The Impact of Language on the Relationship between Spanish-Speaking Women and their Healthcare Providers

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Abstract

The impact of language on the relationship of trust between Spanish-speaking women and their healthcare providers was examined through a questionnaire survey at Esperanza Health Center in Northeast Philadelphia. Eighty percent of the participants (n=25) felt it was very important to have a Spanish-speaking doctor, even if a translator was available. Forty-four percent (n=11) stated they would be less likely to follow health advice from a doctor who did not speak Spanish. Fifty percent (n=12) of the participants preferred to see a female doctor, although this was not correlated with any other findings. This research suggests that the language barrier is an important contributor to lack of trust in the relationship between Spanish-speaking women and their health providers.

Background

This research explores the impact of the language spoken by a healthcare provider on the relationship of patient-provider trust in the female Hispanic population of Philadelphia. Trust is defined as the "assured reliance on the character, ability, strength, or truth of someone or something; one in which confidence is placed" (trust, 2009). Cultural competency may be an important component of building trust with patients from diverse backgrounds. The first step to cultural competency in relating to Hispanic patients is to understand that health beliefs stem from cultural values. The perceptions Latinas have about healthcare providers are influenced by pride in Hispanic culture and tradition (Luquis & Cruz, 2006). Certain qualities are seen as important for a doctor to possess. For example, "personalismo," the quality of being personable, is reflected in warm and friendly interpersonal interactions and may increase patient compliance (Diaz, 2002). "Simpatia," the quality of being polite, pleasant, positive, kind and attentive, is often demonstrated through nonverbal communication; a neutral attitude towards a patient may be perceived negatively (Diaz, 2002). In order to provide culturally competent care to Hispanic patients, these values need to be understood and respected by healthcare providers.

The city of Philadelphia is home to over 151,500 Hispanic residents, including about 30,000 young women ages 13 to 39 (Lim & Drake, 2006). The topic of cultural competency and building trust for effective healthcare is important in reducing health disparities for Latina women in Philadelphia. Although the Hispanic population in Philadelphia has doubled in the last 5 years, few healthcare providers tailor services toward the needs of Hispanic patients, and only 2 of the 8 public district health clinics offer services in Spanish, through Spanish-speaking providers or interpretation (Bixby, 2009). Many Latinas living in Philadelphia are undocumented immigrants and the number of births to undocumented mothers is on the rise; these women are at risk for not receiving adequate healthcare since they are uninsured and may be afraid of deportation if their status is known. However, even legal immigrants are ineligible for state-assisted healthcare plans for their first 5 years living in Pennsylvania (Bixby, 2009). Non-profit clinics such as Puentes de Salud, Latina Community Health Services, and Esperanza Health Center seek to bridge these access gaps by providing low-cost healthcare regardless of citizenship status, and they are building respect and trust in the population they serve. One key aspect of the mission of these clinics is to provide care in Spanish as well as in English.

Health Risks and the Language Barrier

As a population nationwide, Latina immigrants of low socioeconomic status face health risks as a result of acculturation into American society. These risks include poor nutrition, obesity,

and a sedentary lifestyle, which are correlated with a twofold increase in the risk of developing diabetes (Diaz, 2002). Increased tobacco smoking and sexual risk behaviors are seen in the Latina population as well (Diaz, 2002). Latinas have significantly decreased rates of routine cancer screenings and diabetes and hypertension detection, and increased misconceptions about safe sexual practices (Diaz, 2002). Such health risks are related to unemployment, lack of insurance, inaccessibility of health care services, and poor communication with healthcare providers due to language and cultural barriers (Lieberman, Palo-Stoller & Burg, 1997). Because of the many health risks faced by this population, it is important for health providers to focus on addressing the needs of Hispanic women.

Language differences are one of the largest barriers to quality healthcare faced by Hispanic women in the U.S. In general, patients who are not proficient in English are less likely to receive sufficient health information, participate in health decision-making, or receive an empathetic response from their physician (Ferguson & Candib, 2002). Spanish-speaking women are less likely to see one physician on a consistent basis than Asian, black, or white women (Shreffler, McQuillan, Greil, Lacy & Ngaruiya, 2009). These factors have been correlated with higher rates of non-compliance to recommendations made by health care providers (Ferguson & Candib, 2002).

Healthcare providers who do not speak Spanish rely on interpreters to communicate with Spanish-speaking patients. All interpreters used in clinical settings should be formally trained in techniques for accurate interpretation. However, one study of interpreter use in an emergency department found that 88% of the interpreters were "ad hoc," that is, staff, friends or family of the patient with no medical interpretation training (Baker, Hayes & Fortier, 1998). Older literature has shown that ad hoc interpretation results in frequent communication errors: The interpreter may respond to questions without allowing the patient to speak, he may volunteer his own information and opinions about the situation, or he may neglect to translate the patient's own comments (Downing, & Tillery 1992).

While the use of an interpreter is necessary at times, the literature suggests that communication with a provider who speaks Spanish is preferable to many Hispanic women. Shaffer (2002) interviewed 46 women, all of whom said that having a provider who spoke Spanish was a major deciding factor in whom they chose to see for prenatal care. These women relayed negative conceptions of clinic staff who did not speak Spanish, and they expressed a desire to have more personnel who could speak their language (Shaffer, 2002). They did not want to use a translator, because they felt that their feelings and culture would be better understood if they could communicate with the provider directly (Shaffer, 2002). In fact, seeing a bilingual physician has been shown to improve the health outcomes of Hispanic patients with hypertension and diabetes (Diaz, 2002). Luquis and Cruz (2006) conducted a focus group with Spanish-speaking women in South Central Pennsylvania, and found that even those who understood English preferred to communicate in Spanish about women's health concerns. They conclude that this population is best reached through health professionals who are able to communicate in Spanish with their patients.

In summary, the literature clearly demonstrates that Hispanic women are at risk for receiving inadequate care due to cultural and language barriers, that interpreter use is not ideal, and that a bilingual healthcare provider is the most effective solution. However, no literature was found which addressed whether or not the *trust* a Hispanic woman has in her healthcare provider is related to the language that the provider speaks. Is the language barrier a significant impediment for Spanish-speaking women to follow through with health recommendations from non-Spanish-speaking doctors? Additionally, there was no literature which investigated the role that the gender of the healthcare provider plays in the trust of the patient. Is this a significant variable in the issue of language and trust between female Spanish-speakers and their healthcare providers, or is the gender of the provider insignificant? This study sought to explore these knowledge gaps.

Methods

The study was conducted at Esperanza

Health Center in Northeast Philadelphia. The clinic is near the corner of Kensington and Allegheny Avenues, accessible via the SEPTA Market-Frankford line. Esperanza is a Christian "multi-cultural ministry providing holistic care to the Latino and underserved communities of Philadelphia" (*Welcome,* n.d.). Their services include adult and pediatric primary care, gynecological care, HIV testing and care, social services, counseling, nutrition and health education, spiritual support, dental care, and a medication dispensary. Medicare and Medicaid-affiliated insurances are accepted, as well as self-payment on a sliding scale for patients without insurance. All staff members speak at least some Spanish, and many are native Spanish-speakers or are completely bilingual. A bilingual staff member acts as a translator if a provider feels that he/she is not communicating adequately with the patient. Both physicians and nurse practitioners work at Esperanza, but to simplify the questions presented to study participants, all healthcare providers were referred to as "doctors" in this study.

The researcher spent a total of ten hours at Esperanza – four hours shadowing the clinicians to learn more about the practice, and three hours on two separate mornings interviewing patients and collecting data. The researcher approached women in the waiting room and asked if they preferred to speak in Spanish or English. She then introduced herself in the preferred language with this explanation:

Good morning, my name is Julia and I am a nursing student here in Philadelphia at the University of Pennsylvania. I am doing a survey-questionnaire with women in Philadelphia, to learn more about the relationship between language, and your relationship with your doctor. Would you like to participate?

The researcher showed each woman the survey sheet, and if the client agreed to participate, the researcher gave this explanation:

Remember, this is only your opinion - what you think – there is no right answer or wrong answer. Thanks so much!

The client completed the survey on her own and returned it to the researcher. The client's responses were immediately covered so no one else in the room could see or comment on them.

Throughout her time in the waiting room, the researcher participated in friendly conversation with the clients, as seemed socially appropriate. Many of the clients wanted to know where she had learned to speak Spanish, but other topics of conversation included family, food, the weather, politics, the school system, the flu, and the importance of having healthcare providers who speak Spanish. The concept of "trust" in a healthcare provider and the significance of the gender of a healthcare provider were not discussed, since these topics were most pertinent to the investigation and the researcher did not want to bias the participants.

Men, women and children from a variety of cultural backgrounds were present in the waiting room throughout the time that the researcher was there. All women who took a seat in the waiting room were approached about participating, regardless of whether they appeared to be ethnically or culturally Hispanic, to guard against selection bias. If a mother and adolescent daughter were present, the researcher only asked the mother if she wanted to participate. The rationale for this selection was that the adolescent who came with her mother was not yet making her own healthcare decisions.

Thirty-seven women were approached with the option of participating in the study. Of those who refused: 5 did not speak Spanish, 2 spoke but could not read Spanish, 2 left the waiting room before completing the survey, 1 could not read because of poor eyesight, and 2 did not specify a reason. Of the 25 who completed the survey: 4 indicated that they preferred to speak with the researcher in English, and 21 indicated that they preferred to communicate in Spanish. The time to complete the survey was 1-3 minutes. Four participants asked questions of the investigator or others in the waiting room, to clarify the meaning of the questions on the survey, but no one discussed her personal survey responses with anyone else.

Survey Instrument

The survey instrument was drafted in Spanish by the researcher, and then edited and back-translated by two native Spanish-speakers for grammar, accuracy and readability. It was reviewed, critiqued, and approved by the medical director of Esperanza Health Center for use at the clinic. No other instruments were found in the literature that could be used as a precedent in the development of the instrument, so questions were drafted using critical thinking techniques and an effort to avoid biased language. Limited demographic information was collected to enhance analysis. See Appendices A and B for the survey instrument and English translation, respectively.

Results

The sample (n=25) yielded diversity in age, country of origin, years in the U.S. and comfort level with speaking English. The age range was 15 to 59 years old, mean 36 years old, median 35 years old, with even distribution throughout age categories. Countries of birth included: Puerto Rico, n=12; USA, n=4; Mexico, n=3; Columbia, n=2; Dominican Republic, n=3; and Ecuador, n=1 (Figure 1). Number of years in the U.S. ranged from 1 to 38 years for those who were born outside of the U.S. (Figure 1). Half of the women had immigrated as adults at the age 20 or older, and half were born or had lived in the U.S. since childhood or adolescence (Figure 1).

There was a diverse range of participants' self-rated comfort level with speaking English. On a scale of 1 to 10, 8 participants gave a score between 1 and 3 (not comfortable speaking English), 7 participants gave a score between 4 and 7 (somewhat comfortable speaking English), and 10 gave a score between 8 and 10 (very comfortable speaking English) (Table 1). In general, women who lived in the US for a longer period of time rated themselves as being more comfortable with speaking English (Figure 2).

In response to the survey question regarding the importance of seeing a Spanish-speaking doctor, 80% of the participants (n=20) gave a response of 9 or 10, "very important" (Figure 3). The participants who assigned a 7 or lower to the importance to having a Spanish-speaking doctor ranked their English comfort level at a 7 or above (Figure 3). However, even some of the participants who had lived in the U.S. for their entire lives and spoke English with a comfort level of 10, preferred a Spanish-speaking doctor (Figures 1, 3).

In response to the question about likelihood of following the health advice of a doctor who does not speak Spanish, 56% of the participants (n=14) gave a response of 9 or 10, indicating that they were still very likely to follow that health advice (Figure 4). Forty-four percent of the participants (n=11) responded with rankings of 8 or lower, indicating that they were less likely to follow that health advice (Figure 4). In general, women who felt it was very important to have a Spanish-speaking doctor reported a lower score for their likelihood of following the advice of a non-Spanish speaker. Conversely, women who placed less importance on having a Spanish-speaking doctor said they were more likely to follow the advice of a non-Spanish speaker.

In response to the question regarding gender preference for the health provider, 12 women preferred to see a female doctor, 12 women said either male or female was fine, and 1 preferred a male doctor. There is no correlation between the country of origin, comfort level with English, age, or years in the U.S. and the preference for a female physician.

Discussion

The findings reveal that having a Spanish-speaking healthcare provider is very important to many Latina women. This is consistent with research by Shaffer (2002), who associated the preference for Spanish-speaking medical staff with the importance of having a health provider who understands the cultural values of the patient. The findings of this study also demonstrate that even some women who feel comfortable with their English-speaking abilities would prefer to have a Spanish-speaking health provider. This builds on the work of Luquis and Cruz (2006), who found that Hispanic women prefer to communicate in Spanish when discussing women's health topics with their doctors.

Interestingly, this study also revealed more about the difficulties with translator use by non-bilingual health providers. The questions on this survey asked about the importance of having a Spanish-speaking provider even if a "good Spanish interpreter" was available to work with an English-speaking provider. In spite of this qualification,

the participants still believed it was very important to have a Spanish-speaking doctor, and were less likely to follow the advice of a doctor who did not speak Spanish. This is consistent with work done by Baker et al. (1998) which showed decreased patient satisfaction when a translator was used.

Importantly, this study reveals that Spanish-speaking women may be at risk for not following the health advice of a doctor who does not speak Spanish, even when a translator is available, since the questions were asked in this context. This sheds some light on the issue of trust in a healthcare provider which has not yet been explored by other research with Hispanic women. While the responses to the question on trust were varied, the findings are important because they demonstrate that for some women, the issue of speaking a different language from their provider is a real barrier to following through with health advice and interventions. This barrier may be a contributing factor to the disparity in healthcare faced by low-income and uninsured Hispanic women in the U.S., who already face a multitude of health risks related to acculturation. Language differences are not merely an issue of preference, but one that is intertwined on a deeper level with trust and ultimately with the health of thousands of women.

Limitations and Suggestions for Further Research

The sample size was relatively small, so although there was diversity within the sample (eg: age, country of birth, years in the U.S., comfort level with English), there are limitations on the generalizability of the data. The sample may be representative of low-income Hispanic women in Philadelphia, but it cannot necessarily be generalized to Hispanic women of higher socioeconomic status, women living in rural areas, or women in different regions of the U.S. Also, the questionnaire was only provided in Spanish, so women who were native Spanish-speakers but could not read Spanish were excluded from the sample. The instrument itself presents limitations since it was not formally tested with a pilot group for readability, accuracy, validity and reliability. Finally, the issue of gender preference for a healthcare provider was inconclusive in this study; it is apparent that many women prefer a female provider, but no definitive data regarding the reason for this preference was obtained.

Future research should be conducted on the topic of language spoken by a healthcare provider and the trust that Hispanic women have for their health provider. A larger study should include an instrument that has been analyzed for readability, accuracy, validity and reliability. The sample should be drawn from more health centers in Philadelphia, and could even be expanded to include other cities and communities. The topic of healthcare provider gender should be explored through further research, and questions should be developed to target the reasons why some women prefer a female provider, and if this issue is pertinent to trust in the provider.

Recommendations for Multidisciplinary Team

Healthcare providers who work with Spanish-speaking clients on a regular basis should learn Spanish and be wary of reliance on translators. While translation is an important tool, culturally competent care includes speaking directly with patients as much as possible. Bilingual clinicians should always offer to speak in Spanish with their clients, and use the language that the client prefers. This study demonstrated that when Spanish-speaking women are approached and given the option of speaking the language of their choice, a large majority are eager to speak Spanish even with a researcher who is not completely fluent. Offering Spanish communication is worth the effort to build a stronger, trusting relationship between provider and patient, which opens the door for long-term positive outcomes. On a broader multidisciplinary level, social workers, policymakers and others who interact with the Hispanic American population should promote awareness of the importance of Spanish language communication, as a means to break down health barriers and build trusting relationships between healthcare providers and patients.

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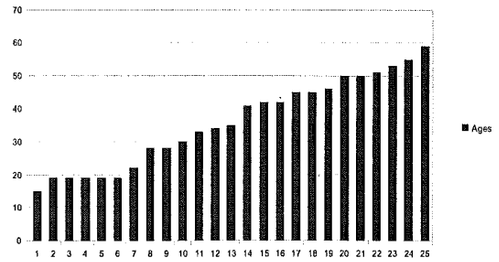
Age Distribution of Participants



Range: 15-59
Mean: 35.96
Median: 35
Mode: 19

Figure 1. Age distribution of participants, women ages 15-59.

Country of Origin, Age and Years Living in the U.S.

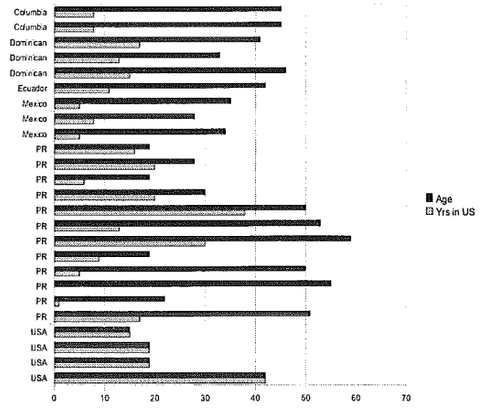


Figure 2. Participants listed by country of origin; demonstrates ages and years living in the U.S.

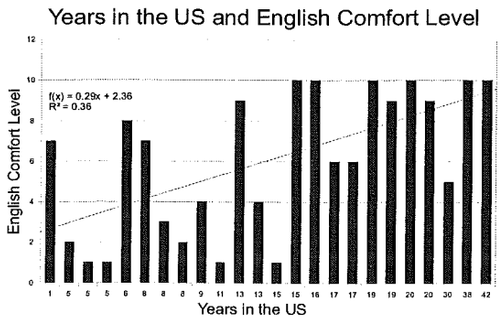


Figure 3. Participants' years living in the U.S. and their self-described comfort level with English. There is a positive correlation between longer length of time living in the U.S. and higher comfort level with English.

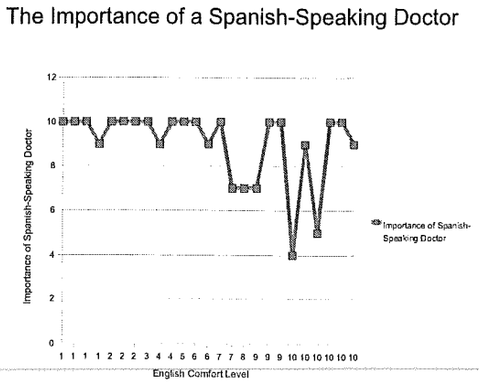
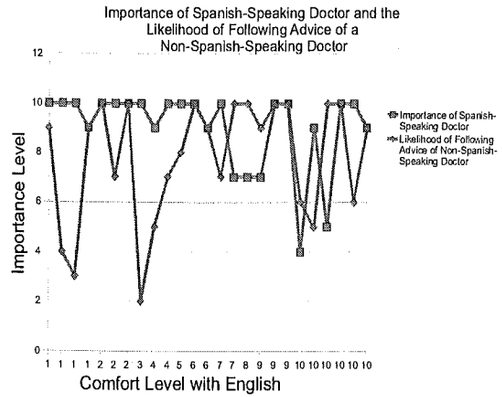


Figure 4. Comfort level with speaking English and the importance seeing a Spanish-speaking doctor. Even some women who said they were very comfortable with English preferred a Spanish-speaking doctor.

Figure 5. Comfort level with speaking English, the importance of seeing a Spanish-speaking doctor, and the likelihood of following the advice of a non-Spanish-speaking doctor. In general, women who gave higher importance to having a Spanish-speaking doctor reported that they would be less likely to follow the advice of a non-Spanish-speaker; women who gave lower importance to having a Spanish-speaking doctor said they would be likely to follow the advice of a non-Spanish speaker.



Self-Reported Comfort Level with speaking English on a scale of 1-10	Number of Participants who self-reported in each category	Qualitative Descriptors for general categorization
1	4	Not comfortable (1-3) n=8
2	3	
3	1	
4	2	Somewhat comfortable (4-7) n=7
5	1	
6	2	
7	2	
8	1	Very comfortable (8-10) n=10
9	3	
10	6	

Table 1. Participants' self-rated comfort level with speaking English. Qualitative descriptors were added in column three to demonstrate the even distribution of English Comfort Level among women in the sample.

Examination of Pregnancy-Associated Breast Cancer Management in Consideration of Associated Ethical Dilemmas

Amanda Fredericks

Abstract

Pregnancy-associated breast cancer (PABC) is breast cancer that is diagnosed during pregnancy, lactation, or within one year of delivery (Ulery, Carter, McFarlin, & Giurgescu, 2009). While the standard approaches to breast cancer treatment include surgery, chemotherapy and radiation, a concurrent pregnancy poses ethical issues due to the potential teratogenicity (i.e., the capability of producing fetal developmental abnormalities) of treatment options that would benefit the mother. Due to the rarity of the condition, case reports, small retrospective studies and literature reviews about PABC treatment are limited in number within the current literature base, thus making evidence-based treatment recommendations difficult. Contemporary literature suggests that chemotherapy during the first trimester is contraindicated. However, while in-utero exposure to many of the chemotherapeutic agents during the second and third trimesters may increase risk of intrauterine growth retardation and low birth weight, the risk of serious malformation or death of the fetus is not significantly different compared to the risk for the general population of women. PABC treatment requires a strong focus on educating the patient about the risks and benefits of all her options, and providing the appropriate support to make this ethically challenging decision about cancer care and pregnancy.

Pregnancy-associated breast cancer (PABC) is breast cancer that is diagnosed during pregnancy, lactation, or within one year of delivery (Ulery, Carter, McFarlin, & Giurgescu, 2009). A diagnosis of cancer during pregnancy is very uncommon (Beidler, 2000; Partridge & Schapira, 2005; Pereg, Koren, & Lishner, 2008). Approximately 1 in 3,000 women are diagnosed with breast cancer during pregnancy in the United States (Visco, Meyer, Xi, & Brown, 2009), making PABC rare when compared with the lifetime breast cancer risk of 1 in 8 women among the general population (Goldman & O'Hair, 2009). However, of all pregnancy-associated cancers, breast is one of the most frequently identified primaries (Cardonick, Usmani & Ghaffar, 2009; Psyrri & Burtness, 2005; Visco et al., 2009). Cancer risk increases with age, and as more women delay childbearing until their 30s or 40s, the incidence of PABC is expected to rise (Goldman & O'Hair, 2009; Pereg et al., 2008). Surgery, chemotherapy and radiation are the standard approaches to breast cancer treatment (Partridge & Schapira, 2005; Visco et al., 2009), however management of PABC with these treatment modalities requires careful consideration of the lives of both mother and fetus.

Mosby's Medical, Nursing, & Allied Health Dictionary (2002) defines "ethics" as "the science or study of moral values or principles, including ideals of autonomy, beneficence, and justice." Treatment of PABC poses ethical challenges in upholding these principles in regards to both mother and baby. Chemotherapy is cytotoxic in nature, in that it kills rapidly dividing cells and may result in genetic damage (Partridge & Schapira, 2005; Patni et al., 2007). While the mother may benefit from chemotherapy's anti-cancer effects, the developing fetus may be at risk for teratogenic (i.e., capable of producing fetal developmental abnormalities) (Mosby's medical, nursing & allied health dictionary, 2002) effects such as spontaneous abortion, intrauterine growth retardation (IUGR), organ toxicity, premature birth, and low birth weight (Beidler, 2000; Partridge & Schapira, 2005; Visco et al., 2009). Radiation therapy, although an important aspect of maximally effective breast cancer treatment, would expose a fetus to intolerable levels of scatter radiation posing risk of IUGR, congenital malformations, or fetal demise (Beidler, 2000; Goldman & O'Hair, 2009; Partridge & Schapira, 2005; Visco et al., 2009). Even surgical removal of malignant tissue, which is the ultimate goal of breast cancer management, poses potential threats to the health of both mother and baby in the context of PABC. While there is concern about exposing the fetus to anesthesia during surgery, there is also dimin-