & Nussbaum (2011), Papic, Malak & Rosenberg (2012), Meeuwesen (2012), and Lee et.al. (2017) have attempted to understand the prevalence of cases, attitudes surrounding the situations, and methods to draw attention and target the issues to improve care. In this thesis, the investigator will explore the research question: In Nashville, Tennessee, how effectively do nurses believe healthcare facilities work with Spanish-speaking patients seeking care to ensure comprehension and quality outcomes? The population of interest will be nurses working with native Spanish

speakers, as Spanish is one of the most prevalent foreign languages spoken in the United States. This research contributes to the existing body of research by focusing on the healthcare of Spanish-speaking population in the Nashville area from the perspective of providers that work in a bureaucratic system of healthcare.

Theoretical Framework

The theoretical framework for this study is Marilyn Ray's *Theory of Bureaucratic Caring* (2006). This theory addresses the complexity of creating a caring and meaningful relationship with patients within the context of a healthcare system (Alligood, 2014). The *Theory of Bureaucratic Caring* was initially structured as a qualitative study. It "represents a dynamic structure of caring, which was created from a dialogue between the thesis of caring as humanistic, social, educational, ethical, and religious/spiritual and the antithesis of caring as economic, political, legal, and technological" (Masters, 2015, p. 363). Ray theorized that "both bureaucracy and complexity influence the ways in which diverse participants describe and intuitively live out their life world experience in the system" (Alligood, 2014, p. 101). Ray (2006) recognized the combination of order and disorder in health care organizations and used her theory in an attempt to assist nurses in recognizing the boundaries of the complex system and improve their ability to make good decisions for care within the system. All those that interact in the system are interdependent, so when one part is neglected or not optimally cared for, the other parts of the system are inadvertently affected. This theory served as a lens for the study's survey questionnaire based on the major themes of the theory.

Literature Review

Healthcare in the United States is a topic that is ceaselessly examined, discussed, and reformed. While there are continuous developments in the field – such as medications, technologies, and policies – Americans remain frustrated with the healthcare system's structures, downfalls, and, perhaps more importantly, negative care outcomes. One particular challenge in healthcare that warrants attention is that of language barriers in provider-to-patient interactions. While research has been conducted on this topic attempting to reconcile the issues that arise when a language barrier is present, a gap in the quality of care remains when full understanding cannot be reached due to language. This gap requires further research and recommendations.

One particular population that is impacted by language barrier is the Hispanic population in the United States.

> 'Hispanic' or 'Latino' refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Origin can be viewed as heritage, nationality group, lineage, or country of birth of the person or person's parents, or ancestors before a person's arrival in the United States. A person who identifies his or her origin as Spanish can be of any race. (Levy & Sidel, 2013, p. 44)

Mayer and Villaire (2007), authors of *Health Literacy in Primary Care: A Clinician's Guide*, stated that "around 78% of Latinos in the United States speak a language other than English," (2007, p. 237). Spanish-speaking Hispanics are a significant portion of the population in the United States. The California Healthcare Interpreters Association in their clinician's guide estimated, "that Spanish-speaking Latinos will ultimately provide 60% of new growth in the state's population between 1990 and 2010" (Mayer and Villaire, 2007, p. 237). Levy and Sidel (2013), authors of *Social Injustice and Public* Health, report "In mid-2012…persons of Hispanic

origin…were 15 percent of the population" (Levy & Sidel, 2013, p. 44). According to the U.S. Census Bureau (census.gov, 2019) the Hispanic or Latino ethnic group now makes up 18.3% of the total U.S. population.

Looking at Nashville specifically, the Hispanic population is the second most prevalent minority next to the African American population. According to the Nashville Health Department (Nashville.gov, 2016), Nashville's population in 2016 was 78.3% White, 15.3% African American, and 7.1% Hispanic. According to the U.C. Census Bureau (census.gov, 2019), Nashville's population in 2019 was 63.2% White, 27.9% African American, and 10.4% Hispanic ("U.S. Census," n.d.). Given these statistics, there is a growing prevalence of non-English speaking people living in the Nashville area, indicating an increased number of potential patients with a language barrier.

Patients affected by language barriers have difficulty with low healthcare literacy. (Mayer and Villaire, 2007). Healthcare literacy can be defined in several different ways, as discussed by Thompson, Parrott, and Nussbaum (2011) in their work *The Routledge Handbook of Health Communication*. Health literacy includes the ability of an individual to utilize verbal, cognitive, and social skills which "allow the person to acquire and use new information" (Thompson, Parrot, & Nussbaum, 2011, p. 307). Complete understanding can be hindered by a sense of discomfort when asking questions. It can also add to the difficultly of developing a trusting, positive relationship between the provider and patient, especially if the two cannot speak directly to one another.

According to David and Rhee (1998), in their historic study "The Impact of Language as a Barrier to Effective Healthcare in an Unserved Urban Hispanic Community," an analysis of MEDLINE studies shows "the quality of the physician-patient communication was positively

correlated with improved health outcome" (p.394). After analyzing available studies, David and Rhee (1998) conducted their own study in a teaching hospital with 261 Hispanic patients. Patients that had self-reported fair to excellent verbal English skills and did not require a translator were assigned to the control group, while patients that had self-reported poor verbal English skills and did require the use of a translator were assigned to the case group. While both groups displayed understanding that knowledge of side effects of a medication is linked to compliance with the medication, about half of the case group reported that side effects of medications were not explained to them (David and Rhee, 1998). This result displays a negative outcome in education of the patient due to language barrier. Another study that addresses the impact of language barriers on health outcomes is "The Impact of Language Barriers on the Health Care of Latinos in the United States: A Review of the Literature and Guidelines for Practice," by Caraway Timmins, CMN, MSN. Timmins (2002) summarizes that language barriers have caused poor health care outcomes validated by data related to the "increased use of expensive diagnostic tests, increased use of emergency services and decreased use of primary care services, poor patient satisfaction, and poor or no patient follow-up when follow-up is indicated" (p.82).

Translators bridge the gap in understanding between provider and patient. Mayer and Vallaire (2007) address the topic of translators and point out the importance of the quality of translation as both provider and patient must blindly trust the translator to adequately and completely inform the other of what they are attempting to convey. Meeuwesen (2012) also presents this point in his article titled "Language Barriers in Migrant Health Care: A Blind Spot," where he states: "The use of interpreters involves more than just a transfer of information; above all it has to do with trust and mutual respect" (2012, p. 135). Trust and mutual respect are two

topics that Ray (2006) also discusses heavily in her *Theory of Bureaucratic Caring*. This trust looks different depending on the type of translator. In a study titled "Through Interpreters' Eyes: Comparing Roles of Professional and Family Interpreters," (Rosenberg, Seller, and Leanza, 2008), analyzes patient-provider interactions where either a professional or familial translator is present to aid the non-native speaking patients. Professional interpreters are beneficial because they are trained with accuracy, medical knowledge, and must be appointed by the provider. Familial interpreters are beneficial because they advocate for the patient and have personal knowledge of the patient, however they lack medical knowledge. Meeuwesen (2012) comments on the need for interpreters, regardless of the type, stating that, "a legal basis for the use of qualitatively good interpreters – be it professional or informal interpreters – seems necessary" (2012, p. 135). This correlates to Ray's (2006) discussion in her theory of the critical role communication plays in ensuring quality care for patients.

Papic & Malak & Rosenberg (2012), in their article "Survey of Family Physicians' Perspectives on Management of Immigrant Patients: Attitudes, Barriers, Strategies, and Training Needs," show that physicians mark language barrier as one of the most significant issues they come across in their practice, noting that they do not adequately use translator resources, and that they have not been properly trained in treating a patient from another culture. Another study titled "Consultations Between Immigrant Patients, Their Interpreters, and Their General Practitioners: Are They Real Meetings or Just Encounters? A Qualitative Study in Primary Health Care" (Wiking, Sundquist, & Saleh-Stattin, 2013) outlines a study in which immigrant patients' experiences of healthcare, when translators were involved, were analyzed and synthesized. Providers, patients, and translators were all interviewed in person. The article (Wiking, Sundquist, & Saleh-Stattin, 2013) identifies a greater need for formal translators and

strategies for all persons involved (such as longer consultations between the provider and patient) to better the experience and care of immigrant patients.

With increasing technological advancements in healthcare, access to remote or technological formats of translation services has continued to improve. When in-person translators are not available, translation lines and systems can be valuable resources for communicating with language barrier patients. Lee et. al. (2017), in their study "Increased Access to Professional Interpreters in the Hospital Improves Informed Consent for Patients with Limited English Proficiency," address the benefit of bedside interpreter phone systems with language barrier patients preparing for invasive procedures requiring informed consents. In their study they found that using, "a bedside interpreter phone system," (2017, p, 863) enhanced informed consent, as reported by limited English proficiency (LEP) patients and was recommended to hospitals for improvement of care for this population. Despite these improvements, they found that this intervention, "did not eliminate the language-based disparity," and suggested, "additional clinician educational interventions and more language-concordant care may be necessary for informed consent to equal that for English speakers," (2017, p, 863).

This literature identifies language barriers as an issue in health care, especially with the Hispanic population which continues to grow in the United States. This population is referred to as both "Hispanic" and "Latino" in the literature. In this thesis, the term "Hispanic" will be used consistently throughout. This research study seeks to address the gaps in prior research regarding the impact of language barriers on health care outcomes. Using Ray's (2006) *Theory of Bureaucratic Caring*, the driving research question is: **In Nashville, Tennessee, how effectively do nurses believe healthcare facilities work with Spanish-speaking patients seeking care to**

ensure comprehension and quality outcomes? Through exploring the research question, the researcher hopes to understand how the healthcare system in Nashville primarily works with Spanish-speaking patients to provide quality, holistic care.

Chapter 1: Research Design

Research Question

The research question is: In Nashville, Tennessee, how effectively do nurses believe healthcare facilities work with Spanish-speaking patients seeking care to ensure comprehension and quality outcomes?

Research Design/Methods

The research design for this study is non-experimental and descriptive, employing a cross-sectional survey. The study used a survey questionnaire, which was constructed by the researcher using the theoretical framework of the *Theory of Bureaucratic Caring* (2006). The research was approved by the Belmont Institutional Review Board (IRB). An IRB was also sought and approved through the Metro Public Health Department (MPHD).

Population: Registered nurses and licensed practical nurses working at the Tennessee Metro Public Health Department and New Horizon Diabetes Clinic.

Sampling Method: A purposeful, convenient sample was recruited through coordination with the director of the health department who identified eligible nurses to participate. The proposed sample size was 10-20 nurses.

Data Collection: The method of data collection for this study was an online survey designed to determine nurses' experiences and opinions. It was distributed through the Metro Public Health Department and New Horizon Diabetes Clinic. Inclusion criteria for this study is nurses currently working with the Metro Public Health Department and New Horizon Diabetes Clinic.

Discussion of Instrument

Since the framework for this study was Marilyn Ray's *Theory of Bureaucratic Caring* (2006) there were themes from this theory that were considered when constructing survey questions, as to focus survey responses to relate to the theory. These include: relationship of all stakeholders, bureaucratic nature of the health care system, use of resources and energies, communication, ethical choice making, caring domains – educational, spiritual-ethical, legal, physical, technological, economic, political, social-cultural, organizational culture, and expression of beliefs of dominant culture – and interrelatedness of stakeholders. The IRB chair at the MPHD, who has expertise in developing survey questionnaires, peer reviewed the study's survey and suggested adding nurse practitioners (NPs) and licensed practical nurses (LPNs) to the targeted survey participants. This expert also improved question 3(g) to include a broader understanding of the nurse's perspective of the provider's attitude.

Survey Questions (with accompanying Theoretical Framework themes):

1. Are you employed in an urban or rural setting? **(short answer)**
    a. Is your clinic or facility easily accessible? **(Y/N)**

    Themes: bureaucratic nature of the health care system and interrelatedness of stakeholders and organizational environment
2. How long have you been working as nurse? **(short answer)**

    Theme: relationship of all stakeholders
3. While working in the Nashville area, have you experienced caring for a patient that primarily spoke Spanish? **(Y/N)**

    Theme: interrelatedness of stakeholders and organization environment

If (Y):

a. How was the patient provided information? **(short answer)**

Themes: communication, use of resources and energies, and the educational caring domain

b. Was technology used to care for this patient (diagnostic tests, medications, other machinery) **(Y/N)**

Theme: technological caring domain

c. Did you feel you had built trust with the patient? **(Y/N)**

  i. If (N): What impeded a trusting nurse-patient relationship? **(short answer)**

Themes: spiritual/ethical caring domain, social/cultural caring domain

d. Did you feel knowledgeable about the patient's cultural norms? **(Y/N)**

Themes: spiritual/ethical caring domain, social/cultural caring domain

e. Did you consider communication with the patient to be a challenge? **(Y/N)**

  i. If (Y): What resources were available to mitigate this challenge? **(short answer)**

Theme: communication

f. Did you employ the use of a translator? **(Y/N)**

  i. If (Y): How helpful was the translator service? **(very helpful, somewhat helpful, not helpful)**

Themes: communication, use of resources and energies, and the educational caring domain

g. If applicable, what was the provider's attitude regarding the barrier? **(short answer)**

Theme: political caring domain

h. Did you feel the language barrier impeded quality of care for the patient? **(Y/N, option to explain)**

Theme: communication

i. Do you speak Spanish? (Y/N)

    i. If (Y): Did you feel your ability to speak Spanish improved quality of care for the patient? (Y/N, option to explain)

Theme: social/cultural caring domain

j. How would you rate your nurse-patient relationship with this patient compared to other patients you have cared for? **(No difference, slight difference, significant difference)**

Theme: social/cultural caring domain

k. In your care for Spanish-speaking patients, what factors, if any, have you identified that could potentially impact health care outcomes? **(short answer)**

Theme: bureaucratic nature of the health care system

l. Do you have any suggestions for improving care for Spanish-speaking patients? **(short answer)**

Theme: bureaucratic nature of the health care system

Data Analysis: The survey results were coded for themes, derived from the *Theory of Bureaucratic Caring* (2006), which enlightened standards of care that are currently upheld, and the need for improvement in care options for patients with a language barrier.

Recruitment of Study Participants

The investigator initiated contact with the Tennessee Health Department and the New Horizon Diabetes Clinic and asked for their interest and/or support of the study. Both contacts communicated via email their interest in the project, and the Tennessee Health Department contact referred the investigator to the nursing director of the MPHD for further collaboration.

Chapter 2: Survey Response Data

The data below is organized by survey question, with identification of applicable themes. The data collection was capped at 30 responses due to time constraints.

Questions 1 and 1(a)

Chart 1: Survey Question 1

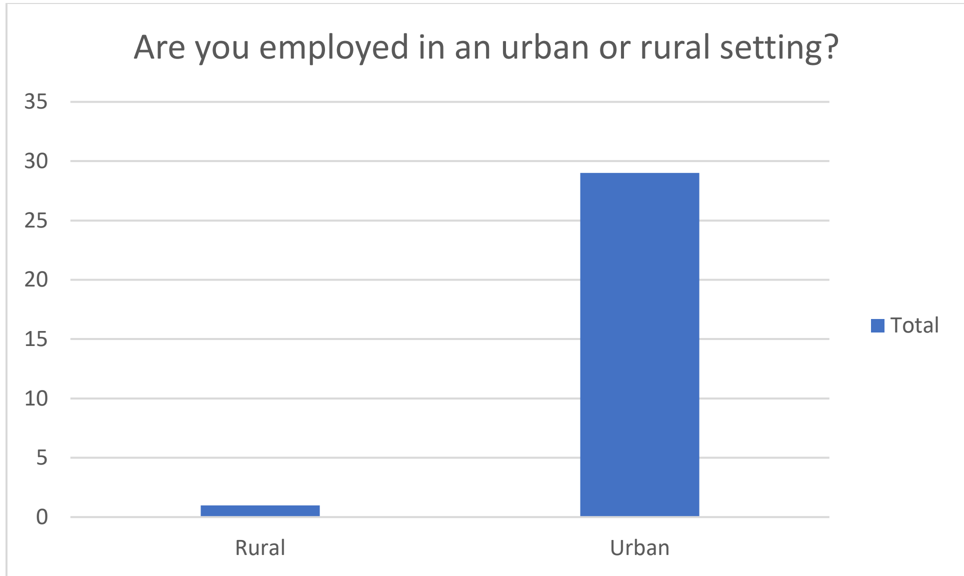


Chart 2: Survey Question 1(a)

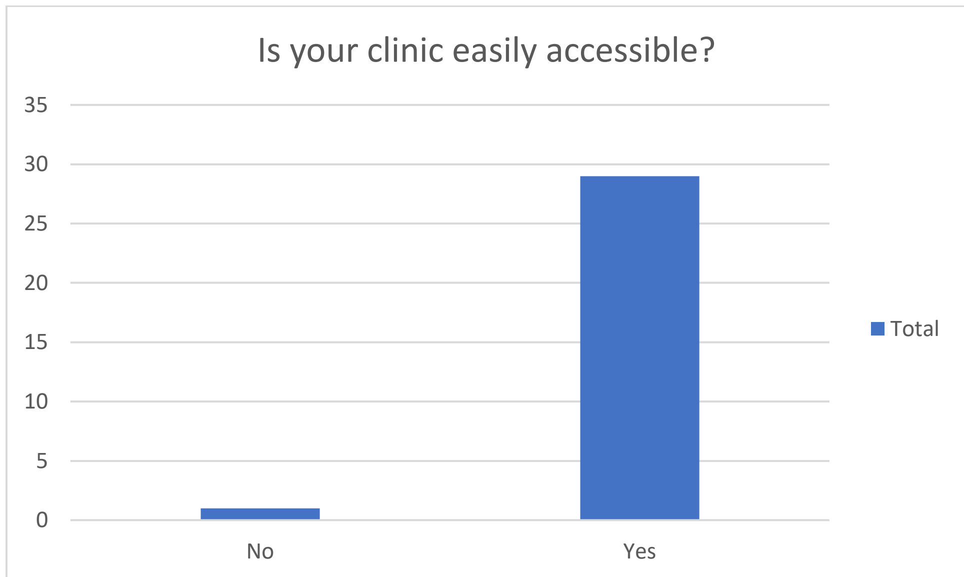


Table 1: Statistics of Question 1(a)

#	Question	Mean	Standard Deviation	Count
1(a)	Is your facility easily accessible?	1.03	0.18	30

The themes these two questions reflect are the **Bureaucratic nature of the health care system** and **the interrelatedness of stakeholders and organizational environment**. 96.67% of nurses responded that they worked in an urban setting and their facility was easily accessible. 3.33% of nurses responded that they worked in a rural setting and their facility was not easily accessible. The single nurse that reported working in a rural setting is not the single nurse that reported their facility not being easily accessible.

Question 2

Chart 3: Survey Question 2

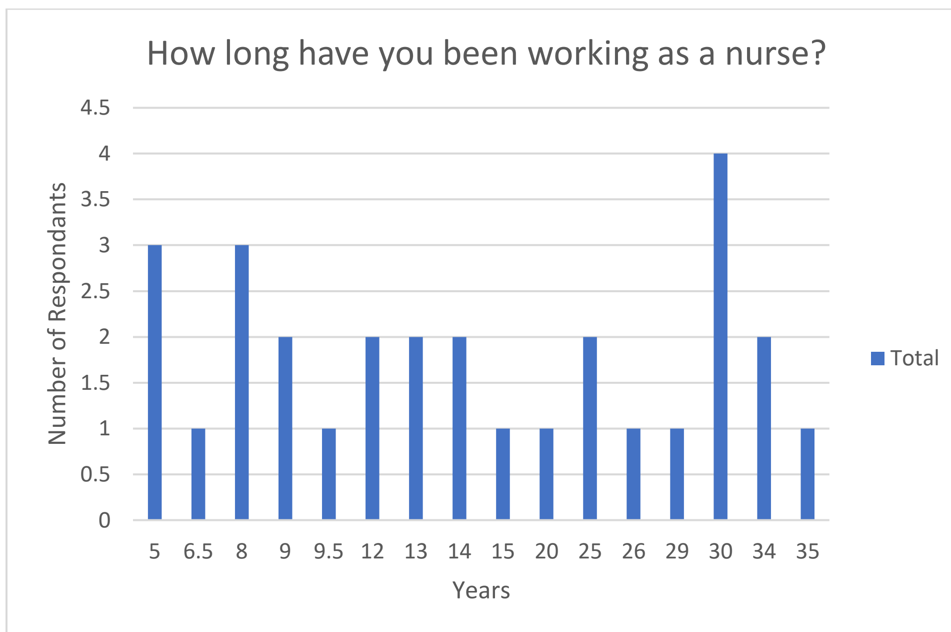


Table 2: Statistics of Question 2

#	Question	Mean	Count
2	How long have you been working as a nurse?	17.72	29

This question reflects the theme of **the relationships of all stakeholders.** One of the 30 survey participants did not enter a response for this question, so 29 data points were considered.

Question 3

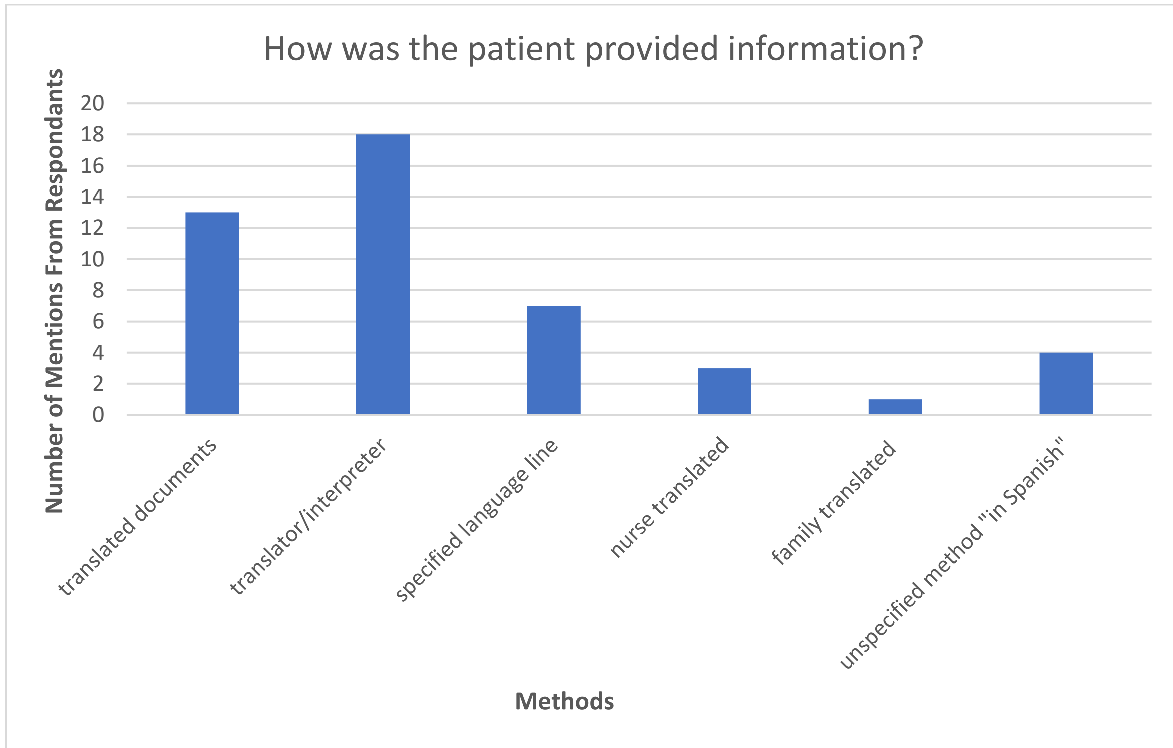
Table 3: Statistics of Question 3

#	Question	Mean	Standard Deviation	Count
3	While working in the Nashville area, have you experienced caring for a patient that primarily spoke Spanish?	1.00	0.00	30

This question reflects the theme of **interrelatedness of stakeholders and organizational environment.** 100% of nurses that responded to the survey have experienced caring for a patient that primarily spoke Spanish in their nursing career.

Questions 3(a), 3(f), and 3(f-i)

Chart 4: Survey Question 3(a)



Question 3(a) was a short answer question. Chart 4 was created based on methods mentioned by participants in their responses. Not all 30 nurses answered this question, and some nurses mentioned more than one method in their response.

Chart 5: Survey Question 3(f)

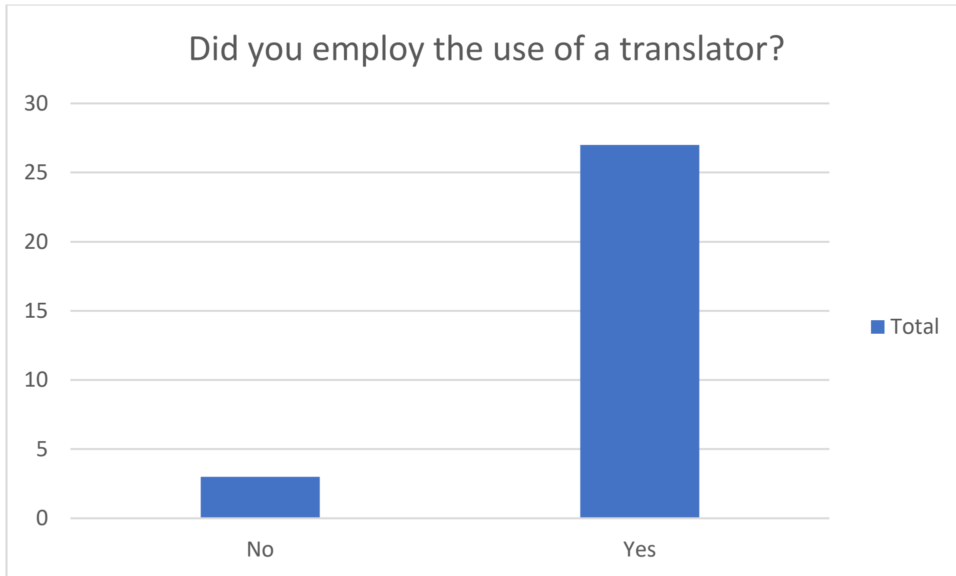


Table 4: Statistics of Question 3(f)

#	Question	Mean	Standard Deviation	Count
3(f)	Did you employ the use of a translator?	1.10	0.30	30

90% of nurses responded that they did employ the use of a translator. 10% of nurses responded that they did not employ the use of a translator.

Chart 6: Survey Question 3(f-i)

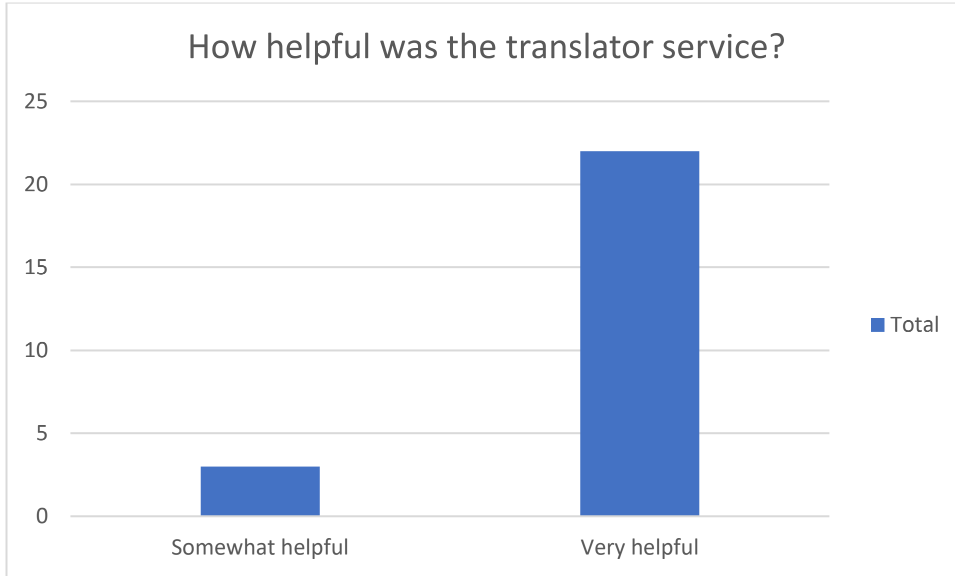


Table 4: Statistics of Question 3(f-i)

#	Question	Mean	Standard Deviation	Count
3(f-i)	How helpful was the translator service?	1.12	0.32	25

88% of nurses that employed the use of a translator thought it was very helpful. 12% of nurses that used a translator thought it was somewhat helpful. 0% of nurses responded that the translator service was not helpful. In addition to the three nurses that said they did not employ the use of a translator, there were two nurses that answered “yes” to question 3(f) but did not respond to question 3(f-i).

These three questions all reflect the themes: **communication, use of resources and energies,** and **the educational caring domain.**

Question 3(b)

Chart 7: Survey Question 3(b)

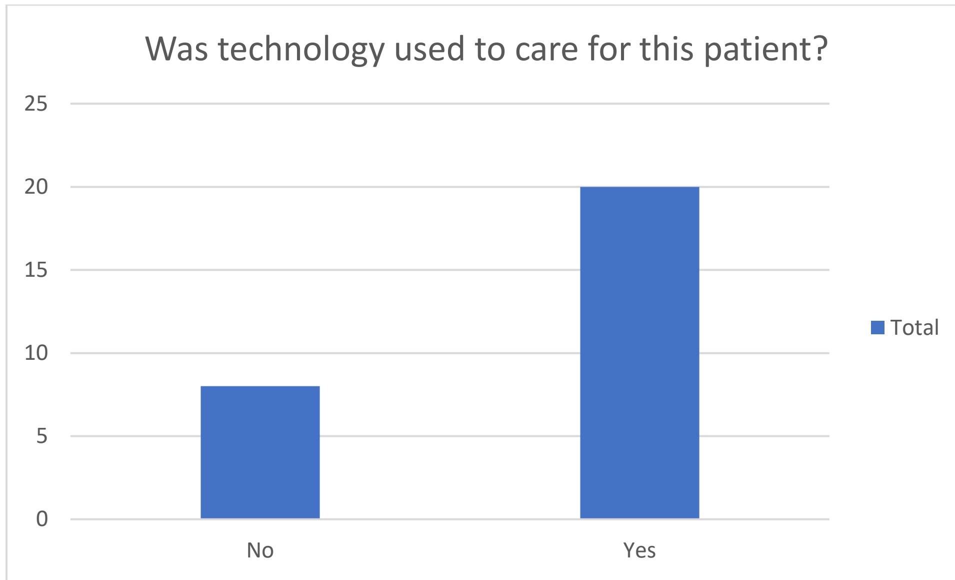


Table 5: Statistics of Question 3(b)

#	Question	Mean	Standard Deviation	Count
3(b)	Was technology used to care for this patient?	1.29	0.45	28

This question reflects **the technological aspect of the caring domain theme.** 71.43% of nurses responded that they did utilize technology to care for their Hispanic patient. 28.57% of nurses responded that they did not utilize technology. Two nurses did not respond to this question, so 28 data points were considered.

Question 3(c), 3(c-i), and 3(d)

Chart 8: Survey Question 3(c)

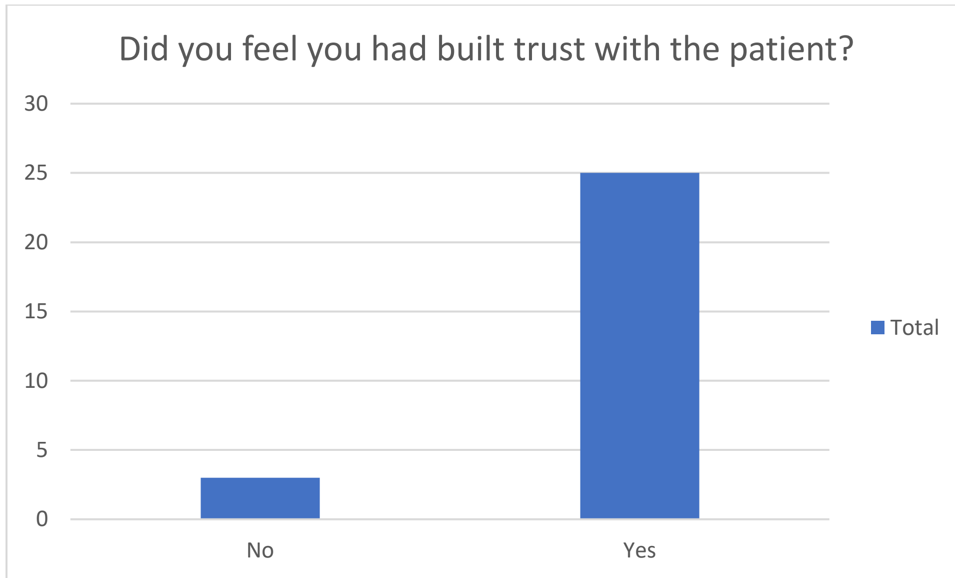


Table 6: Statistics of Question 3(c)

#	Question	Mean	Standard Deviation	Count
3(c)	Did you feel you had built trust with the patient?	1.11	0.31	28

89.29% of nurses felt they were able to build trust with their Hispanic patient. 10.71% of nurses felt they were not able to build trust with their Hispanic patient. Two participants did not respond to this question, so 28 data points were considered.

Table 7: Survey Question 3(c-i) – What Impeded a Trusting Nurse-Patient Relationship?

Relevant Theme	**Participants' Responses**
Communication	"language barrier" "patient inability to speak English and my inability to understand Spanish" "communication barrier"

Chart 9: Survey Question 3(d)

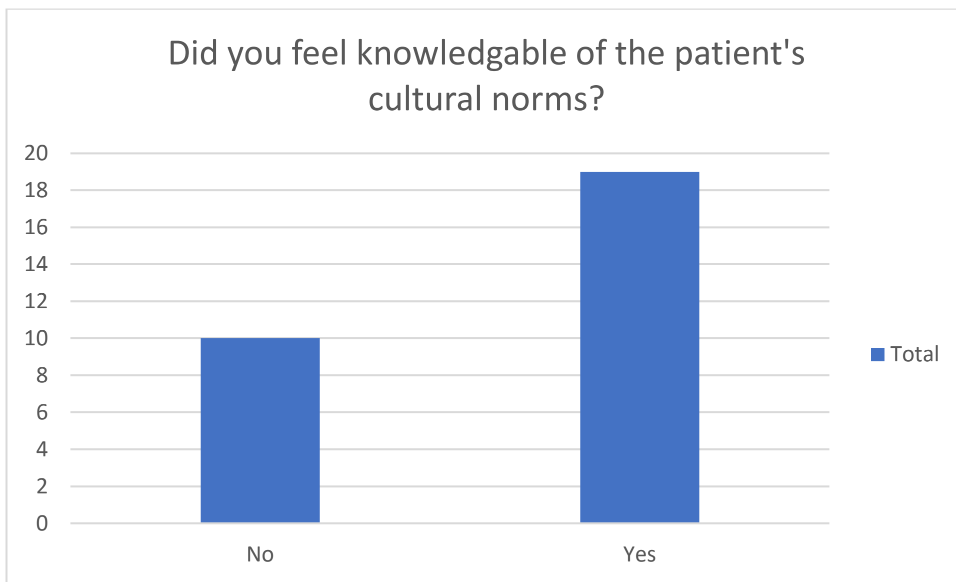


Table 8: Statistics of Question 3(d)

#	Question	Mean	Standard Deviation	Count
3(d)	Did you feel knowledgeable of the patient's cultural norms?	1.34	0.48	29

65.52% of nurses responded that they felt knowledgeable of their Hispanic patient's cultural norms. 34.48% of nurses did not feel knowledgeable of cultural norms. One participant did not answer this question, so 29 data points were considered.

These three questions all reflect the **spiritual/ethical and social/cultural aspects of the caring domain theme.**

Question 3(e), 3(e-i), and 3(h)

Chart 10: Survey Question 3(e)

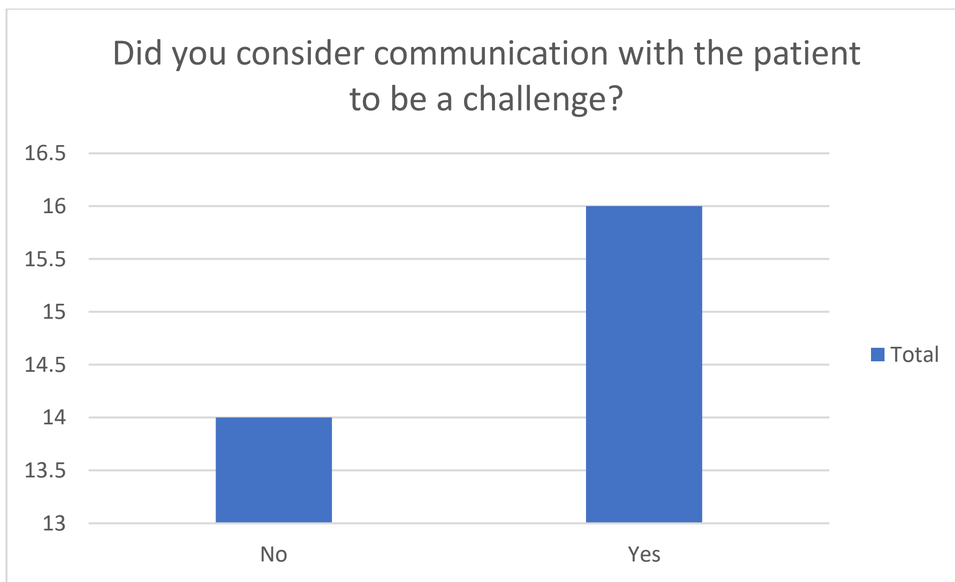


Table 9: Statistics of Question 3(e)

#	Question	Mean	Standard Deviation	Count
3(e)	Did you consider communication with the patient to be a challenge?	1.47	0.50	30

53.33% of nurses did consider communication with the patient to be a challenge. 46.67% of nurses did not consider communication to be a challenge.

Table 10: Survey Question 3(e-i) – What Resources Were Available to Mitigate this Challenge?

Relevant Theme	Participants' Reponses
Use of Resources and Energies	"interpreter/translator," "translators," "information in written translation," "translation services," "a translator," "on-site interpreter," "almost every form that we have in English is also available in Spanish," "many of our documents are written in Spanish," "translator," "translators," "finding or getting the translator or the translation done," "Spanish/English dictionary," "interpreter," "interpreted documents," "handouts/paper resources"
Caring Domain: spiritual/ethical	"smiles"
Caring Domain: technological	"phone app," "language/interpreter services," "language line," "the translation line"
Communication	"communication through interpreters," "family member present that spoke English," "we both speak Spanish"
Relationships of All Stakeholders	"on-site interpreter," "in person translators," "we both speak Spanish"

Chart 11: Survey Question 3(h)

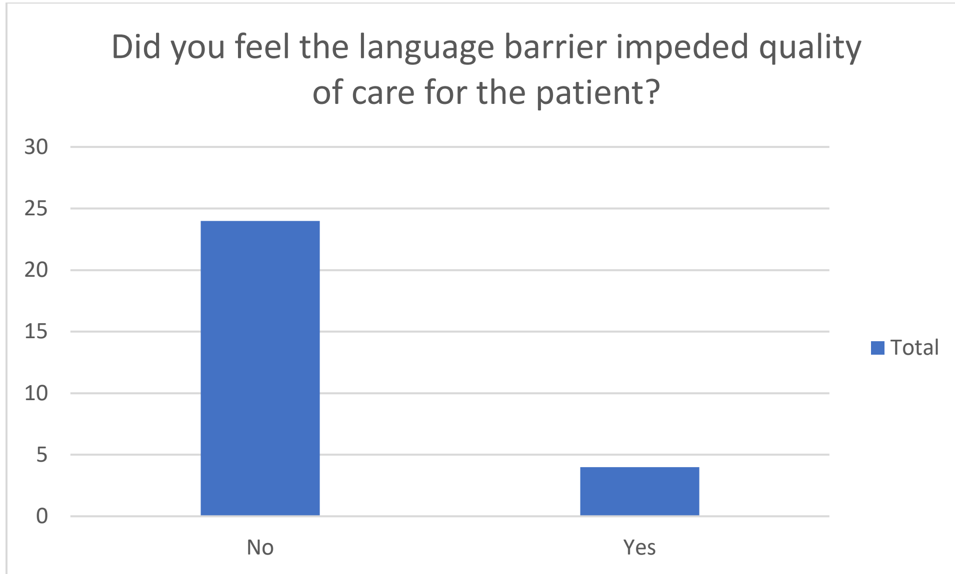


Table 11: Statistics of Question 3(h)

#	Question	Mean	Standard Deviation	Count
3(h)	Did you feel the language barrier impeded quality of care for the patient?	1.86	0.35	28

14.29% of nurses felt that the language barrier between the nurse and patient impeded quality of care. 85.71% of nurses felt that the language barrier did not impede quality of care. Two participants did not answer this question, so 28 data points were considered.

These three questions all reflect the theme of **communication.**

Question 3(g)

Table 12: Survey Question 3(g) -- If Applicable, What Was the Provider's Attitude Regarding the Barrier?

Relevant Theme	Participants' Responses
Caring Domain: political	"frustration," "the provider always try to meet patients' needs in order to achieve adequate medical care"
Caring Domain: spiritual/ethical	"understanding," "understandable since many times translators cannot see the patient's or families expressions of concern or fear," "positive"
Use of Resources and Energies	"I have found that providers I have had contact with already have translators in place"
Interrelatedness of Stakeholders and Organizational Environment	"good in comparison to other areas of the county worked," "understandable since many times translators cannot see the patient's or families expressions of concern or fear," "I have found that providers I have had contact with already have translators in place"
Communication	"very good, our provider at the time spoke pretty good Spanish"

This survey question was designed to reflect the **political aspect of the caring domain theme.** Several other themes emerged in participants' responses. Nine nurses provided responses regarding physician attitudes. Of these nine, only one nurse's response reflected a negative

attitude. Five nurses that responsed indicated that the physician's attitude was not applicable. The other sixteen nurses did not respond to this question.

Question 3(i), 3(i-i), and 3(j)

Chart 12: Survey Question 3(i)

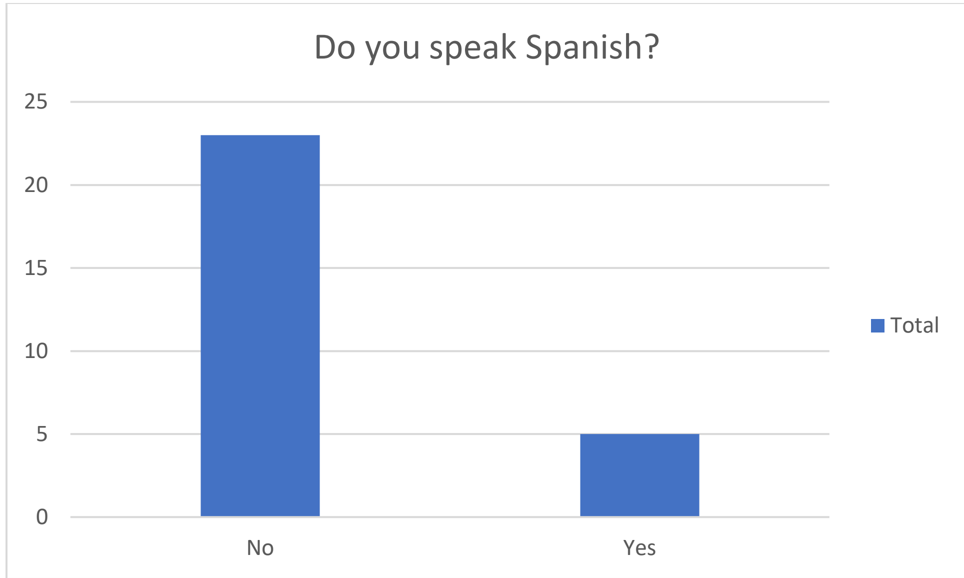


Table 13: Statistics on Question 3(i)

#	Question	Mean	Standard Deviation	Count
3(i)	Do you speak Spanish?	1.82	0.38	28

17.86% of nurses responded that they did speak Spanish. 82.14% of nurses responded that they did not speak Spanish. Two participants did not answer this question, so 28 data points were considered.

Chart 13: Survey Question 3(i-i)

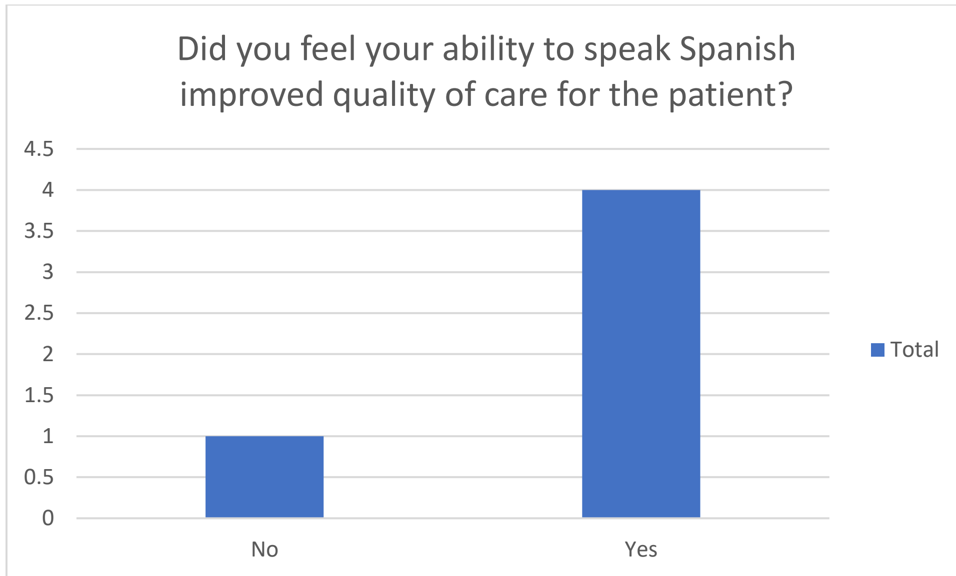


Table 14: Statistics on Question 3(i-i)

#	Question	Mean	Standard Deviation	Count
3(i-i)	Do you feel your ability to speak Spanish improved quality of care for the patient?	1.20	0.40	5

Of the five nurses that spoke Spanish, 80% believed that improved quality of care for their patient. 20% did not feel their ability to speak Spanish improved quality of care for their patient.

Chart 14: Survey Question 3(j)

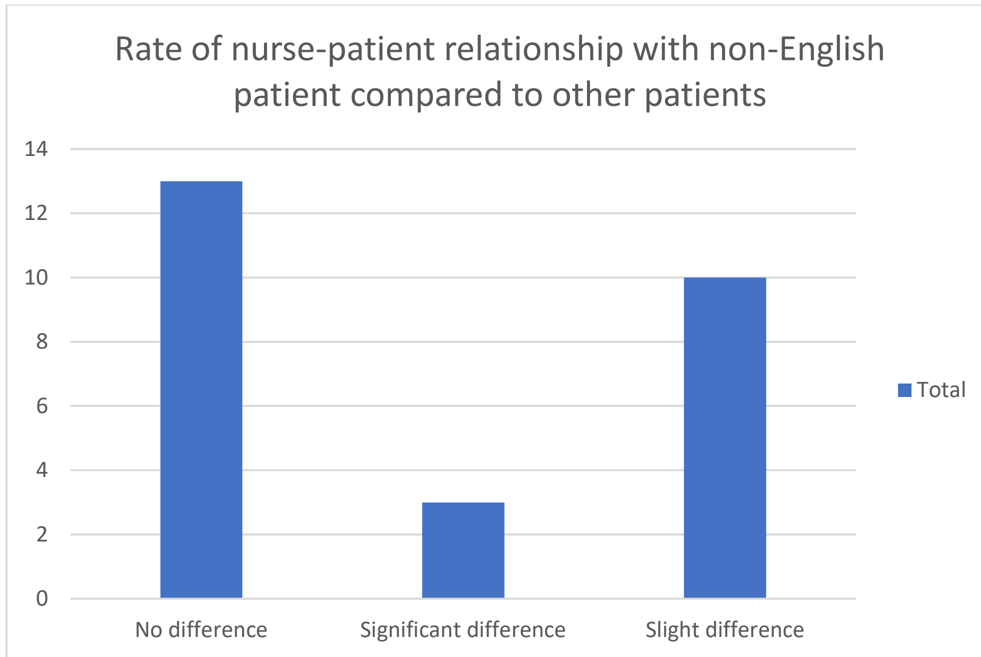


Table 15: Statistics on Question 3(j)

#	Question	Mean	Standard Deviation	Count
3(j)	How would you rate your nurse-patient relationship with this patient compared to other patients you have cared for?	1.62	0.68	26

50% of nurses felt that their relationship with their Hispanic patient had no difference compared to other patients they have cared for. 38.46% felt there was a slight difference in their relationship. 11.54% of nurses felt that there was a significant difference. Four of the thirty participants did not respond to this question.

These three questions all reflect the **social/cultural aspect of the caring domain theme.**

Question 3(k) and 3(l)

Table 16: Survey Question 3(k) -- In Your Care for Spanish-Speaking Patients, What Factors, if Any, Have You Identified that Could Potentially Impact Health Care Outcomes?

Relevant Theme	Participants' Responses
Relationship of All Stakeholders	"Many of them cannot read or write and have difficulty filling out medical histories or forms. I have offered to do it for them with their input if I sense slight hesitancy. They are embarrassed to tell anyone."
Bureaucratic Nature of the Health Care System	"how quick you can get a translator in emergencies"
Use of Resources and Energies	"The caregiver must be willing to utilize the resources available to them so that each patient can receive equitable amount of care and education related to their condition and treatments. If you have a healthcare provider that is just supplying the paperwork, but then not utilizing interpreter services to answer any patient questions, that is not equitable care for all." "To determine if in fact the patient can read prior to given literature related to their disease," "the ability to have someone speak their language helps build trust," "the low literacy from patients, despite the provider speaks Spanish, is the biggest barrier in taking care of Hispanic patients"

Caring Domain: educational	"Many of them cannot read or write and have difficulty filling out medical histories or forms. I have offered to do it for them with their input if I sense slight hesitancy. They are embarrassed to tell anyone."
Caring Domain: spiritual/ethical	"the ability to have someone speak their language helps build trust." "Many of them cannot read or write and have difficulty filling out medical histories or forms. I have offered to do it for them with their input if I sense slight hesitancy. They are embarrassed to tell anyone." "Spanish speaking patients have a harder time trusting medical providers associated with 'the government.' There is a lot of fear."
Caring Domain: economic	"many are uninsured and do not have primary care provider to follow up with," "barriers to access to care (no health or dental insurance)"
Caring Domain: political	"fear of the current cultural climate of the US" "Spanish speaking patients have a harder time trusting medical providers associated with 'the government.' There is a lot of fear."
Caring Domain: social/cultural	"cultural norms or beliefs that go against modern medical practice," "cultural differences"
Interrelatedness of Stakeholders and Organizational Environment	"access to healthcare"
Communication	"misunderstandings about info. needed," "the patient's ability to read English, and to determine if in fact the patient can read prior to given

	literature related to their disease," "trying to interpret their actual understanding of the information provided to them, even if a family member is the interpreter, it's difficult to ascertain the patient's understanding," "misunderstanding of expressed complaints/concerns. Miscommunication of care and treatment measures moving forward," "words getting lost in translation," "possibly language barriers if the person interpreting is unfamiliar with medical terms but I have not seen that so far," "important information lost in translation"

Table 17: Survey Question 3(l) – Do You Have Any Suggestions for Improving Care for Spanish-Speaking Patients?

Relevant Theme	**Participants' Responses**
Relationship of All Stakeholders	"have more bilingual healthcare providers" "I think Spanish should be a requirement in nursing school" "offer to fill out forms if they hesitate to complete forms"
Use of Resources and Energies	"on site interpreters," "increased pay for Spanish-speaking healthcare workers," "more face to face translators," "classes to understand cultural norms or beliefs," "always use interpreter," "translator on site," "translators," "we need more education documents in Spanish regarding health and development," "provide services to teach them the English language," "use the translator service and build rapport. Provide documents in patient's first language for easier comprehension," "additional on-site

	Spanish interpreter availability," "patients need to learn to read more and learn about their disease"
Caring Domain: educational	"make sure you are explaining things thoroughly and make sure they understand. Ex. Don't just ask 'do you eat healthy?' ask 'what do you eat on a typical day?' This will be much more informational because they might think what they eat is healthy. There are a lot of superstitions and wives' tales that they believe that need to be debunked, i.e. when you get wet in the rain you will get sick." "we need more education documents in Spanish regarding health and development" "provide services to teach them the English language" "patients need to learn to read more and learn about their disease. Stop believing that a miracle plant is going to take care of everything."
Caring Domain: spiritual/ethical	"They enjoy humor, and it relaxes them. They can sense if they are being talked down to or belittled." "use the translator service and build rapport"
Caring Domain: social/cultural	"classes to understand cultural norms or beliefs" "There are a lot of superstitions and wives' tales that they believe that need to be debunked, i.e. when you get wet in the rain you will get sick" "making sure those caring for them are culturally competent and sensitive to their cultural needs as well as their health needs"
Caring Domain: political	"reassure patient that immigration status is not a factor in receiving care,"

These final two questions were intended to target the theme of **Bureaucratic nature of the health care system** and reveal what aspects of the Bureaucratic nature of health care facilities may hinder or could improve care outcomes for Hispanic patients.

Chapter 3: Data Discussion

Study Limitations

The study was limited in its number of participants. Firstly, the nursing director at the New Horizon Diabetes Clinic was the only staff member at that facility able to participate in the survey. This is due to the inclusion criteria set by the investigator requiring participants to have a nursing license (be a registered nurse). The investigator discovered that the clinic only had one primary NP with assisted nursing personnel, so these staff members were not able to participate. This was an unforeseen limitation in the data collection for the study.

The number of participants were also limited by time constraints. While the response rate of 30 registered nurses was greater than the proposed sample size, it is still an overall small sample size. The investigator is aware that a larger sample would increase the strength of the data.

Another study limitation is that only the nurse's perspective was investigated. To fully evaluate care outcomes for Hispanic patients, it would be helpful to survey the patient population about their health care experiences in Nashville. This evaluation was outside of the possible scope for this study; however, this could be the focus of future studies.

Discussion

The research question for this study was: In Nashville, Tennessee, how effectively do nurses believe healthcare facilities work with Spanish-speaking patients seeking care to ensure comprehension and quality outcomes? After analyzing survey responses from 30 participants, the investigator concludes that nurses in the surveyed sample believe that healthcare facilities are effectively ensuring quality outcomes for Hispanic patients but could be doing more to ensure comprehension and culturally competent care.

Question 1 and 1(a) were designed to highlight the Bureaucratic nature of the healthcare system by assessing what kind of environment survey participants work in. Urban and rural geographic areas would have different bureaucratic and organizational environments. The goal was to assess how the environment a facility is located in impacts the ability for patients to receive care. The difference in environment, rural or urban, could impact availability of resources, number of available staff at a facility, patient population, etc. As seen in Chart 2, 96.67% of nurses responded that they worked in a setting that was easily accessible. Because only one nurse responded that they worked in a rural area, comparison of these two organizational environments is not reliable. The data is interpreted mainly as reflecting the urban healthcare environment in Nashville.

Question 2 was designed to reflect the relationships of all stakeholders. The nurse and patient are both stakeholders. The amount of experience the nurse has, which is assumed to be correlated to number of years worked, impacts the quality of care the patient receives. As seen in Table 2, the average number of years a participant has worked as a nurse is just over 17 years. This indicates that the majority of nurses that answered the survey have extensive experience in patient care, which translates to insightful responses. The investigator could have also inquired how many years the nurses have been at their current facility. Length of time at their specific facility in Nashville, i.e. the New Horizon Diabetes Clinic or the Metro Public Health Department, could impact their knowledge of available resources and optimal utilization of these resources. A connection between number of years worked at a facility and utilization of resources is something to investigate in future study.

Question 3 was designed to confirm that the population of surveyed nurses have in fact interacted with Hispanic patients, the population of interest. As noted in Table 3, all 30

participants answered the question “While working in the Nashville area, have you experienced caring for a patient that primarily spoke Spanish?” and 100% of respondents “yes.” This indicates the relevance of the study. The fact that every single nurse that answered this survey question has experienced working with a language barrier patient in the Nashville area specifically denotes that the survey population chosen is adequate for the study and validates that the nurses met the criteria the investigator set for participants. It also substantiates the prevalence of Hispanics as a patient population in the Nashville area, furthering thought that there is a need for understanding this patient population and their health care needs.

Questions 3(a), 3(f), and 3(f-i) were grouped together as they all reflect the themes of communication, use of resources and energies, and the educational aspect of caring domain. Question 3(a) asked participants what resources were used to support care of the Hispanic patient. Translators were expected to be the most used resources. This is confirmed in Chart 3, as 18 of the 30 participants mentioned using a “translator” or “interpreter.” Because translators were expected to be a common resource, questions 3(f) and 3(f-i) were designed to further investigate their use. As seen in Chart 5, 90% of the 30 nurses employed the use of a translator. Furthermore, of all nurses that reported use of translators, none reported that they were unhelpful, 12% reported that they were only “somewhat helpful,” while 88% reported that they were “very helpful.” This data, displayed in Chart 6, reflects that this resource is successful in overcoming the language barrier, but there is room for growth. In Table 16, one nurse noted that the speed at which “you can get a translator in emergencies” is a factor that impacts care outcomes. This speaks to the complexity and intricacy of the health care system, which could affect the availability of the translators. There may be a translator available, but it may take too much time to obtain this service. This is especially a barrier in emergent situations when care

needs to be delivered as quickly as possible. For further study, one could investigate the availability of translators when needed, and the effect of care outcomes when utilized.

Another point to consider is the use of translators in person versus over a language line. Some nurses specified in their response that they utilized a translator in person or that they utilized the language line, but many nurses simply stated “translator” broadly. It is unclear, based on the qualitative data collected in this study, how many nurses used in person translators. The language line does seem commonly used, as it was specifically mentioned seven times in response to question 3(a). Nurses may want more in-person translators because language lines can become busy and in-person translation may help build trust and reduce fear experienced by patients. As one nurse responded, noted in Table 16, “the ability to have someone speak their language helps build trust.” Another nurse stated, “Spanish speaking patients have a harder time trusting medical providers associated with ‘the government.’ There is a lot of fear.” According to this qualitative data, there is already difficulty for Spanish-speaking patients to feel comfortable communicating with health care faculty, which may be magnified if they cannot make in-person contact with that faculty. One nurse responded that “smiles” are helpful in reducing communication challenges. This is an example of the benefit face-to-face contact can have. This benefit may explain why four nurses specifically mentioned increasing the number of on-site interpreters as a way to improve care for Spanish-speaking patients, as seen in Table 17.

Questions 3(c), 3(c-i), and 3(d) are designed to highlight trust in a nurse-patient relationship, which reflects the spiritual/ethical and social/cultural domains of caring. In Chart 8, it is shown that 25 nurses, 89%, reported that language barrier does not interfere with gaining trust and rapport with their Hispanic patient. Of the 11% that reported they did not create a trusting relationship with their Hispanic patients, all attributed the challenge to language barriers.

Question 3(d) highlighted social/cultural caring through assessing nursing knowledge of cultural norms. Roughly one third, 34.48%, of nurses that responded to the question did not feel knowledgeable about Hispanic patients' cultural norms. In Marilyn Ray's *Theory of Bureaucratic Caring* (2006), she discusses cultural competence as an important factor in providing quality, holistic care. A significant number of respondents to this survey did not feel culturally competent, which is a huge issue in the care of patients with a language barrier and should definitely be studied further. Future studies could investigate potential improvement of nursing environments with cultural seminars for facility staff. Table 17 displays nurses' suggestions for improving care of Spanish-speaking patients. Several notable answers related to cultural competence include: implementing "classes to understand cultural norms and beliefs" and "making sure those caring for them [Spanish-speaking patients] are culturally competent and sensitive to their cultural needs as well as their health needs." It is a responsibility for facilities to know their patient population and ensure their nurses receive proper education about cultural beliefs and practices of the most common cultures among their patient population.

Questions 3(e), 3(e-i), and 3(h) all highlight communication. In response to the question, "do you consider communication to be a challenge?" 53.33% nurses said yes, as seen in Table 9. This indicates that language barriers significantly impact communication in the nurse and patient relationship. Surprising to the investigator is that, while over 50% believed communication to be a challenge, 85.71% of respondents did not feel that the language barrier impeded quality of care, as seen in Table 11. The investigator interprets this as indicating that the resources available to mitigate the communication challenge were successful. Qualitative data from survey participants, shown in Table 10, reveals that helpful resources included on-site interpreters, language line

services, family members that spoke English, bilingual nurses, Spanish documents/handouts, and warm body language such as smiling.

Question 3(g) highlights the political caring domain. This domain is defined to incorporate the physician's role in the functioning facility to provide care for the patient. Referring to the literature review, research has shown that provider's attitudes with Hispanic patients have been negative and derogatory, believing that it is the patient's responsibility to learn English and western cultural practices. The survey results from this study indicate that providers from surveyed facilities are overall doing a good job of sensitively communicating with and caring for patients with a language barrier. In Table 12, qualitative data includes: "the provider always tries to meet patients' needs in order to achieve adequate medical care," "understanding," "positive," "good in comparison to other areas of the county worked," and "very good." These comments demonstrate the sensitivity of providers from the surveyed facilities when caring for Hispanic patients. In relation to this, one nurse responded to question 3(l) regarding suggested improvements for care of Spanish-speaking patients with "I think Spanish should be a requirement in nursing school." This expresses initiative and consideration to learn the language of a prominent cultural minority in the area instead of expecting all people residing in the United States to learn English on their own. A possible suggestion is to add a course in medical Spanish and cultural norms into nursing school curriculum. To be achievable, the course would need to be specific to medical practice.

Several nurses did respond to question 3(l) indicating a need to educate the Hispanic population on western medical practices and the English language. These suggestions from nurses were interpreted as coming from a place of consideration for the patient and what would help them improve their health care outcomes. In Table 17, responses are recorded such as:

"there are a lot of superstitions and wives' tales that they believe that need to be debunked," "provide services to teach them the English language," and "patients need to learn to read more and learn about their disease." These comments underline a belief by nurses that if Hispanic patients increased their health literacy and knowledge of western medical practices, the effectiveness of the nurse-patient interaction may increase, leading to better personal health and care outcomes for the patients. The key is to support the education of this population in a sensitive and empathetic way. This could include offering classes to increase patient comfort with western medicine by explaining the reasons behind practices. This is an area that would be apt for future study, as it would be important to explore the difference between "wives' tales" that offer a holistic, non-clinical approach to health and those that actually hinder patients' health. Offering language classes for patients may also be helpful for the patients when they need to fill out medical forms. As shown in Table 16, one nurse described that Hispanic patients "have difficulty filling out medical histories or forms" and they are "embarrassed to tell anyone." Another nurse notes in Table 16 that "the low literacy from patients...is the biggest barrier in taking care of Hispanic patients." These responses indicate that future study focusing on health literacy of language barrier patients would be greatly beneficial.

Conclusion

After analyzing the survey response data, the investigator concluded that registered participants in the Nashville area working at the New Horizon Diabetes Clinic and the Metro Public Health Department believe that their health care facilities are effectively ensuring quality care outcomes for Hispanic patients. However, they note necessary improvement in ensuring comprehension and culturally competent care for this patient population. Marilyn Ray's *Theory of Bureaucratic Caring* (2006) was an effective framework in studying the nurse-patient

relationship in situations with a present language barrier. Her dialectic model for merging the Bureaucratic nature of health care environments with the necessary caring domains to provide holistic care successfully shaped this study in evaluating the quality of care of a prominent minority in the Nashville area. Through this evaluation, it was discovered that the domain of social/cultural care notable in Ray's theory, is an area in need of growth for the surveyed healthcare facilities in Nashville. The Hispanic patient population could benefit from an increased comprehension of their care through increased health literacy and faculty resources such as on-site interpreters. Language barriers in healthcare is a topic that should continue to be studied in order to facilitate growth and support for cultural minorities.

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