A Quest for Common Ground: Communication Factors Among Latino Patients, Medical Practitioners and Interpreters in the Daviess County, Kentucky Area

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A QUEST FOR COMMON GROUND: COMMUNICATION FACTORS AMONG
LATINO PATIENTS, MEDICAL PRACTITIONERS, AND INTERPRETERS IN THE
DAVISS COUNTY, KENTUCKY AREA

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LATINO PATIENTS, MEDICAL PRACTITIONERS, AND INTERPRETERS IN THE 
DAVIESS COUNTY, KENTUCKY, AREA

Sandra Faye Merkel-Finley  December 2000  Pages iv-vi

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Statistical evaluation of the number of Hispanics in the United States in a given year varies. However, all data suggest that the Hispanic population will become the largest ethnic minority in the United States in the new millennium. This research illuminates for health care providers and interpreters cultural factors to consider in the delivery of patient-centered and efficacious care for the ethnic patient, specifically the Latino. The research project answered the question What culture-related factors impact effective communication between Mexican patients and American medical nurses in the Daviess County, Kentucky area? The project focused on the interpersonal aspects of culture and communication that occurred during the communication process of sharing ideas, information, and feelings.

Previous studies focused on health care communication cast in the traditions of medicine, psychology and sociology. This project adds research results to a communication process described by clinically based medical journals that only anecdotally refer to communication patterns and concepts. Cultural background may give
insight into why and how patients and their family make decisions related to care. By recognizing personal philosophy, values, biases, attitudes and religious beliefs, which are based on culture, a person can facilitate effective communication. This data provides medical practitioners and interpreters insight into the cultural, medical, and communication concepts and characteristics that exist among the Latino patients, the interpreter and themselves. Through this understanding the health care professionals may gain practical application to provide better care and service to Latino patients, enhanced patient compliance, and possibly awareness about themselves and their own worldview. The research provides additional support to Edward Hall’s theory that states that the way people act and react during communication is based on past experiences and cultural beliefs.

This study, conducted at a local health department, utilized a questionnaire and participant observation based on a new cultural paradigm. The paradigm combines parts of the frameworks established by Harris and Moran (1996) and Kielich and Miller (1996): orientation (ethnic identity), religion, time orientation, relationships (gender, age, status...), language (verbal and nonverbal), education, values and norms, and beliefs and attitudes (especially toward health). The questions also added another component, acculturation. The design involved a written questionnaire for the nurses who provided care through the Green River District Health Department, a written questionnaire in the native language of the Latino patient, a written questionnaire for the interpreter, and participant observation of the medical examination. The research methodology controlled for variability by including only native-born Mexican patients. The project focused on
one particular ethnicity with three interpreters and five Mexican patients.

This study indicates that several cultural factors impact communication among Latino patients and American medical practitioners. Overcoming the language barrier should be the first step in diminishing the communication gap. However, cultural aspects of communication outlined in the research need addressing to achieve intercultural communication success. The data reveals new ideas for intercultural communication research in the areas of medicine. By combining the disciplines perhaps a better product will be developed—a synergistic approach to health care communication.
CHAPTER I
The Problem, Theoretical Foundation, and Basic Research Plan

Introduction

As the world grows smaller, communication opportunities become greater. In 1991 the United States Bureau of the Census predicted that by the year 2000, 85 percent of the new entrants into the labor force would consist of minorities and women (Albert, 1994). U.S. minorities come from all over the world bringing with them different worldviews that influence how they communicate. According to Samovar and Porter (1994), “The link between culture and communication is crucial to understanding intercultural communication because it is through the influence of culture that people learn to communicate” (p. 19). Samovar and Porter add that one should consider culture when evaluating the communication among people, because culture plays a critical role in the entire process.

Statistical estimates of the number of Latinos in the United States in a given year vary. However, all data suggest that the Latino population will become the largest ethnic minority in the United States in the new millennium. According to Samovar and Porter (1995), “The Latino population, composed of people from Mexico, Puerto Rico, Cuba, and Central and South America, is the fastest-growing co-culture in the United States, and demographic experts predict that it will grow to over 35 million by the year 2000” (p. 241).
The Daviess County, Kentucky, area provides a multitude of agrarian opportunities for migrant workers. Latinos compose the majority of migrant workers in Daviess County and surrounding communities. The new cultures create new challenges to the communities, especially in the field of health care. According to Ruben (Ray & Donohew, 1990), “For the patient, even “routine” history-taking, physical exams, and tests are discomfoming. This is a consequence of the necessity for levels of verbal disclosure and physical contact normally reserved for intimate relationships” (p.52). After the initial diagnosis, the patient must sometimes make behavioral modifications, continue with testing, or accept uncertainy about his or her health. I decided to add another component when focusing on the communication process occurring among health care providers and patients. This study analyzed and evaluated patient/health care provider interaction through the lens of intercultural conceptual frameworks. The research project addressed this question: What culture-related factors impact effective communication between Mexican patients and American medical nurses in the Daviess County, Kentucky, area?

Application of Communication Concepts and Theories

According to Pettigrew and Logan (Berger & Chaffee, 1987), “Health communication has no overarching theory from which to proceed, nor an exemplar of research. This lack of coherence is due to three conditions: the peculiar nature of health care context, the vast range of communication phenomena to study, and the fact that communication has been studied from the points of view of other disciplines” (p. 675). Pettigrew and Logan also state that past research focused on health care communication cast in the traditions of medicine, psychology and sociology. They say that researchers
need to apply communication theories to help provide advancements on the interpersonal level in health communication. They suggest that some of the research done on doctor-patient relationships does not thoroughly apply and test theory from the communication discipline leaving us with only a vague understanding of how patients and health care providers interact.

To encourage effective communication Kielich and Miller (1996) suggest that physicians and health care providers discuss with the patient the reasons behind the tests prior to diagnosing. Determining the meaning a patient affixes to certain words and situations before imparting the results of the test will help the practitioner frame the message (Kielich & Miller, 1996). This approach, which urges the practitioner to create person-centered messages to gain a better chance of reaching his or her goal for communicating, reflects Jesse Delia’s (1982) Constructivism Theory.

Creating person-centered messages requires a cognitively complex individual, according to Delia’s theory. To determine the cognitive complexity of an individual the researcher would use three frames of reference: differentiation, abstraction and organization. An individual would describe another based on his or her interaction with that person. Differentiation involves the number of different personality constructs used to describe an individual such as entrepreneurial, creative, and ingenious. Abstraction involves mentally deriving visible behavior in relation to psychological processes. For instance, to say that someone is chivalrous requires visibly connecting action with a mental process. Last, the individual then organizes opposing impressions of the other individual. For example, a person may be chivalrous but insensitive to others’ feelings, cognitively complex individuals will use more constructs; basically, they will think of
more terms to describe someone based on what they see and experience with that individual. Griffin’s (1994) synopsis of the theory states that the cognitively complex individual, a sophisticated observer of the human scene, pictures people as intricately individualistic. Creating person-centered messages relies on constructing communication in a way that the receiver can understand.

As regards to the issue of compliance with medications, hygiene, and immunizations, another communication theory may apply in conjunction with the person-centered messages. Sherif’s (1965) Social Judgment Theory involves persuasion and influence which depends on latitudes of acceptance, rejection and noncommitment (Sherif, Sherif, & Nebergall, 1965). Medical practitioners strive to receive 100 percent patient compliance. According to Sherif’s (1965) social judgment theory, if a practitioner becomes aware of the values a patient holds, that practitioner could influence whether or not a patient will accept, reject, or feel noncommittal about medical directives.

According to the Social Judgment theory, when a person hears a message, he or she immediately places judgment based on the three zones of latitude. The level of importance an individual places on the topic, which is termed ego-involvement, determines the degree of latitude. For instance, if a person does not see the issue as important to himself or herself -- low-ego involvement -- the wider his or her latitude of noncommitment will be. The theory also states that the higher the ego-involvement on an issue the more difficult it will be to persuade that individual to change his or her attitude. For example, according to Cassell (Vol. 2, 1985) some people, after receiving a possible prognosis that may occur in the future, will take medications or directives seriously. The message was within the patient’s latitude of acceptance or was close enough to be
“assimilated.” However, Cassell states, “For another patient, saying that the medication must be taken now to forestall some far future event (as in the prevention of stroke or heart disease in hypertension) is the equivalent of diminishing any sense of the importance of the event and, therefore, of taking the medication” (Vol. 2, 1985, p. 28). In this instance, the message fell within the latitude of rejection for the patient who now considers the issue unworthy of consideration, a process Sherif calls “contrast.”

This situation brings up a question from a cultural standpoint; would Latinos, classified as oriented in the present, take preventative medications as directed less often than would Americans, classified as future oriented? Finding the latitude of acceptance may provide a common ground to promote communication and, according to Sherif’s theory, achieve “assimilation.” Although certain situations require persuasion, understanding and tolerance of others’ belief systems become the basis for productive communication in the health care environment. For instance, in the study of diabetic Latinos, Lipton et al. (1998) said that nurses and dietitians gained credibility in the eyes of the Latinos because of a close affiliation with the patient’s physician. However, the respect at times inhibited communication. Patients refrained from asking questions. “According to one physician, ‘they nod yes out of politeness’” (Lipton et al., 1998, p.70).

With increased competence, patients and medical professionals can share positive aspects from their prospective cultures. A holistic approach to treating people requires consideration of three distinct cultures in the provider-client process: the culture of the client, the culture of the primary care nurse, and the culture of the health care system in which the interaction occurs (Burk, et al., 1995).
Although from a one-sided perspective, Kielich and Miller (1996) take the philosophy one step further by providing a guide for cultural assessment of patients. The cultural components include communication style, orientation, nutrition, family relationships, health beliefs, education, and religion. Kielich’s and Miller’s guide almost mirrors Harris’s and Moran’s (1996) general paradigm, which helps people understand either a macroculture or a microculture. However, Harris’s and Moran’s guide included sense of self and space, dress and appearance, work habits and practices and time and time consciousness. However, neither of these cultural guides nor Burk and his co-authors’ philosophy allow for the concept of acculturation, a component that merits consideration (LaFromboise, et al., 1993; Kim, 1980; Chavez, et al., 1977; Alba, 1995; & Lipton, et al., 1998). By evaluating the meaning of acculturation and establishing a core of pervading principles, we may begin to understand the need for more effective communication between ethnic patients and health care professionals. Understanding how acculturation and communication impact each other will help people gain bicultural-multicultural competence. With increased competence patients and medical professionals can share positive aspects from their prospective cultures. The literature to date also lacks a another cultural component, the interpreter.

Effective communication begins with the realization that everyone’s actions and reactions grow out of past experiences, cultural beliefs, and cultural heritage. In general, increasing knowledge about and application communication theories to health care interactions may provide assistance to those who struggle with bridging gaps to create understanding. Achieving effective communication in situations outlined in this review of literature proves a difficult task because of the extreme differences of perceptions
between the American health care workers, the interpreters, and the patients from other cultures. Providing efficacious care to Latino patients requires effective communication. At a minimum, three cultural perspectives exist in a patient examination. This research project attempts to meld the aspects and concepts, such as time orientation, relationships and language from the disciplines of communication and medicine in an effort to discover the communication factors and patterns that exist between American medical practitioners, Latino patients, and interpreters. The data will provide medical practitioners and interpreters insight into the cultural, medical, and communication concepts and characteristics that exist among the Latino patient, the interpreter, and the medical practitioner.

Through this understanding, the providers will gain practical application to provide better care and service to Latino patients, enhanced patient compliance, and possibly awareness about themselves and their own worldview. Communication factors influence the amount of information that patients retain and their level of satisfaction (Pettegrew and Logan, 1987). On an even higher level of interpretation, Craig (1989) states that communication as a practical discipline extends beyond explanation, prediction, control, understanding, intertextuality, and human emancipation. Craig (1989) adds, “As a practical discipline, our essential purpose is to cultivate communicative praxis, or practical art, through critical study” (pp. 97-98). Bormann (1989) agrees, “While it may be fun to write think pieces about our philosophical underpinnings, much of what we do relates to our study and application of special theories to the daily communicative needs of our societies” (p. 138).
Analysis

Because culture makes us who we are, I doubt that we will ever free ourselves completely. However, by acknowledging the latent forms of cultural behaviors of others and ourselves, we move forward in the quest for effective communication across cultures. Hall (1977) stated that culture shapes our lives through a series of situational models for behavior and thought. He recognized that raising awareness of the latent forms (i.e., unstated realm of culture) of cultural models would help people interact effectively interculturally and understand each other’s cultures. Hall said, “Man must now embark on the difficult journey beyond culture, because the greatest separation feat of all is when one manages to gradually free oneself from the grip of unconscious culture” (1977, p. 240). I embarked on this research project to help loosen the grasp of unconscious culture on the medical practitioners and thereby enable them to provide better care to the Latino patient.

I selected the Green River District Health Department for this study because of the accessibility allowed for the research, the variety of medical services provided emphasizing preventative health care, accessibility for Latino patients to receive care, and the situational context that does not involve medical emergencies. Based on the situation, people act according to the stated and unstated rules of their cultures (Hall, 1977). Hall said, “The situational frame is the smallest viable unit of a culture that can be analyzed, taught, transmitted, and handed down as a complete entity. Frames contain linguistic, kinesic, proxemic, temporal, social, material, personality, and other components” (1977, p. 129). By isolating and identifying certain frames and the actions associated with those situations, researchers can study and learn about cultures. “Frames represent the
materials and contexts in which action occurs—the modules on which all planning should be based,” he added (Hall, 1977, p. 129).

The Green River District Health Department personnel showed a willingness to participate in this type of research and expressed an appreciation for any information that would help them in achieving their mission of improving the quality of life through promoting, protecting, and enhancing the health and well being of the public. This willingness showed promise of the personnel’s inclination to develop culturally perceptive communication techniques. This willingness fosters a good environment for change and growth to occur, according to Hall (1977). He said that knowledge about other cultures should come from our own desire to grow rather than from imposed sanctions from outside sources. He also said that we will grow individually by learning more about other cultures. Hall (1977) said, “To do so, however, we must stop ranking either people or talents and accept the fact that there are many roads to truth and no culture has a corner on the path or is better equipped than others to search for it” (p. 7).

The study revealed general viewpoints of the individuals involved, thus giving some insight about how the participants viewed the communication process. We must understand how and why we think and feel about situations before we can adequately analyze another individual’s standpoint. Hall said, “Self-awareness and cultural awareness are inseparable, which means that transcending unconscious culture cannot be accomplished without some degree of self-awareness” (p. 212).

In their mission statement the Department vows to try to identify all those elements within the community that may threaten the health of its populace and make changes to provide workable solutions to the challenges. Doka (1998) states, “...a basic
goal of care giving is to assist clients in understanding the ways their own worldview can provide strength, comfort, and meaning rather than attempting to impose another worldview on them” (p.4). This research offered information for a comparison of these data to previously documented intercultural health communication, but also documented the communication characteristics and patterns such as eye contact, nonverbal dynamics and relationship sharing occurring among the participants for practical use.

The data provided information regarding interaction and relationships between patient and a medical practitioner other than a physician which remains currently underrepresented within communication studies (Sharf, 1993). This project provided additional support to Hall’s (1977) theory that the way we act and react during communication is based on past experiences and cultural beliefs. Hall said, “In summary, regardless of where one looks, one discovers that a universal feature of information systems is that meaning (what the receiver is expected to do) is made up of: the communication, the background and preprogrammed responses of the recipient, and the situation. (We call these last two the internal and external context)” (1977, p.100). This project also added research results to a situation described by clinically based medical journals that only anecdotally refer to communication patterns and concepts.

The questions used in this research relate to a cultural paradigm combined from Harris and Moran (1996) and Kielich and Miller (1996): orientation (ethnic identity), religion, time orientation, relationships (gender, age, status…), language (verbal and non-verbal), education, values and norms, and beliefs (especially toward health). In addition, I added the concept of acculturation. The acculturation questions for the Latinos consist of two types of networks: general communication and friendship (Yum, 1989).
Although the review of literature and the interviews related certain common aspects among Latino peoples, I wanted to reveal systematically rather than assume meanings and patterns of the communicative activity to apply a theoretical model (Yum, 1989). The survey question I asked related to the general communication network which involves people with whom the Latino person talks most frequently during the week, either face to face or over the telephone. The social context plays an important role in the communication interaction. According to Yum (1989), “The network paradigm brings a new perspective to general theories of communication” (p. 494). She said that many of the communication theories emphasize the individual as the unit of analysis, based on personal characteristics, socioeconomic status or even just an individual’s message. These theories may relate more to Americans’ focus on individualism than to other cultures which value collectivism. The communication network paradigm also addresses social context, which, as found in this review of literature, contributes to the intercultural communication process.

Although the guide I chose to apply does not address every aspect of culture, I focused on certain characteristics of culture rather than taking a systems approach (Harris & Moran, 1996, p. 129). I feel that this guide produces a framework to help understand and delineate the nature and scope of cultural variation between the American medical practitioner and the Latino patient. The framework helps provide a starting point in contexting the communication situation. Each situation may require differing amounts of time and effort. Hall stated, “From the practical viewpoint of communications strategy, one must decide how much time to invest in contexting another person. A certain amount of this is always necessary, so that information that makes up the explicit portions of the
message is neither inadequate nor excessive” (1977, p. 92-93). Through my analysis I am delivering data to help others in their efforts to contextualize the Latino during the medical interview.

This research offers information for a comparison of these data to previously documented intercultural communication, but also documents the communication characteristics and patterns occurring among the participants in Daviess County area for practical use. Cassell (1985, Vol. 2) concludes that medical practitioners cannot understand a patient’s health status without knowing the subtle nuances of the patient. He states that communication provides the opportunity for balanced medicine.

The research project addressed this question: What culture-related factors impact effective communication between Mexican patients and American medical nurses in the Daviess County, Kentucky, area? The project focused on the interpersonal aspects of culture and communication that occur during the sharing of ideas, information, and feelings between the medical practitioner and the Latino patient.
CHAPTER II
Review of Literature

Introduction to Literature Review

The review of ethnographic literature presents issues that may relate to providing health care for Latinos in the area Daviess County, Kentucky. Interviews with Sister Fran Wilhelm (June 12, 1998), Centro Latino Director in Daviess County, Kentucky, and Octavia Rodriguez (June 18, 1998), a native of Veracruz, Mexico, who now lives in Daviess County, provide additional information about the local Latino population. The review begins with a broad overview of culture and intercultural communication and then focuses on defining the term Hispanic/Latino. A general cultural analysis of the Latino population intertwines with an outline of some of the health care issues faced by medical professionals and Latino patients. This chapter concludes with an overview of the methodology and theoretical framework that guides the analysis.

Culture and Intercultural Communication

To understand how culture impacts communication we must first understand what composes culture and how those components influence us even as we influence them. Samovar and Porter (1994) state, “Culture is the deposit of knowledge, experience, beliefs, values, attitudes, meaning, hierarchies, religion, notions of time, roles, spatial relations, concepts of the universe, and material objects and possessions acquired by a group of people in the course of generations through individual and group striving” (p. 11). Harris and Moran (1996) agree that people create the components that make up
culture based on physical or biological environment which they then pass on to future
generations. Over time the practices or customs become unconscious manifestations that
the group accepts as “truths” of life.

Awareness that culture impacts communication may help in bridging the
intercultural gaps in communication. The awareness of personal communication process
such as what a person said and how he or she said something plays only a small role in
the process. To arrive at a deeper understanding is to question what made them think the
way you did in order to reply in that manner. According to Samovar and Porter, “It is
quite clear that knowledge of intercultural communication can aid in solving
communication problems before they arise. School counselors who understand some of
the reasons why the poor perceive school as they do might be better able to treat young
truants. Those who know that Native Americans and Latinos use eye contact in ways that
differ from other Americans may be able to avert misunderstanding. And, perhaps, those
who realize that some people treat illness as a curse may be better able to deliver
necessary health care” (1994, p. 2). Understanding involves more than just awareness.
Gudykunst (1987) suggests that understanding means interpreting incoming stimuli in
order to describe, predict, or explain. Then in turn, understanding cycles back into and
influences social cognitive processes.

“Hispanic” Versus “Latino” – What’s in a Name

In 1970 the United States Bureau of the Census created the term “Hispanic” to
identify people of “Spanish origin” (Siantz, 1994). Now a refinement of the term
includes four subdivisions: Mexican or Mexican-American including Chicano; Puerto
Rican or Boricua; Cuban or Cuban American; “Other” Spanish or Hispanic, including
Central and South Americans. Some scholars feel that more Spanish-speaking people prefer the term "Latino," which focuses on Latin America rather than Spain. According to Kielich and Miller (1996), the Los Angeles Times barred the use of the word "Hispanic" because of this preference.

Some people dislike the use of one word to identify a general grouping of culturally related individuals. Novello (1991) said, “Too often, the term “Hispanic” is used simplistically, referring broadly to all populations with ancestral ties to Spain, Latin America, or the Spanish-speaking Caribbean. Such uncritical ethnic labeling can obscure the diversity of social histories and cultural identities that characterize these populations and, in turn, can influence health behaviors, the way care is accessed, and ultimately, health outcomes” (p. 106).

From a local perspective, Sister Fran (personal communication, June, 12, 1998) said that according to her experience most Latinos prefer categorization by country. Sister Fran works on a daily basis with the Spanish-speaking people in the area, specifically helping the migrant workers through the Centro Latino, a center that provides services to the migrant population. Sister Fran, who studied Spanish in college, crafted her language and cultural knowledge by living and studying in Venezuela, Bolivia, Chile, Colombia, and Mexico. According to her, the area’s migrant and immigrant population also includes the following nationalities: Salvadorans, Panamanians, Hondurans, Venezuelans, Cubans, Argentines, Puerto Ricans, Dominicans, Guatemalans, Colombians, and Bolivians. Each of these nationalities harbor distinct cultural differences. Similar to variations between New York and California cultures, differences between and within the Latin American cultures depend upon class distinction, city
versus urban dwelling, indigenous versus European descent, educational level, and climatic variances.

Although the word stereotype may deliver a negative connotation, basing generalizations about a culture from an analytical standpoint may help further understanding and communication. This research will define some generalizations regarding themes and patterns to help provide a basis for creating understanding among Latinos and health care professionals. Galanti (1991) states, “A stereotype is an ending point. No attempt is made to learn whether the individual in question fits the statement. A generalization is a beginning point. It indicates common trends, but further information is needed to ascertain whether the statement is appropriate to a particular individual” (p.2). I use the word Latino throughout the review as a general term to describe Spanish-speaking people, realizing that each culture within that generalization maintains distinct differences culturally--yet similarities also exist.

Health Care and the Latino—The Issues

The remainder of this review delves deeper into one particular area of life that presents communication challenges regardless of ethnic differences--health care. This section of the review highlights some issues and cultural factors that impact communication. The topics include the health care culture, the culturally-defined meaning of health, the role of folk medicine in the Latino culture, and the evolving Latino culture.

The health care culture. Health care and the personnel within the field represent a distinct professional culture. Ballweg, Stolberg, and Sullivan (1994) describe health care
as a subculture with its own language, clothing, status symbols, and a set of expected behaviors for patients and practitioners. Ruben (Ray & Donohew, 1990) posits that the patient/medical practitioner interaction in the simplest sense demonstrates an intercultural relationship. When compounding this occurrence with a variety of ethnicities and worldviews of patients and their families, communication challenges increase. According to Bekman, communication allows for the sharing of scientific advances among the medical professionals and the end user, the patient. According to Bekman, “Moreover, the process of communication is central to the way individuals and societies conceptualize and cope with illness” (1989, p. 51). According to Ruben (1990), patients communicate in order to describe symptoms for the medical practitioner to interpret, diagnose, and treat the problems. However, communication also provides the conduit for the flow of information in hopes of achieving patient compliance for treatment. Frankel and Bekman (1989) add that a large proportion of patients’ noncompliance relates to poor communication during the health care interaction.

A cultural concept of health. Not everyone views health in the same way. The concept of health differs among cultures (Dodd, 1991). Health is partially based on how people adapt to their physical and social environment. Therefore, health and culture closely interrelate. Kielich and Miller (1996) said, “According to the U.S. Immigration and Naturalization Service, 800,000-900,000 new immigrants cross the borders of the United States each year. Each group of new immigrants brings a unique set of cultural beliefs about sickness and health, a vocabulary of medical terms, and, often, a medicine cabinetful of folk remedies, challenging American physicians to use skills not typically taught in medical school” (p. 60). Also, medical statistics show that Latinos face some
medical problems more than do non-Latinos. In the article “Hispanic Health in the United States” (1991) the Council on Scientific Affairs states, “Hispanics are at an increased risk for certain medical conditions, including diabetes, hypertension, tuberculosis, human immunodeficiency virus infection, alcoholism, cirrhosis, specific cancers, and violent deaths” (p. 248). Many of these illnesses require ongoing treatment to control the effects on the body.

The lack of education in some of the rural areas in Latin American countries may impact the understanding of certain aspects of health care, such as immunizations or insulin treatment. The Council on Scientific Affairs (“Hispanic,” 1991) reports, “Certain factors contributing to morbidity and mortality features are endemic among Latinos, particularly when examined by subgroup. In addition, cultural norms, poor knowledge of English, and socioeconomic status affect Hispanics’ use of health care” (p. 248). Latinos may not seek medical attention because they lack knowledge about the health care system in the U.S. In their homeland, the majority of Latinos do not receive medical attention for several reasons. Rodriguez (personal communication, June 18, 1998) said that although Mexicans respect physicians and nurses, many families do not value health. She also said that in some of the rural Mexican areas where she worked, the majority of that population, uneducated individuals, misunderstood certain aspects of health care. During National Day, a day set aside for immunizations, many children did not receive inoculation from diseases such as tuberculosis because parents feared that the shot would sterilize their children.

The inability to pay medical bills also keeps migrant workers and immigrants from seeking medical attention. At home if they cannot pay the bill, they do not receive nor
request medical attention. Rodriguez (personal communication, June 18, 1998) said that in Mexico, people with excellent jobs have health social security, but the majority of the population can not pay for care even at reduced costs. She also said that in Mexico a person buys drugs such as antibiotics at the store without a prescription, with the exception of addictive pharmaceuticals. Therefore, many people bypass the medical diagnosis and self-prescribe and treat. Other barriers to Latino health care in the United States include language and insurance, leading to under-utilization of American health care services and possibly an increased utilization of folk medicine, which forms a topic of discussion later.

In communicating and interacting with patients, medical practitioners discover culturally-based reactions and behaviors. The Council of Scientific Affairs (“Hispanic,” 1991) reports, “When communicating with a Hispanic patient, health care providers are often, either directly or indirectly, communicating with the patient’s family. Most Hispanic families emphasize interdependence, affiliation, and cooperation” (p. 250). Sister Fran (personal communication, June 12, 1998) supported this statement saying, “Very seldom do you find the nuclear family. It’s common for grandparents, uncles, aunts and/or cousins to live in one house. That’s why a home (in Daviess County) rented to two men may soon house eight.” Octavia Rodriguez, a physician from Veracruz, Mexico, now works in a factory in Owensboro. Rodriguez said, “In Mexico the family lives together for economical reasons” (personal communication, June 18, 1998). She said that the cultural behaviors and values reflect many years of socioeconomic inadequacies of medical care, housing, and social security. In Hofstede’s (p. 222, 1980) evaluation of individualism, the United States ranked 91 out of a possible 100 points as
compared with Mexico, which ranked 30. Individualistic cultures value the individual and that individual’s rights more than group rights. This low ranking shows a strong tendency toward collectivism, valuing the family and relationships, on the part of Mexicans. According to Lipton et al. (1998), the family plays both positive and negative roles. The positive aspect includes emotional support for the patient. However, patients, especially women, did not agree to change family nutrition habits to facilitate management of their diabetes. According to Lipton et al., “Because a common attitude was that the woman’s needs were secondary to the good of her family, expenditures for diabetes medications and supplies were considered less important than other family necessities” (1998, p. 70).

Health care professionals assist patients and families in making ethical decisions. Some of these difficult decisions relate to life and death situations and also major life-changing occurrences. Wright, Cohen and Caroselli (1997) said that decisions become more difficult to make when cultural insensitivity or unawareness inhibits effective communication. Adler (1996) comments that the challenge lies in the medical professional’s realization that his or her personal reality does not reflect everyone’s concept of reality. In evaluating intercultural communication in health care one must also consider acculturation, the dissemination of health information, types of medical treatment, individual’s rights, and cultural beliefs. Novello (1991) agrees that acculturation plays an important role in influencing health.

The impact of folk medicine. Commonly phrased as ‘home remedies,’ the non-medical treatment of illness plays a role in most cultures. However, according to the Council on Scientific Affairs, Latino patients may be more likely than those of some
other cultures to incorporate folk medicine practices to treat some illnesses. However, as Helman (1990) suggests, most cultures believe in folk illnesses. He says that a folk illness represents a unique disorder, recognized mainly by members of a particular culture who present symptoms, diagnosis, and treatment in patterned ways. For instance, American society describes certain life-threatening illnesses such as cancer and AIDS like a “folk illness.” According to Helman (1990), “These diseases (especially those that are difficult to treat or control) come to symbolize many of the more general anxieties that some people have, such as a fear of the breakdown of society, or of invasion, or of divine punishment. In the minds of many in the population, these diseases become more than just a clinical condition: they become metaphors for many of the terrors of daily life” (pp. 99). For instance, the media portray the increase of gangs and drugs in society as a “cancer,” a terrible force that destroys society. In the Latino population some studies reveal that HIV/AIDS patients seek alternative health care, curanderismo. Rivera (1990) reports that some HIV/AIDS patients receive therapy from curanderos and curanderas, indigenous folk healers. The Latinos, in this case particularly people of Mexican descent, may align the disease with certain folk illnesses such as susto, described below. Helman (1990) says that most societies that correlate sickness with social causes and supernatural causes support folk healers. The healers approach sickness holistically, focusing on all aspects of the patient’s life, including the family in diagnosis and treatment.

Some of the cultural folk medicine practices provide the basis for today’s scientific treatments. According to Chesney, Thompson, Guevara, Vela, and Schottstaedt (1980), “Mexican-American folk medicine originated in the humoral medicine of Western Europe, which was brought to the New World by the conquistadores. Humoral
medicine was combined with the herbal medicine of the Aztecs and has been handed down by successive generations throughout Latin America” (p. 567-568). Although many of the medications used today stem from early discoveries, American medical practitioners sometimes scoff at medical treatment that deviates from technologically-based medicine. The United States worldview focuses on the aspect of science over religion (Samovar & Porter, 1995, pp. 126-127). According to Chesney et al. (1980), “Physicians may indicate by their attitude, words, and nonverbal behavior what they think about folk medical illnesses and treatments” (p. 573). They cited a situation in which an elderly Mexican-American said that when he tried to describe some of the folk remedies to a doctor at the medical school, the doctor laughed at him. Helman (1990) warns medical practitioners about failing to realize the necessity of understanding folk illnesses. In his example of how AIDS has become a metaphor for moral punishment, invaders, and a plague, Helman (1990) shows that in some cases this medical disease has become a folk illness, and that some patients do not receive the compassionate care and medical treatment they deserve.

Aside from the anecdotal information retrieved from patients regarding ethnocentric behaviors of the medical personnel, the study performed by Chesney et al. (1980) found that Mexican-Americans chose scientific medicine and/or folk medicine based on symptoms. The randomized sample of 40 families lived in close proximity to a large university health care facility in Texas. According to Chesney et al., “Descriptions of folk medicine among Mexican-Americans have identified three aspects which appear to be central. One is the role of the social network, particularly kin, in diagnosing and treating illness. Another is the relationship between religion and illness, which includes
the use of religious ritual in many healing processes. Yet another is the remarkable consistency of beliefs among Mexican-American communities about symptoms, etiology, and regimens of healing” (p. 568). Helman (1990) describes illness causation in a broader sense. He says that lay theories place the etiology of illness 1) within the individual patient, 2) in the natural world, 3) in the social world (i.e., witchcraft, sorcery or evil eye), and 4) in the supernatural world (i.e., gods, spirits or ancestral ghosts). By using these guidelines a patient gives meanings to his or her sickness. Culture helps people give meaning to sickness and also develops guidelines for expressing illness through behavior. According to Helman (1990), “Folk illnesses are more than specific clusterings of symptoms and physical signs. They also have a range of symbolic meanings – moral, social or psychological – for those who suffer from them” (pp. 97). Therefore, medical practitioners should understand how folk illnesses generate, how people acquire them, and how the illness affects the patients’ behavior and diagnosis.

The following data represent documented information regarding folk illnesses reported by Latinos, particularly Mexican-Americans. Chesney et al. (1980) found that with some symptoms such as stomach pain, loss of appetite, skin rash, headaches and/or swollen ankles, Mexican-Americans tended to seek a home remedy or curandero over medical treatment. More than half sought medical attention for earaches, toothaches, shortness of breath, pain in the chest, lump in the breast, blood in the stools, burning on urination, excessive urination, seizures, and eye problems. However, the Mexican-Americans sought all three treatments when experiencing diarrhea, nausea and vomiting, fatigue, craving food and water, blood in stools, and/or burning on urination.
The Council on Scientific Affairs ("Hispanic," 1991) warns medical practitioners that folk-defined illnesses may seem more prevalent because the researchers find the subject intriguing and write about that topic more than others. The report also states that although Latino patients may describe illness according to their cultural understanding, biologic bases may cause the symptoms, which supports Helman’s (1990) statement that medical practitioners should clearly understand folk illnesses. According to Helman, "In most cases lay theories of illness aetiology [sic] (like medical explanations) are multicausal; that is they postulate several causes acting together. This means that individual, natural, social and supernatural causes are not mutually exclusive, but are usually linked together in a particular case" (1990, pp. 110). Chesney et al. (1980) identify some specific folk illnesses for Mexican-Americans including *empacho, mal ojo, susto and caida de mollera*, but agree that not all Mexican-American families believe in specific folk illnesses.

According to Chesney et al. (1980, pp. 572), the Magnolia Homes Area Survey of 40 Mexican-American families reported the following folk illness descriptions and sources.

*Empacho* – An illness caused by a bolus of poorly digested or uncooked food sticking to the wall of the stomach. Associated symptoms include lack of appetite, stomach, diarrhea, and vomiting. Massaging the stomach and drinking a purgative tea (*estafiate*) are the treatments of choice.

*Mal ojo* (evil eye)—* Mal ojo is an illness to which all children are susceptible. It results from an admiring or covetous look from a person with a strong eye. Symptoms are vomiting, fever, crying, and restlessness.
The evil eye may be prevented if the person with the strong eye touches the child as he admires him. The illness is treated with a *barrida*. A *barrida* is a ritualistic sweeping of the body with eggs, lemons, and bay leaves. The sweeping is accompanied with prayer and is believed to have both diagnostic and treatment value.

*Susto* (fright)—an illness usually associated with a traumatic experience such as witnessing a death. Children are more susceptible than adults. Accompanying symptoms include anorexia, insomnia, hallucinations, weakness, and various painful sensations. Treatment can include a *barrida*, herb tea, and prayer.

*Caida de mollera* (sunken fontanel)—An illness, occurring in infants, which has fallen fontanel as its most prominent symptom. Other symptoms include, crying, failure to suckle, sunken eyes, and vomiting. Treatments include holding the child upside down over a pan of water, applying a poultice to the depressed area of the head, and/or inserting a finger in the child’s mouth and pushing up on the palate.”

Trotter (1991) also reported on these four folk illnesses. However, on empacho he adds that some people believe that eating the wrong food at the wrong time or forcing individuals, especially children, to eat foods they do not want to eat will cause this ailment. He also states that those who are vulnerable, such as children and the elderly, may experience *mal ojo*. Trotter (1991) gives more detail for the cause of *caida de mollera*. He states, “It is an illness specific to infants, prior to the time their fontanelle closes. It is caused by rough handling, accident (e.g., falling from a bed or suffering a
strong bump), or pulling the child away from the nipple too fast” (p. 116). Helman (1990) states that the belief in the evil eye illness also exists throughout Europe, the Middle East, and North Africa. According to Harris and Moran (1996), the culture dictates how the individuals act and react to situations. They will not pay attention to ideas or options that contradict the ‘truths’ or customs that their culture established. Harris and Moran (1996) state, “When cherished cultural notions are challenged and one must confront change, problems develop and a culture can lag behind new discoveries, insights, and realities. Scientific and technological advances, for instance, have outrun common cultural teaching. This is one of the byproducts of the acceleration of change, and results in a culture gap” (p.124-125).

Given all these variances and some of the similarities and, aside from the normal patient care issues facing health care providers, the influx of people from varying cultural backgrounds introduces additional challenges. According to Sennott-Miller (1994), three categories of barriers to health care include availability, accessibility, and acceptability. Sennot-Miller said, “Availability refers to long waits and inconvenient hours in health service settings. Accessibility is described as problems such as lack of transportation, cost, ignorance of health care facilities, loss of pay or no one to care for children” (p. 810). These two factors pertain to many of any ethnic origin. The last factor, acceptability, involves cultural paradigms that impact issues such as verbal and nonverbal communication, values and norms, beliefs and attitudes, religion, time orientation, socioeconomic factors, education, and acculturation (Harris & Moran, 1996, p.120-137).

The evolving Latino culture. With a population of 467,202,199, which includes Mexico, Central America and South America, generalizations about Latinos do not
surface easily (Harris & Moran, 1996). In these areas 23 countries exist with people descending from Native Indians, Europeans, Africans, and Asians. According to Harris and Moran (1996), the people of Indian descent represent the largest percentage of the population, some integrating into modern civilization. Harris and Moran add, “After the development of fairly sophisticated Indian civilizations, there was a period of European colonization and exploitation from the fifteenth through the eighteenth centuries, followed by the wars of independence and attempts at federation during the 19th century. Since the early 20th century, Latin American nations have been engaged in internal and external conflicts” (Harris & Moran, 1996, p. 235).

According to Harris and Moran (1996), Latin American countries vary as regards to governance, socio-economic status, education, history, and society, but common themes and patterns exist and overlap. Some overlapping themes include the influence of the Catholic Church, the value of the family, and the separate and distinct male and female roles. At present many Latin Americans participate in Roman Catholicism. However, statistics show a decrease in impact on daily lives and in numbers of people.

Sister Fran explains that when the Spanish colonized, the priests baptized everyone but did not fully instruct the Mexicans in their new faith. Now other religions have begun to gain a stronghold in Mexico. According to Harris and Moran (1996) “With a conversion rate of 400 per hour, demographers predict Latin American [sic] will be evangelical before the end of the 21st century! The ‘born again’ movement matches the transition toward industrialization and urbanization. The religious cultural shift is away from the more tolerant, feminine orientation with its tragic sense of life and death, toward self-reform, spiritual empowerment, and taking responsibility for improving one’s
own life” (p. 236). Sister Fran agreed that she noticed a change in other Latino cultural characteristics, such as class distinctions. For instance, when meeting with people of the church (with the exception of Chile), Latinos maintain limited eye contact to show respect and class distinctions (*respeto*). Garcia (1996) states, “Implicit in daily conversations, native Spanish-speakers constantly affirm status by manifesting *respeto*. It is implicit conversational nature that reaffirms the cultural vestige of class distinction” (p. 146).

Sister Fran confirms and adds insight into the manifestation of *respeto* in the Latin American culture. “When the migrant workers or immigrants first come they won’t look me in the eye. It would be disrespectful. Looking someone straight in the eye means relationship,” Sister Fran said (personal communication, June 12, 1998). The downcast eyes may also illustrate a subservient attitude. However, Sister Fran said that class distinctions exist but are lessening in importance, especially in Mexico. She attributes this decline to time spent in the United States. People in the United States believe in equality and respect all kinds of work Sister Fran said. This concept of equality Hofstede (1980) termed as low power distance, and high context cultures classify people’s importance based on criteria such as job type, some which are considered more important. The interaction with people in the United States causes additional changes in the Latino culture. The changes may seem positive, but Rodriguez said that the lack of extended family and the constant mobility of the majority of Latinos in the area cause a decreased or nonexistent sense of community among the Latino population in the area. This phenomenon may stimulate an increase in acculturation to the host culture in some respects.
**Acculturation.** For individuals striving to survive in a culture different from their own, change occurs. These adaptations that the individuals make may challenge their cultural ‘truths.’ According to Dodd (1991), “Acculturation refers to the long-term process of adapting to new cultural behaviors that are different from one’s primary learned culture” (p. 310). This definition represents a basic premise on a complicated subject. Some researchers provide more detail to describe the intricate process of acculturation with their models. LaFromboise, Coleman, and Gerten (1993) demonstrate five models with variances in the way people “acculturate” according to psychological processes, social experiences, and individual challenges associated with more than one culture. The terminology describes distinct processes in how people accept or do not accept another culture (LaFromboise et al., 1993). Acculturation represents one of five models, and the term bicultural means the acquisition of an additional culture different from the original.

However, Riveria-Sinclair (1997) uses the terms acculturation and biculturalism at times to describe the same process. At other times the author uses the term biculturalism to mean an approach to acculturation. Unfortunately, the term acculturation stands among many other terms used loosely in the area of culture acquisition, which causes difficulties for a novice to develop guidelines and benchmarks for comparison. LaFromboise et al. (1993) found it difficult to conduct research on the psychological impact of biculturalism because the information spreads across many disciplines. Therefore, the incongruities in terminology result not only from the wide array of disciplines involved but also from the methodologies used in gathering data.
For the purpose of clarity, acculturation is assumed here to mean adaptation of a person from one culture to a different host culture. According to Kim (1980), stretching a coiled spring represents the process of adaptation. The spring stretches and grows but pulls back from its resistance. The process results from positive and negative experiences, sometimes moving forward and then moving backward. According to Kara and Kara (1996), if immigrants do not associate themselves with the host culture as much as they associate with their native culture, acculturation will not occur.

The process of acculturation, one component in providing patient-centered care, poses several potential challenges for health care providers in the Daviess County area. Immigrants living in the area for several years maintain a mixture of U.S. and Latino behaviors, and migrants who move season to season maintain “home” behaviors without the support systems such as family. According to Samovar and Porter (1994), changes and adaptations such as transportation, food and dress, generally affect only the surface structure of the cultures. The foundation of the culture such as beliefs and behaviors related to morals, attitudes toward gender and age, and the importance of past, religious practices remain steadfast, resisting major changes.

The lack of extended family and the constant mobility of the majority of Latinos in the Daviess County area may cause a decreased or nonexistent sense of community among the Latino population. This phenomenon may stimulate an increase in acculturation to the host culture in some respects. However, in the instance of health care, the tendency exists to revert back to familiar ways and behaviors during time of crisis or uncertainty. Although many times researchers evaluate the acculturation process through specific ethnic groups using various research modalities, a core of principles
pervades (Dodd, 1991). The principles include ethnic identification, friendships, and cultural involvement.

**Ethnic identification.** LaFromboise et al. (1993) use the term groundedness, meaning having a well-developed social support system. Groundedness displays similar attributes of ethnic identification. Rodriguez finds that Puerto Ricans in New York City who live in the ghetto maintain more positive attitudes about succeeding in the mainstream economic system than those who live in Anglo-dominated suburbs (as cited in LaFromboise et al., 1993). Rodriguez also has discovered that the association of the ethnic group provided a more psychologically supportive environment. However, through the process of acquiring ethnic identity, especially as regards to children and young adults, acculturative stress may result (Chavez, Moran, Reid, & Lopez, 1977; Kaplan & Marks, 1990). Kim (1980) also states that an overtly strong ethnic bonding can reduce adaptation. Getting beyond this obstacle, Rivera-Sinclair (1997) reveals that Cuban participants appeared to exhibit less stress when they did not need to make a choice between identifying themselves as either Cuban or American. They chose to identify themselves as “Cuban-Americans,” thus eliminating a conflict of divided loyalties.

Ethnic identification, however, poses yet another complicated concept. What do we think about those people who lack ethnic identity? Are these people successfully acculturated? Alba (1995) states that for ethnic groups derived from European immigration, “assimilation (acculturation) refers to opportunities of loosened ties between ethnicity and specific economic niches; a shift in residence away from central-city ethnic neighborhoods to ethnically intermixed suburbs; and intermixing across ethnic lines, resulting in high rates of ethnic intermarriage and ethnically mixed ancestry” (p. 4). A
comparative analysis of United States census data from 1980 and 1990, excluding people of Latino and other minority origins, finds that Americans’ self-concepts do not include ethnic ancestry (Alba, 1995). Assimilation, derived from making choices in order to take advantage of opportunities to improve social situations, sometimes impacts the future more than the present generations (Alba, 1995). Ballweg, Stolberg, and Sullivan state, “At times, participation in mainstream institutions, such as hospitals, universities, and places of employment, leads to pressure on the person to reject his or her cultural identity. Part of cultural pride is the ability to retain ethnic identity and still be successful in the majority culture” (p. 92).

If an individual feels no ethnic identity, Naisbitt (1994) suggests that a resurgence of tribalism will occur. He suggests that in today’s modern society people do not maintain a sense of belonging. The fast-paced society does not provide a sense of permanence or stability. He thinks that people seek membership, a belief system, or religion to obtain something of their own that will last. According to Lipton et al. (1998), a strong ethnic identity can either benefit or interfere with the delivery and implementation of medical care. Therefore, all variables such as clinical, behavioral, intellectual, and social relate to ethnic identity and ultimately impact the compliance with treatment recommendations and medical outcomes. The study also revealed a reason for the refusal of free medicine, the notion that services would eventually necessitate payment or destroy one’s dignidad, strong feeling of pride and self-reliance.

Intercultural friendships and cultural involvement. Although Dodd (1991) separates friendship and cultural involvement, the two aspects cross over into one another. Contact, as related by LaFromboise et al. (1993), becomes an essential element
to develop first a positive attitude toward both cultures. The length and type of contact also contribute to the attitude. If a person lived in rural El Salvador and maintained no contact with American culture until forced to emigrate in early adulthood, that person's sense of personal and cultural identity would be different from his or her United States-born child, who attended public schools since kindergarten (LaFromboise et al., 1993).

As noted earlier, according to Kara and Kara (1996), if immigrants do not associate themselves with the host culture as much as they associate with their native culture, acculturation will not occur. But perhaps more importantly in relation to health care, Yum (1989) states that the more an individual expands his or her interpersonal network beyond ethnic boundaries, the more likely he or she will acquire general information about the host society such as where to receive certain medical services.

In evaluating acculturation one must consider contact and time. Rivera-Sinclair (1997) indicates that the length of time in the United States also played a role in acculturation of an individual. The study finds that the anxiety level of the person decreases as the length of time in the United States increases. Kim states that a person becomes culturally involved if certain conditions exist (Dodd, 1991). The components include acculturation motivation, linguistic competence, education, dual membership, occupational status, uncertainty reduction, and communication difficulty. Intermarriage may figure into this third concept in acculturation. According to Alba (1995), a high rate of intermarriage signals that individuals of different ethnicity do not perceive social and cultural differences significant enough to create a barrier to a long-term commitment.

The study of acculturation and communication involves a dynamic interplay of individuals’ dispositions, environmental constraints, and situational variables. Health care
and the personnel within the field represent a distinct professional culture. When compounding this culture with a variety of ethnicities and worldviews of patients and then adding their families, communication challenges increase.

More Issues and Challenges: Disseminating and Understanding Health Information

Some of the challenges in educating a culturally diverse public include language barriers, literacy, religion, cultural values, biological variations, and level of acculturation. Freimuth (Ray & Donohew, 1990) states that knowing the target audience on as many levels as possible will help build a stronger foundation in health education campaigns. Freimuth adds, “The content of messages must be simple and concrete and, wherever possible emphasize immediate rather than long-term benefits. The messages must be adapted sensitively to the target audience’s cultural beliefs. A message developed for White general public audiences cannot simply be translated into Spanish and be effective with Hispanic audiences” (p. 181). According to Kielich and Miller (1996), a message regarding health must address socioeconomic status, lifestyle behaviors, and cultural values. For example, Kielich and Miller state that a medical practitioner may use the same approach for an acculturated Latina woman as he or she would use for a non-Latina. However, a recent arrival to the United States, for instance, requires a different communication approach. B. Marin and G. Marin also found that level of acculturation impacts knowledge of health issues (K. Organista, P. Organista, Alba, Moran, & Carrillo, 1996). Regarding AIDS and HIV transmission, Latino subjects living in the United States who maintained a low acculturation level harbored more erroneous beliefs about casual transmission than subjects higher in acculturation.
In addition to the intricate workings of cognition based on level of acculturation, basic physiological dilemmas exist. For many of the Latino migrant workers, traveling to and from their homeland may create several health issues for them individually and for the health status of people living in the United States because of the “homeland” status of health care, such as tuberculosis, a communicable disease, and intestinal parasites. Rodriguez (personal communication, June 18, 1998) related an incident in Daviess County of a family of seven. Two of the school-age children tested positive for tuberculosis. Juanita May, a representative from Owensboro Mercy Health System’s (OMHS) Infectious Disease Control, classifies tuberculosis, an airborne disease, as moderate to high level of contagiousness (personal communication June 23, 1998). She commented that children especially could spread the disease more rapidly because of contact with others. She stated that if a person does not complete the treatment, drug resistance might occur, complicating the therapy.

Another family arrived from Honduras with four children sick with diarrhea and intestinal parasites. According to Dr. Arup Maitra, a physician at the Daviess County Health Department, intestinal parasites are a common ailment in developing countries (personal communication, June 23, 1998). He and May said that they did not know of many, if any, cases of intestinal parasites in the U.S.. However, Rodriguez said that a Latino man visited the OMHS emergency room complaining of pain located in the upper part of his abdomen. The patient did not speak much English. She said that the physician did not ask the man anything and never touched him to explore the exact location of the pain. The physician ordered numerous tests. Many of the evaluations centered on the
number one killer of Americans, cardiovascular disease. After many time-consuming and
costly tests, the physician discovered that intestinal parasites infected the man.

According to Rodriguez, a personal history and physical exploration, or what she
called personal contact, alone would reveal the answer. She said that American health
care professionals rely too heavily and too quickly on the advanced technology to make
the diagnoses of patients. “They need more dialogue with the patient,” she said. Getting
to know the patient, personalismo, emphasizes that the client’s relationship is with the
individual provider rather than the institution, building an atmosphere of trust and
intimacy which enhances self-disclosure (Burk, Wieser, & Keegan, 1995). Rodriguez
said that Latinos believe in relationship building prior to disclosing “private” information.

These types of one-on-one discussions about the patient’s ailment without pressure
of time illustrate two types of cultural characteristics: polychronic versus monochronic
time and control versus harmony with nature. The Latino culture tends to prefer a
polychronic orientation valuing relationship to the activity, whereas the American
viewpoint prefers monochronism, valuing the activity and the schedule (Harris & Moran,
1996; Samovar & Porter, 1995). Rodriguez said that if the physician had talked more to
the patient, as would happen in Mexico, instead of relying on technology, he would have
discovered the illness sooner, whereas in the United States medical practitioners rely
more on controlling nature through the use of technology. The role of the today’s patient
as the communicator of the illness has declined. The medical culture depends more
heavily on the technological outcomes of diagnosis and evaluation of illness. The
patient’s viewpoint many times borders on ‘obtrusive’ rather than helpful. According to
Cassel (1985), the technological approach may appear more unbiased and objective to the
medical practitioner. The tests produce something that the American culture values, evidence. Rueben concludes by saying that medical practitioners need to strike a balance between the biologic processes and understanding the illness as experienced and communicated by the patient.

Although hiring interpreters to overcome the language barriers seems the easiest answer, communicating effectively cross-culturally encompasses more than one approach. An example is the case of the Latino man described above who experienced pain in the upper abdomen. Myocardial infarction exhibits with characteristic types of pain. Generally, everyone who experiences angina, for instance, tends to describe the pain similarly as is also the case with pressure on a nerve root (Cassell, Vol. 2, 1985). However, "everyone" represents American peoples for medical practitioners in the United States. Spanish vocabulary may not translate exactly to the words used in English.

Also, according to Helman (1990), pain behavior, which is patterned by culture, manifests nonverbally. According to Helman, "For example, in the Argentine, shaking one of the hands smartly so that the fingers make an audible clacking sound can mean 'Wonderful,' but can also signify pain when one says ‘Ai yai’ following an injury” (1990, pp. 164). Also when evaluating for a possible heart attack, the medical practitioner will ask the length of time the pain occurs and the lapses in between the pains. For a culture that bases most things on clock and calendar time the answers probably come easily. The answers may not come easily for the Latino patient whose value of time may translate differently.

Sister Fran (personal communication, June 12, 1998) also discussed the concept of time in the Latino population in comparison to the American viewpoint. The way she
described the Latino population in the area depicted a polychronic rather than monochronic orientation. "We seldom start mass on time because the people aren't there," Sister Fran said. "If mass is at 2:00 p.m., they arrive around 2:10 p.m. They take a more leisurely and flexible attitude toward time." She indicated that the activity rather than the schedule holds the importance for the Latino.

Providing medical care to culturally diverse patients requires the practitioner to understand what the patient says and what the patient means. However, practitioners also face this challenge with English speaking patients. Cassel (Vol. 2, 1985) states, "When reporting the details of timing and causality, and when choosing the words to describe events, the patient can only reflect the meaning of these events in his or her own spatiotemporal, causal, and value terms. A month may have thirty days, but which is longer, thirty days of health or thirty days of pain?" (p. 31). According to Stewart (1995), effective interpersonal communication includes contact, confirmation, understanding, clarity, responsiveness. These elements occur in all cultures. However, the means in which a person communicates these elements differ from culture to cultures.

Rodriguez (personal communication, June 18, 1998) stated that the Daviess County area needs more translators. The Latinos in the area need translators during health care situations, but much of the important information becomes scrambled or omitted because the translator lacks disease-specific knowledge or because the specific information does not translate into English. An example of language and cultural meaning involves the word diarrhea. Rodriguez said that in Mexico they use a different word that does not translate exactly, because they regard the ailment as private. She said in America people talk about the ailment openly. Kaufert and Putsch (1997) state that the interpreter’s role
includes not only translation but also issues such as value clarification, mediation of cultural differences, autonomy in consent agreements, socioeconomic status, lack of linguistic equivalence, disparate use of language, and truth telling in end-of-life decisions. The unequal distribution of power among the participants also complicates the situation for the interpreter, they said. Kaufert and Putsch (1997) also add that the interpreter’s ability to omit, introduce, or embellish additional information into the decision-making process illustrates the informal power held by the interpreter.

The question exists about the role of the interpreter as one of neutral and objective translator or as a culture broker or mediator. Culture brokering, a term that evolved from anthropology, represents the linking or mediating between persons or groups to reduce conflicts or produce change through understanding. According to Jezewski (1990), “In health care, it involves brokering between patients and representatives of the orthodox health care system. The concept of culture brokering was first described by Eric Wolf in 1956 and Clifford Geertz in 1960” (p. 497). Although allowing more freedom of interpretation increases the potential for harm, Solomon (1997) states that interpreters should help build shared meaning through asking questions of patient and practitioner and providing additional context. Maybe by engaging the interpreter as a culture broker resolutions may occur more readily. Especially in situations that according to Kaufert and Putsch (1997), “…could not be resolved by the adoption of more culturally ‘sensitive’ communication styles or by educating the health care provider on the cultural beliefs of patients and families” (p. 72).

Complicating the issue further, practitioners must consider patients’ literacy levels. According to Davis, Meldrum, Tippy, Weiss and Williams (1996), about one in
five people cannot read the simplest brochure, but among the elderly and minority populations this figure increases to two in five. A lack of functional health literacy skills leads to therapeutic misdirection, resulting in below average care or often no care at all. Although the levels of literacy demand attention, another issue exists. Davis, et al. (1996) state that in health care reading represents one small step in the process. The patient must comprehend, absorb, and apply the information to his or her life. The individual may be able to read the information but he or she does not possess the abilities to comprehend, retain and implement the changes.

Although many people consider health care in America the best in the world, the population continues to lead unhealthy lifestyles. According to Kielich and Miller (1996), “Contrary to popular belief, most immigrants arrive here in better health than their U.S.-born counterparts—but their health deteriorates in direct proportion to their length of stay” (p. 62). Ironically, as immigrants strive to become American, they also adopt American bad habits such as smoking, drinking, and consuming fat-laden, nutrient-deficient foods.

These types of lifestyle behaviors translate into loss of health. Many families must face disabilities, chronic illnesses, and life-threatening illnesses of people close to them. During times of excessive loss, such as disability, life-threatening illness, or death of a loved one, communication challenges increase in complexity. In the following area of research the term bereaved means loss. Grief involves internal thoughts and feelings of the bereaved, and mourning represents the external expression of grief. This evaluation of bereavement includes aspects related to loss of health, grief, and death in relation to culture and acculturation.
The bereaved – Loss of health. Perceptions of life-threatening illness and disability also vary from culture to culture. Groce and Zola (1993) state, “Many ethnic and minority populations, reflecting their own unique and long-standing cultural beliefs, practices, and support systems, do not define or address disability and chronic illness in the same manner as ‘mainstream’ American culture” (p. 1048). Concerns, solutions and approaches may differ. However, variations may provide alternative methods of meeting needs.

Many people in America value their right to know about the details of their health. Wright et al. (1997) state that the American Hospital Association’s Patient’s Bill of Rights mandates a decision-making partnership between the health care system and the patient, facilitating the patient to determine his or her own future. According to Wright et al. (1997), “The concept of self-determination implies that the patient accepts the typical dominant American value of self-determination” (p. 64). In regard to loss of health and life-threatening illness, Perez-Stable, Sabogal, Otero-Sabogal, Hiatt, and McPhee (1992) state that cancer signifies loss of luck, punishment from God, and a death sentence to less acculturated Latinos. Less acculturated Latinos also believe that no prevention exists for cancer and usually do not want to discuss the disease with friends or even receive information about the presence of incurable cancer. In the Latino or Hispanic culture many maintain a concept of fatalismo which means that fate controls all (Harris & Moran, 1996, p. 238). They accept what they consider the inevitable and what God wants. This example illustrates a culturally perceived cause, an issue that Groce and Zola (1993) state appears commonly in cross-cultural studies of disability and chronic illness. Two other issues include expectations of physical survival and expectations of social participation.
Groce and Zola (1993) find that many cultures, including the Latino culture, also see chronic illness and disability as a form of punishment or witchcraft. Lipton et al. (1998) said that in the study with diabetic Latinos, many patients experienced difficulty in acceptance of the disease. Many saw the disease in a fatalistic sense, as a judgment from God, and felt that faith would provide a cure (Dios me ayudara). Many of the patients did not seek medical attention unless they felt sick. They did not perceive the need for medical maintenance of the disease. According to one of the diabetes educators, some patients would first try folk remedies, and only when complications set in, would they seek medical treatment and attention. Some of the medical participants of the study felt that patients used home remedies instead of medical treatment because of the reduced cost not because of mistrust of hospitals. Cross-culturally, the challenge exists in achieving a delicate balance between valuing another’s cultural beliefs and not denying an individual’s basic civil and human rights.

The bereaved – Aspects of mourning and grieving. Most people experience mourning and grieving at some point in their lives. These processes do not necessarily relate only to the loss of life. The loss of a level of health (i.e., the onset of diabetes in adult life) may cause a person to experience aspects of mourning and grieving. According to Steen (1998) although virtually no studies of bereavement in non-Western cultures exist, culture decides the symptoms, duration, and expression of grief. Doka (1998) also acknowledges that individuals grieve differently and the grief process should not be homogenized. He identifies many critical variables that may affect bereavement outcomes including age, gender, developmental level, social class, cultural and religious beliefs and practices, family, and external and internal support systems. According to
Doka and Davidson, “All of these newer understandings help us understand grief for what it is: not a process that makes all individuals the same, but rather one that is as complex and multi-faceted as the individuals who experience it” (1998, p. 5).

According to Steen (1998) massive social losses and uprooting, as experienced by refugees, must be considered sources of significant bereavement. Bereavement of any kind may result in physical and mental ailments. When an individual of any culture faces death of a loved one, he or she faces an adaptation process. Martin and Doka suggest that the bereaved attempt to adapt to the immediate and short-term demands of grief. The adaptation occurs in the redistribution and channeling of energy created by the loss (1998, p. 136). According to Steen (1998), emotional support, protection through the period of helplessness, and assistance to discover new models of the world appropriate to the new situation help a person to healthfully work through grieving and mourning. He adds that health care providers should also consider bereavement issues in evaluating any person from an ethnic or racial minority presenting with somatic complaints, chronic ill health, or unremitting depression.

Black (1987) states that acculturation plays a role in attitudes relating to bereavement and death. However, people from other cultures may vary in their approach to these issues of loss depending not only upon acculturation level but also socioeconomic status and educational background. According to Ellis, bereavement may trigger thoughts, concerns, and memories of other times (Doka & Davidson, 1998, p. 260). Therefore, the potential exists for an acculturated person to behave in a less acculturated way. Steen (1998) defines a temporary return to ethnic roots by acculturated people as adaptive rather than regressive. Achieving a positive foundation for
communication in situations of extreme loss proves a difficult task because of the extreme differences of perceptions between the American health care workers and the patients from other cultures.

Approaching Multiculturalism from a Health Care Perspective

Understanding and awareness of culture can assist medical practitioners in providing effective care. According to Groce and Zola (1993), a medical practitioner should not categorize an individual based on cultural background. However, that cultural background may give insight into why and how the patient and their family makes certain decisions related to care. Doka (1998) states, “...a basic goal of care giving is to assist clients in understanding the ways their own worldview can provide strength, comfort, and meaning rather than attempting to impose another worldview on them” (p.4).

Medicine as an art should focus on balancing the commonalities of human physiology with the individuality of the participants. According to Kielich and Miller (1996), “Each and every patient is your best opportunity for education about a new culture” (p. 66). However, before trying to assess another person’s cultural variations, medical practitioners must first take a look inwardly. By recognizing personal philosophy, values, biases, attitudes, and religious beliefs, a person can facilitate effective communication. These concepts, formed by past communication experiences and changed by future experiences, affect how a person communicates with others (Stewart, 1995, p. 124).

Novack, Suchman, Clark, Epstein, Najberg, and Kaplan (1997) state that health care professionals who understand their own needs and abilities in relation to others can function more effectively. They suggest including personal awareness courses as a part of
medical training. Identity and self-esteem contribute to the way people communicate. An individual’s definition of life, health, and death includes self-concept and identity.
CHAPTER III
Methods and Results

Methodological Strategy

This research design involved four components: a written questionnaire for the nurses who provided care through the Green River District Health Department, a written questionnaire in the native language of the Latino patient (either English or Spanish), a written questionnaire for the interpreter, and participant observation of the medical examination. Virtually, three realities existed in the interaction, those of the interpreter, the Latino patient, and the caregiver. I performed a study that evaluated these three perspectives and also included firsthand observation. The research methodology controlled for variability by including only native-born Mexican patients. As described in the preceding review of literature, people of various Latino descents maintain cultural similarities but also differences. The project focused on one particular ethnicity with three interpreters and five Latino patients.

I requested permission to audiotape the participant observation for analytic purposes. However, all patients preferred that I only take notes. Before participating in any of the data collection methods, I explained the nature of my research, stressing and ensuring anonymity and confidentiality of the participants. Subjects read and signed an informed consent form. The only time that signatures from the patients for consent was an issue occurred when visiting the patients’ home and governmental forms needed completion. I also committed to share the results of the study with the subjects, explaining that the information becomes part of the public domain.
Collection of data proved difficult at times for various reasons (i.e., Health Department personnel unsure of which patients on the schedule were Latino, too many patients at one time with too few interpreters, interpreters not available, or patients not showing up for the appointment.) In this type of data collection, my eight years of experience working in the medical environment gave me a foundation that included medical knowledge and health care practices. This foundation helped in the analysis of the participant observation. My background in Spanish also assisted in translation of the communication and acceptance from the Latino participants. In future studies fluency in Spanish for the researcher and knowledge of medical terminology in both languages would increase the ease of data collection.

Participant/Observation Results

Background and Method

I went to the Health Department on two occasions for scheduled appointments but the patient and interpreter never arrived. However, working in the medical environment, I know that “no shows” are frequent in the American culture also. Because all variables—such as availability of an interpreter, Latino patients, and timing needed to be synchronized—arranging these visits required constant interaction with the Health Department. Eventually, one nurse manager in prenatal became involved and ultimately helped me gather enough interviews to complete the study.

First Interview

Some nurses visit the homes of the patients. When I contacted the Green River District Health Department about my project, they told me about an upcoming visit that
lacked an interpreter. I called Sister Fran Wilhem, and she gave me the name of an interpreter. I called the interpreter and asked if she could reaffirm the home visit appointment and also ask the patient’s permission for research purposes. The interpreter agreed and called me later to confirm.

The day of the appointment I picked up the interpreter at her home and drove to Hancock County Health Department where we met the nurse. We spent about 45 minutes there with the nurse explaining what the visit needed to accomplish. The nurse said, “One problem is the (educational) literature is in English. We run on a shoestring budget. However, there are some brochures in Spanish. There is less information for postpartum.” She said that Latinos can attend a Spanish Lamaze class.

The interpreter appeared somewhat distraught when she learned about the paperwork the patient needed to sign. The government guidelines had changed for benefits and the patient would need to complete new paperwork. The interpreter explained that when she had called the patient to ask her permission for me to conduct research, she promised the patient that she would not need to sign anything. I related to the interpreter that I had previously told her that I would need a consent form signed by the patient. The interpreter said that request was permissible but that she was not sure about all the other governmental forms. Finally, the nurse told the interpreter that if the patient did not sign the papers today, the baby would not receive food.

In this situation the patient, a new mother, needed to sign numerous governmental forms to secure food for her baby. The baby was on his last bottles of special formula. If the nurse had not visited that day, the baby would not have gotten milk for the weekend. The nurse went into the pharmacy the day before to make certain that someone there
would order the formula in advance of the paperwork. She came in on her vacation day to make certain that the mother completed the necessary paperwork.

We followed the nurse to the patient’s home. Walking to the door of the home the nurse suggested that many times the patient will not disclose the accurate number of people living in the home, commenting on the number of cars seen outside the home, (6+). She said that this patient’s location was different from the one she was originally given in another interview. Before leaving the facility a similar discussion ensued when the nurse began discussing a requirement of proof of residence for the forms. A receptionist at the facility, who was present during this discussion, said about the patient, “I think she has plenty of people living with her, because she never comes in here with less than three or four people.”

As we entered the home the interpreter began complementing the young patient on the home and its decorations. She also commented on the beautiful pine trees outside. The patient nodded and thanked her. In the home, the nurse and patient sat together on the couch and the interpreter sat in a chair across from them. The nurse looked at both interpreter and patient. However, the nurse addressed the interpreter when asking questions, but looked at the patient when the patient answered. The interpreter carried on a conversation without communicating to the nurse what had been said. The nurse would ask if the patient had anything with an address on it to show that this house was, in fact, her place of residence. The interpreter translated that into "Do you have a bill with your address on it?"

From the questions on the forms, we discovered that two families inhabited the home. The patient’s husband was looking for employment, and they were sharing the
home. The new mother stated that the other family was not helping them financially.

The nurse gave the forms to the interpreter to read to the patient so that the patient would understand the information completely. The interpreter communicated to the patient that if she felt uncomfortable about my conducting research to tell us. The patient said she was fine. This interaction went on without the nurse knowing what was being said. The nurse never asked.

The patient appeared hesitant about signing the forms until the interpreter told her that she would need to do so for food for her baby’s sake. The forms were not translated to her word for word. A general statement was made about them. The patient, with a frown on her face, began signing the forms and asked if the forms would be bad for her and her baby. The interpreter assured the patient that it was for the good of both. The other Latina lady who lived there entered the kitchen through a side door that led outside. She said "Hola" and pulled up a bench and sat down. She remained there watching the interaction through the rest of the visit. The baby stirred in the other room. The mother got up to check. The nurse commented on the instinct that the mother had, and the interpreter related this comment to the mother when she returned. The patient smiled. The nurse began asking questions about the patient’s recent health. The baby stirred again. The mother brought the baby to the living room totally wrapped in a heavy blanket and a receiving blanket. The baby’s face was completely covered. The temperature was warm enough to go without jackets, but it was slightly misting outside. The interpreter asked to see the baby and the mother unwrapped him. He wore a fairly thick outfit with a matching blue hat. The interpreter made complimentary comments about the baby. The
mother seemed grateful but did not appear overly communicative or open. Then she recovered the baby.

The nurse continued the interview and discovered that the mother was not breast feeding. The baby was not accepting. The nurse urged the mother to try and breast feed. The interpreter disagreed with the nurse about trying when the baby was not accepting the breast. However, the interpreter told the patient about her own successful experience with nursing.

The nurse began telling the patient post-partum health guidelines including abstinence from sex until 6 weeks after childbirth. The patient appeared a little upset upon hearing this information and asked why her doctor had not told her. The nurse asked who her physician was and then replied that she didn’t know why he didn’t tell her.

During the interview, the interpreter commented on the wonderful plants that sat on the front porch. The patient indicated that the other Latina lady owned them. The older woman smiled, nodded, and said thank you. As the interview continued the mother slowly unwrapped the baby. The nurse presented the patient with a gift bag of new mother goods from the local extension office. The mother said thank you very much and smiled a little. Then the telephone rang. The telephone conversation that followed created extreme tension. The physician’s office called trying to collect money for the delivery. The mother searched for the document the caller requested via the interpreter. During the phone interpretation, the nurse commented on how some interpreters have a difficult time with all the dialects of the local migrant workers. She commented on how brave "these people" are coming to live in the US not knowing the language. I asked her how she communicates without an interpreter? She replied that they use hand signals to
communicate or many times a family member will interpret. She commented that it’s amazing how much you can communicate without words.

The interpreter became very agitated and told the nurse and me that the person on the telephone began asking her name and information. The interpreter’s uneasiness spread to everyone else in the room. The interpreter began saying that she liked to help but this example is why she does not like to sign consent forms or give her name for anything. Her voice became somewhat shrill and raised. Her arm and hand gestures became more elaborate. The patient reentered the room and started looking at each of us. She appeared worried and asked the interpreter if everything was okay. The interpreter, realizing the mounting tension, regained composure and assured the patient everything was fine. She finished the phone call getting a name and number for the patient to return the call.

The interview concluded with the nurse giving an appointment card to the patient, in English, and asking her to sign more forms. The patient coughed throughout the interaction, but the nurse never commented. The nurse asked the patient at the end, in general, how she was feeling. The mother began coughing hard again, and the interpreter asked if she needed water. Then the nurse asked if she was taking anything for the cough. The nurse told her what she could take since she was breast-feeding. She asked the mother if she could examine the baby. The patient handed the baby to the nurse who then examined him.

This interview lasted four hours. After the interaction and intense emotions caused by the telephone conversation, the interview was exceptionally exhausting as determined by comments made by nurse and interpreter and my own personal experience.
The government forms also complicated matters because they are confusing enough even if you understand English, according to the nurse. The entire visit felt strained. The patient never really let her guard down. She smiled infrequently and for the most part maintained a worried and apprehensive look on her face. The patient faced the interpreter throughout most of the interview. She also addressed the interpreter more than the nurse. The interpreter, a Latina, translated fluently. She asked the nurse once about the meaning of a word, hemorrhoid. However, comments made later by the nurse, via a supervisor, revealed the unhappiness the nurse felt about the way the interpreter handled the telephone situation. She stated that she did not want to work with that interpreter again.

However, later in the research project the nurse and the interpreter worked together again, this time without incidence.

Discussion of first interview. Although language did not seem to inhibit communication in this interview, personalities and relationships played a large role. The opinion of the interpreter regarding breast-feeding stopped the flow of communication between the nurse and the patient. The patient, uneasy from the start, sat casting perplexed glances back and forth between interpreter and the nurse while the dialogue ensued between them. The exchange, brief and to the point, included nonverbal gestures such as the interpreter shrugging and raising her eyebrows outwardly showing her disbelief of what the nurse said. However, ultimately the interpreter tried to use her experience to help stretch the patient’s latitude of acceptance regarding breast-feeding her baby. She told her how big and healthy her own baby became after breast-feeding.

The edginess of the interpreter during the phone conversation, her raised voice, arm and hand gestures and tensed body, automatically created tension, halting
communication among everyone. The communication took on one direction. At that point, I felt that the interview would end. Everyone sat somewhat frozen, not knowing what to say or do, afraid that to say something would bring more tension. The patient entered the room and asked the interpreter a simple question, “Esta bien?” (things are okay?) which seemed to help the interpreter regain control. The interpreter in this situation did not complete a questionnaire. She sat in the chair and read it but did not complete it.

In my opinion, the communication barriers began before the interview even started. The interpreter passed on her distrust of signing forms when she made a promise to the patient that no forms needed signing. The relationship between the nurse and interpreter went awry early on when we met at the health department and the nurse explained the agenda for the meeting. The interpreter became agitated from the start, and the nurse seemed confused about her reaction. The confusion turned into exasperation as the process continued throughout the four-hour period.

Although communication did not flow freely, the nurse achieved her goal, signed papers. The lack of relationship-building also inhibited communication. Although the interpreter made friendly comments when entering the house, the interview started with the governmental paperwork. The patient and the nurse never established a bond between themselves. Personalismo did not exist; therefore, self-disclosure never occurred to the fullest capacity. In the eyes of the nurse, signing the paperwork to secure formula for the baby was the main goal. This approach to business first and fast represents the American monochronic time orientation versus the Latino, polychronic orientation which values
relationship over activity. The presence of an interpreter does not help establish a bridge to this cultural difference.

A reason for why the baby did not take the breast did not surface from the interview. Many reasons could exist. For instance, the mother did not know the proper technique, the mother had another personal reason; or perhaps the baby was having problems physically? In my opinion, the strained atmosphere inhibited communication. Also, I feel that, at least partially, the inhibited communication contributed to the lack of attention concerning the mother’s health.

In my opinion, the American culture does not understand and, in this case, is suspicious of the relationship and bonding that the Latinos maintain in the area, (i.e., many families living together). In this case study, one nurse said that the question about the number of inhabitants exists on the forms because the government bases the amount of aid on the financial income of the household. Her comment about the number of cars in front of the house and the fact that the woman does not live in the same place denoted the presence of suspicion. Also the comment from the receptionist that the patient lives with “plenty” of people because at least 3 to 4 people come with her for her appointments implies that she assumed the patient lived with those people. The use of the word “plenty” also denotes a judgment that the speaker may think that too many people live in one house, if, in fact, they all live there. Just as Rodriguez (June 18, 1998) suggested, in this case, the families live together for economic reasons. The tendency toward collectivism for the Latino plays an important role in survival for the family.

Second Interview
This interview took place at the Health Department in Daviess County. This time the interpreter, an American, drove the patient to the interview. I arrived at the same time as the patient and the interpreter. Before we saw the nurse, the patient received a health questionnaire to complete. We entered the large general waiting room, which had chairs lining the walls. We sat in some chairs against the large windows. Hanging in the corner of the room a television played some cartoons in English. Magazines in English rested in holders, on chairs and tables.

The interpreter began asking the questions on the form. Just as they were finishing the questionnaire, a voice called out a name we thought belonged to the patient. The pronunciation was not exact. We walked to the room number that the voice stated. The nurse sat behind a desk that faced the wall. The patient sat in the chair next to the desk, and the interpreter moved a chair over in between the nurse and patient and sat down. The nurse handed the interpreter another health form for the patient to complete. The interpreter and the patient began talking while the nurse read other paperwork.

Through the process we learned that the woman was five months pregnant. For the most part during the interview, the nurse addressed the interpreter with questions and the patient looked at the interpreter to answer. The nurse indicated that the patient needed lab work completed. We moved to the lab. The interpreter, the nurse and the lab technologist stood in the rather large lab room in somewhat of a semicircle conversing in English about miscellaneous information not relating to the case. The patient sat in a phlebotomy chair with her hands in her lap, showing no facial expression and obviously not understanding the conversation.
A child and young mother came into the lab area for service. They knew the interpreter, and she began conversing with them while the technologist drew blood from the Latina patient. The tech moved the patient’s arm at a 90-degree angle after blood was drawn and told her in English to “keep it there.” The Latina patient just stared blankly at her. Again, everyone in the room conversed about miscellaneous topics while the patient sat in the chair staring ahead.

We returned to the general waiting room. The patient and the interpreter did not talk. When the receptionist called the patient’s name over the intercom she mispronounced it; thus we weren’t really sure if it was our turn.

We were called back and the questions began again. We returned to our earlier positions in the room. The interpreter commented to the patient that these questions were the same as those previously asked on another form they had filled out before the interview. During the interview, there were instances when the interpreter would not know the Spanish word for illnesses such as chicken pox, but she worked through most of them by describing the illness. Periodically, the interpreter and the patient discussed the questions on the form but did not relay the conversation to the nurse. While the nurse filled in the answers, no one spoke.

The nurse began talking about precautions to take during pregnancy. The nurse also discussed the importance of breast-feeding. The interpreter commented in English that the patient would probably go back to work very soon after the baby was born and that breast-feeding would probably not continue. “I’ve got these people down pat,” she said. The nurse commented that returning to work “wouldn’t be bad.” The interpreter said, “No, the more I get them down pat, the more I love them.” Then a discussion about
how to eat healthfully began, specifically about eating a balanced meal according to the food guide pyramid. The interpreter started telling the patient in Spanish the items she should eat. She included culturally based types of foods such as tortillas. She did not relay this information to the nurse.

The questions then began to relate to personal and family medical history. The nurse asked if the patient had a family history of immune system deficiency. The interpreter did not know how to translate and said she would call back with the answer. At one point a question regarding neurological disorders was the topic, and the interpreter relayed it as problems with nerves, which is not the same ailment. However, the patient answered and the nurse wrote it down. A question was asked about circulation problems, and after the interpreter translated, the patient commented that in the past she had some problem with her veins. The interpreter must have thought that the problem did not relate because she did not relay the information to the nurse. The nurse asked if the patient had been immunized for specific diseases; she specified Rubella. The interpreter asked, in general, had the patient received vaccinations when she was young but never stated the exact vaccinations. The patient answered yes, and the questioning moved forward. The nurse asked if the patient had TB in the past or had lived around anyone with TB. The interpreter asked the patient had she ever had TB. The patient answered no.

After more questions the interpreter began to show frustrations with being asked the same questions, stating that these are the same questions in Spanish to the patient. She sighed many times and began to slouch in her chair. The patient seemed fairly familiar with the procedures. She appeared less annoyed with the “same” questions than the interpreter. This expected child would be her second. Although not a part of the
form, the nurse and the interpreter asked the patient the name and age of the first child. The nurse asked for a signature from the patient. All forms were in English. The nurse, who apologized for the lack of Spanish brochures, gave the patient English prenatal brochures.

Toward the end of the interview, the nurse began asking multiple questions and stating directives all at the same time. The interpreter found some of these questions difficult to translate. Through a question about the father, we learned that the patient is not married and shares a home with several other Latinos. She stated that the father no longer lives in the area.

Throughout the interview the interpreter joked around some with the patient but appeared not to know her well. The patient, who learned that I knew Spanish when we met, was friendly toward me and smiled often at me. At times, when the communication among the participants became confused or stilted the patient would turn her face toward me looking for help. The whole process was mentally and emotionally draining to everyone, including myself. The entire process lasted about 2 ½ hours. All the participants, even the observer, appeared exhausted.

Discussion of the second interview. In general, eye contact between the nurse and the patient did not occur. Many times the nurse did not see the nonverbal facial gestures that the patient portrayed because the nurse focused on the paperwork. Therefore, subtle nuances, such as the dilemmas in communication that happened, were not seen.

Relationship building, personalismo, did not happen between the nurse and patient throughout the interview. In one instance, the nurse and interpreter asked about the patient's daughter. The rest of the interaction related specifically to completing the
paperwork. This distinct focus on the business at hand instead of relationship building represents a cultural difference between the American population and the Latino population. Through the interview process we discovered that the Latina patient shared a home with other Latinos. This time, as opposed to the first interview, we did not learn whether or not economics promoted this collectivistic situation.

Relationship building, however, did occur among the English-speaking participants who were not involved in the interview process. When this conversational exchange occurred, the Latina patient became isolated. In the midst of this English-spoken conversation the patient received diagnostic treatment without translation.

The absence of Spanish throughout the areas visited created an ethnocentric environment that only accelerated when the nurse gave English language, patient education materials to a patient who did not know the language. The language also proved a barrier to communication in this scenario. The interpreter’s lack of medical terminology posed problems in accuracy and effectiveness of the medical evaluation.

The choice of words used by the interpreter regarding her knowledge of the Latino population, “having these people down pat,” made me wonder about the stereotyping that may occur. The question arose, will that or has this belief impacted the communication and possibly the health care that a patient receives. In this instance, I don’t think that it did. From the nurse’s response, she may also wonder.

The interpreter’s cultural beliefs regarding health, for instance, immunizations, may affect the efficacy of the diagnosis and treatment of the Latino patient. The interpreter’s knowledge of foodstuffs eaten by Latinos helped communicate the nutrition
component of the interview. However, she only generally named the foods. She did not specify exactly what the nurse said regarding the importance of balance.

Third Interview

I arrived and met the patient and her husband, who served as the interpreter, in the prenatal waiting room. Both greeted me with a smile. The husband appeared more at ease than the wife. I explained to him my purpose, and he relayed the information to his wife. Although this is their first baby, the patient is three weeks away from delivery and had made numerous prenatal visits to the health department. They agreed to participate.

The prenatal waiting room mirrored the general waiting room except that this room held only about \( \frac{1}{4} \) the number of patients. The patient's husband said that she spoke a little English, but I never heard her speak more than a few words of English during this interview. I shared with them that I knew some Spanish, too.

The nurse came in and escorted us into a very small room. I sat on a filing cabinet because the room could not hold three chairs. The nurse sat at the desk that faced a wall. The husband stood leaning against the wall with the wife in a chair next to the desk. A blue and white curtain served as a door.

The nurse looked at the husband and spoke to him. The wife and husband began speaking, and the husband then told the nurse what they discussed. The nurse addressed the patient in English, and the husband translated. The husband told us that his wife understands some English but prefers to speak in Spanish. After learning that the patient knew some English, the nurse directed some questions to the patient. The patient would laugh and smile, seemingly a little uncomfortable. At times the patient would reply in short sentences in English. The more the patient would reply in English, the more nurse
would increase her eye contact and direct questions directly to the patient. The patient, however, began to get uncomfortable; her body started to tense; and her eye contact wavered from the nurse. The patient started focusing more on her husband. When the husband answered, the nurse turned and started looking at him more. Throughout this interview the patient and the husband included me in the conversation with eye contact and smiles while they were talking.

Toward the end of the interview the nurse told the husband about a program that would help the couple pay expenses. She also told him to share this information with friends and family. While the couple completed some information, the nurse shared with me that she has consulted with patients without interpreters, but that type of situation is difficult. In that instance, she said she conducted the interview like always, but would rethink the questioning and then try to say it in simple terms. “I’d be very frightened (if I were them),” she said. “They (the Latinos) have to put their trust in you.”

Discussion of the third interview. This interview only lasted about 45 minutes. The participants in this interview did not seem to struggle with the tenseness or stress that occurred in the other interviews. Only when the nurse began directing many questions to the patient did some tension occur, but nothing in comparison to the other interviews. Many factors may contribute to the relaxed atmosphere including the spouse’s presence with the patient, the trust level the patient feels for the interpreter, the brevity of the visit, the less detailed questioning of the interview, the fact that all conversation was relayed to everyone, and the familiarity of the patient to this environment due to frequent visits to the clinic in the past.
The husband relayed all the conversation between himself and his wife to the nurse. The dialogue appeared very open and free flowing. When he asked a question and the nurse answered, he would then relay that information to his wife.

Fourth and Fifth Interviews

The fourth and fifth interviews included two interpreters and four women. Three patients were pregnant, and one was seen for a general gynecological evaluation to receive birth control pills. One of the women I had seen in an earlier interview; therefore, I did not follow her on her medical interviews this time. The other woman was already in the process of her evaluation when I arrived. I followed the other two pregnant women throughout their evaluations to the best of my ability. However, I was not present for the entire evaluation of each because the patients alternated between rooms and tests, and many times the nurses saw them at the same time in different rooms.

All four women came to the Health Department with the interpreters. The interpreters participated in the study with other patients, too. I asked the interpreters to complete the questionnaire again since most of the questions pertained to the specific interview.

The interpreters scurried between cases. Many times the nurse evaluated the patient without an interpreter. I tried to participate in the interviews that involved the nurse, interpreter and patient. However, that strategy proved impossible. Appearing frustrated at one point in the process, one interpreter asked several times about the whereabouts of the other interpreter. She indicated that she thought the other interpreter spent too much time with only one patient.
The first interview began in the lab with the interpreter standing, the patient sitting and the lab technologist moving around preparing instruments. The interpreter and the patient conversed in Spanish. The patient seemed a little nervous as she watched the technologist make preparations to draw blood. The interpreter asked the technologist, “She wants to know if it is necessary for you to draw blood when she is pregnant?” The technologist responded, “Say what now?” and released a large sigh. She appeared frustrated that she must answer questions. The interpreter repeated the question and the technologist replied that the lab helps determine the health of the individual.

The technologist tried to draw a vial but was unsuccessful. She tried again. At this point the patient appeared even more nervous turning away when the needle entered her arm. The interpreter began conversing with the patient about other things trying to distract her from the task at hand. After the blood draw, the technologist asked the patient to choose a flavored drink to consume as part of another test. The technologist told her not to eat or drink anything else and to return after a certain amount of time. Via the translator the patient received her instruction and the drink, and we returned to a small waiting room for prenatal visitors. A couple of Caucasian patients watched television and some looked at magazines. The literature and the television programs were in English. However, in the hallways, I noticed some Spanish language posters about sexually transmitted diseases, smoking and rape.

The lab technologist called the second patient to the lab. After the patient sat down, the interpreter quickly instructed her about what would happen. She asked the patient if she was fine ("esta bien?") and then the interpreter left to check on another case. The technologist went to the patient and said in English before she inserted the needle,
“It’s a little stick.” The patient shrugged and smiled at the technologist. The technologist retrieved a tourniquet from a drawer and both started pushing up the patient’s sleeve. The technologist showed the patient how to make a fist. The patient nodded and made a fist. The technologist said "stick” and proceeded to draw blood while the patient closed her eyes. The technologist asked if she was okay. The patient looked at me, and I translated in Spanish. The woman nodded and smiled at me.

After the blood draw the technologist began asking her what flavor drink she wanted for the next test. The patient obviously did not understand and looked panicked. With eyes wide she looked back and forth between the technologist and me. I translated telling the flavors and that she needed to finish the drink in 10 minutes with nothing else to eat or drink. We returned to the prenatal waiting room. In the waiting room, the Latina patients came and went for different tests.

In the next office interview situation, the interpreter stood in the doorway and the nurse and patient sat in chairs around the desk. The usual health questions were asked. When the patient began talking about the unborn baby, eye contact between the nurse and the patient increased. As the nurse asked the interpreter to explain the urine sample protocol the patient needed to complete, someone came into the room to ask the interpreter to come to another case. The interpreter quickly explained to the patient as we advanced into the hallway. The interpreter handed the container to the patient. The patient giggled and smiled taking the container and retreated to the restroom.

We moved on to the next case. En route to the next interview the interpreter told one of the nurses not to take a lot of time talking about prenatal issues with one of the patients, because the patient might return home before the baby was born. The
interpreter, patient, and the nurse went into another room to discuss the situation. They came out of the room, and the interpreter and I proceeded into the next interview with a different patient and nurse. On the way to the next interview someone asked the interpreter the whereabouts of another patient she was previously helping. The interpreter commented that the patient was having a standard gynecological exam for birth control pills, and that she really did not need an interpreter in the room.

We arrived at the next interview. The interview began and questions came up regarding the eligibility of Medicaid cards for the patient, but no one knew the exact guidelines. During the interview, at one point, while the nurse recorded information the interpreter stared blindly into space. The interpreter commented that she had not started her Christmas shopping, and here she was interpreting. “It’s been crazy today,” she said.

In the next interview the nurse maintained eye contact with the patient throughout the interview. She spoke and smiled at the patient often. The interpreter sat near the doorway. The nurse asked the patient to slip off her undergarments and lie on the exam table. Before the interpreter translated the question, she asked the patient if she was content with us being in the room. The patient nodded her head and answered yes. The interpreter and I turned to face the wall. The interpreter translated the exam as the nurse told the patient what would be happening as she examined the baby in the womb. The nurse talked quickly not allowing much time for translation. Luckily the interpreter was a native speaker.

During the hustle and bustle of gathering the patients for appointments and later preparing to leave I was able to talk with a three of the nurses. One of the nurses said that the prenatal patients of the health department receive more services than a patient who
sees a gynecologist. Another nurse commented, “Every culture has myths about childbirth, and we can’t dispel them if they don’t tell us.” Yet another nurse said, “It’s (nursing) different for me with an English speaking person. The Spanish just complicates the situation.”

The interviews lasted approximately 2 ½ hours, and the interpreters stated that they were ready to go home. One commented that her family would be getting home soon and she wanted to begin preparing dinner. The other was trying to gather the patients and was saying come on “vamos” (let’s go).

I reminded them about the need for the questionnaire data. They reluctantly said they would stay for the patients to complete them. Each interpreter also completed a questionnaire. The patients looked confused as the interpreters tried to quickly gather them to leave and then stopped them in the hallway beside a table. The patients stood at the table to complete the questionnaires.

The patients had difficulty with the questionnaire. One interpreter started to help and ended up completing some of the questions. I saw her complete a question without asking the patient. I turned to her and asked her if she answered for that patient. She replied that she knew what the patient thought, because they were both from the same country. The patient took the questionnaire out of the interpreter’s hand and began completing it for herself. The interpreters really did not want to remain at the facility for the patients to complete the questionnaires, and everyone could sense that attitude. The patients seemed willing to complete the questionnaire, and tried to do so. The patients thanked me when they left.
Discussion of fourth and fifth interviews. The fast-paced atmosphere did not lend to building any relationships (personalismo) with the patients. Time controlled most everything right until the end of the interviews when the interpreters anticipated leaving. This preoccupation with time and keeping to schedules reflects the American time orientation of monochronism. This monochronistic approach became especially highlighted when the interpreter told the nurse not to take time explaining prenatal issues because the patient might return to her homeland. Time proved more important than the information or communication. The patients did not seem preoccupied with the time. They waited patiently and did whatever the nurses or interpreters asked them to do.

The patient asking about the blood test showed a lack of understanding as regards to preventative health diagnosis and treatment for the baby and the mother, something that is considered a standard of care in the American culture. The patient seemed concerned about why the technologist needed to draw blood while she was pregnant. Perhaps she perceived that a problem could occur endangering the baby. The technologist’s reaction did not create an environment of open communication. Everyone in the room sensed her exasperation.

The one-way communication that predominated caused a problem with a patient who chewed gum after drinking the flavored drink. In the waiting room another Latina patient commented to the woman that she should not have the gum because of the test. The patient looked worried and quickly disposed of the gum. The lack of education about why the tests and procedures took place did not cultivate learning about health or patient compliance.
The social context played a role in the situation with the patient and the urine specimen explanation. The patient received instructions in the hallway, which caused her some discomfort, because she appeared embarrassed and giggled nervously. If she had a question about the procedure, she probably did not feel comfortable enough to ask. Plus, the constant movement toward the next exam room showed lack of desire to wait around for questions.

Overall, the lack of interpreters decreased the amount and quality of the communication. The language proved a definite barrier. Some patients may have held some cultural health beliefs, but no one delved deeper to discover them. The cultural time orientation prohibited communication and in my opinion the delivery of efficacious care. The communication flowed in one direction, from the nurse to the patient. Overall the patients did not ask many questions.

Questionnaire Results

Background and Method

The questions included the following culturally-based categories: orientation (ethnic identity), religion, time orientation, language, values and norms, beliefs (especially toward health), and acculturation (general communication and friendship network). For this part of the study five Mexican patients, two Mexican interpreters, one American interpreter, seven nurses and one laboratory technologist all of American ethnicity completed questionnaires.

Each patient completed only one questionnaire during the study. However, the interpreters and the medical professionals may have completed more than one survey
during the overall study because only a handful of them provide services at the location for the prenatal program and because of the scarcity of interpreters. Also, I requested that the interpreters and the medical professionals complete a questionnaire each visit because the majority of the questions specifically addressed communication for that particular medical interaction. However, some failed to complete them. Ideally, the patient, nurse, and the interpreter would complete the questionnaires in separate rooms. This scenario proved impossible. In many cases the lack of space in the facility prohibited the separation and in others the patients seemed to cling to the interpreters.

Two interpreters and all the nurses agreed that the number of Latinos in the area continues to grow. The other interpreter did not respond. Five of the nurses said that between 1-5% of the patients they see are Latino. Although five of the nurses said that interpreters are readily available, five also answered that they had to administer care to Latino patients without interpreters. Two of the Latina patients obtained a primary education, one secondary, one preparatory and one university. The largest city that any of the participants lived in contained between 5,001 and 20,000 people.

**Cultural Paradigm Components**

**Religion.** Religion did not impact the patients’ communication or interaction with the medical professionals. Out of five patients, three were Catholic, one Christian, and one Mormon.

**Acculturation.** Three out of the five patients have lived in Daviess County and the United States for less than one year. The majority of their friends was of Latino descent and speaks Spanish during the week. All interpreters agreed that the longer the Latino individual lives in the United States the more compliant he or she is. Two interpreters
and three nurses agreed that the Latino individual who lives in the U.S. for two or more years will seek medical treatment more readily than newly arrived people. The husband strongly disagreed to this point along with two nurses. Half of the nurses agreed that the longer the Latino patients live here the more they comply. The other half neither agreed nor disagreed.

Language (verbal and nonverbal). The patients could read Spanish and did not read or speak English. However, one patient answered undecided to that question. None of the nurses spoke Spanish. When asked if the nurse and the interpreter understood what they were saying, the majority agreed with one patient answering that she completely disagreed and another answered undecided. Only one patient, not the one previously noted, answered undecided about being able to understand the nurse’s instructions and information. Four said they understood the instructions. However, three of the patients also agreed that they understood the words the interpreter used but not the significance. Only one, the patient whose husband interpreted, completely disagreed with this question. However, all the interpreters felt that they had adequate knowledge of medical terminology for the appointment. But when asked if they had trouble translating medical terminologies to the patient two chose the category "neither agree nor disagree." One interpreter chose "disagreed." On the other hand, one interpreter agreed that the medical jargon was difficult for the patient to understand, but they all agreed that the patient did understand the instructions from the nurse and that the nurse understood the patient’s situation.

One interpreter felt that dialect inhibited effective communication with the patient. Both Latino interpreters answered that language inhibited effective
communication with the patient. The other interpreter replied no. All but one nurse, who marked neither agree nor disagree, felt that no problems existed in their communication with the interpreter. Nor did they think that meaning was lost in the translation (one neither agreed nor disagreed). However, six commented that language inhibited communication with the patient.

The Latino interpreters agreed that eye contact with both male and female Latino patients is difficult to establish and that Latino patients will nod and smile even when they don’t follow the instructions later. The other interpreter marked neither agree nor disagree on all accounts. Three nurses responded that making eye contact with a female patient was difficult with five disagreeing in varying degrees. Half the nurses neither agreed nor disagreed to the same point regarding the male Latino patient, and the other half disagreed.

Values/Health. The majority of the patients did not visit a medical facility at least once a year. The majority of the patients responded that they did not seek medical treatment for preventive purposes here or in their homeland. However, these women visited the clinic for the prenatal treatment, which constitutes as a form of health prevention. The majority of the patients responded that they would prefer to speak with a male health professional. When asked if they preferred a female two said yes, one said no, and the other two did not respond. The two Latino interpreters agreed that the patients had an understanding of maintaining health before coming to the appointment. The other interpreter neither agreed nor disagreed on this point.

Beliefs. One patient answered that she sought treatment from a curandero in her homeland, but that same person answered “never” when asked when was the last time she
visited a curandero. This same individual answered in a subsequent question that she
does not use alternative methods of treatment because she does not accept them.
However, she along with another patient acknowledged that other treatments exist in their
homeland that American medical professionals do not suggest. Two said no and the other
did not respond to this question. One patient answered yes that she uses these other
treatments; however, she answered no to the question about the actual existence of the
treatments in her country.

All interpreters believe that the Latino patients comply with treatment. Although
the two Latino interpreters and two nurses agreed that they have witnessed resistance to
treatment that they did not understand, the other interpreter neither agreed nor disagreed
and three nurses disagreed. One nurse specifically wrote that she did not understand the
resistance to breast-feeding. The nurses basically neither agreed nor disagreed about
compliance with male and female Latino patients. One nurse disagreed with compliance
for the male and a different nurse for the female Latino patient compliance.

The two Latino interpreters believed that folk medicine may have interfered with
the nurses’ recommendations with these patients. The other strongly disagreed. Both
Latino interpreters acknowledged that Latinos seek medical treatments from sources other
than American medical sources. They were also in agreement that some of these
treatments are effective. The other interpreter remarked “neither agree nor disagree” on
these points. Both Latino interpreters said that the nurse asked them to ask the patient if
she was using other treatments. Only one nurse responded that she did ask the patient if
other treatments were being utilized; five answered no and two did not respond.
Six nurses, on the other hand, answered that they did not agree nor disagree that Latinos seek treatment from other sources. Two nurses disagreed that Latinos seek treatment from other sources. Almost the exact numbers hold true for their perception that folk medicine interfered with their recommendations and the effectiveness of folk medicine. None of the nurses answered yes to having heard of any of the folk illnesses or that the patient talked about any of them.

The American interpreter had heard of empacho and mal ojo, and stated that the patient discussed caida de mollera. The other interpreter (husband) marked yes on all accounts and the other interpreter left them all blank.

**Time orientation/relationships.** Two of the five thought that the medical professionals in the United States talk less with the patients compared to their homeland. One patient answered undecided. However, when asked if the nurse spent enough time with them on this particular visit only one answered undecided and the others agreed on varying levels. The interpreters also agreed that the nurses spent an adequate amount of time with the patients. All but one nurse felt that the time they spent with the patient was adequate. Three of the five patients found communicating their condition to another individual difficult.

Most agreed that they made appointments to visit this clinic but not clinics in their homeland. The interpreters agreed also that appointments were made for the clinic visits and that the patients arrived on time. The nurses were divided on this issue--three agreed to a varying degree and four neither agreed nor disagreed with one disagreeing. The majority of the nurses felt that the patients arrived on time if appointments were made.
Two interpreters said they met with the patients before the nurses arrived. The husband answered no. The majority of the nurses responded that they did not meet with the interpreter before meeting with the patient. None of the patients brought family members except for the husband and wife. The husband served as the interpreter.
CHAPTER IV

Conclusions and Discussions

Overall Discussion and Conclusions of the Study

The research paradigm

The results of this study indicate that several cultural factors impact communication among Latino patients and American medical practitioners. I combined several cultural components documented by other researchers and added an acculturation component to establish this new, more inclusive paradigm. The paradigm used to address the research question included religion, acculturation, language (verbal and nonverbal), values, beliefs, time orientation and relationships. I also added a third perspective, the interpreters’ impact on the communication process. I based these conclusions on the results from a combination of participant/observation and the questionnaires.

Religion. Religion did not appear to impact communication. However, the results supported the point made in the literature review that religions other than Catholicism exist in Mexico. Therefore, in the future, we may see some changes in culture based on the conversions.

Acculturation. Although the questionnaire results showed that few respondents interacted with English-speaking people on a friendship level, that outcome does not mean that the respondents have not become acculturated in some ways. However, the
friendship network does reveal whether or not a person achieved a deeper level of acculturation. The amount of time also impacts the level of acculturation, and only one participant had lived in the area or in the United States for more than five years. The respondents had changed the surface level such as the clothing, transportation and some foods.

Language (verbal and nonverbal). Although the nonverbal communication, such as eye contact between the nurse and the patient, varied from situation to situation, overall, I conclude that more often than not the nurse would address questions to the interpreter rather than to the patient. Also when the interpreter and the patient interacted, the nurse would be looking down at papers and writing. The nurse did not observe the interaction between the interpreter and the patient, therefore the nonverbal aspect of communication did not play a role in the evaluation from the nurses’ perspectives. In my opinion, this factor impacted the effectiveness of the communication process. Observing subtle facial expression and other nonverbal body language might have helped the nurse interpret the feelings and understanding of the patient.

My presence became more acceptable to the patients when they realized that I understood and could speak some Spanish. Beforehand they nodded their heads, signed the consent form and briefly acknowledged me. After they learned that I understood their language, the patients’ eye contact with me increased, as did their facial expressions. Generally, when the communication became stilted because of lack of understanding the patient would look at me with an expression of need. When they would describe their situation, they would include me in the eye contact. I conclude that if the medical practitioner knew some Spanish that the communication would become more effective.
As interviews progressed, everyone began to slouch and sigh more. The tension and strain of overcoming language barriers and medical terminology taxed everyone involved. In all situations except the home visit and the evaluation of the size of the baby in the womb, the nurse sat at a desk and the patient and interpreter in chairs at the corner of one side of the desk. The proximity factor stated in the literature did not seem to play a role in the communication process in this study.

**Values/Health.** The women, who reported that they did not visit medical practitioners on a regular basis for preventative means, do maintain their prenatal visits. This one factor may imply a change in value of health. However, it also may imply the strong sense of family that the literature review uncovered. For example, the expectant mother may put the welfare of her baby above her own needs.

**Beliefs.** According to the responses from all the participants except the medical practitioners, some Latinos utilize some folk medicine practices. Some contradictions occur in the Latino questionnaire results. However, enough evidence existed between their answers and those of the interpreters to conclude that the belief system of folk medicine remains and may impact the communication. The results also show that the medical practitioners do not acknowledge the presence of this culturally based factor. Therefore, the lack of awareness of these treatments and the value placed on them by Latinos impact not only the communication between the parties but also the health care the Latino receives. This point receives verification from two of the three interpreters who agreed that folk medicine has interfered with American medicine.

**Time orientation/relationships.** On different occasions either the interpreters or the nurses made comments that the Latinos move around from home to home even within
the same town. They stated that transience made the task of completing paperwork required for medical treatment difficult. The American views of completing paperwork as all-important do not mesh with the Latino worldview of relationship reigning over task. The interpreters also commented that several families or individuals usually live together in one home. From comments made by the American practitioners, one can conclude that the collectivistic viewpoint does not make sense to the practitioners, and that Americans may not agree with the Latino collectivistic approach of living together. This negative viewpoint of a cultural-based worldview may impact communication.

The Latinas arrived on time for their appointments. This fact contradicts information from the literature review. I would venture to say that this promptness might indicate that a level of acculturation had occurred. Also, in my experience, I think that they arrive on time because an American person takes them to the appointment.

American culture values the schedule. The Latinas responded that in their homeland they do not make scheduled appointments to visit the clinics, but they make appointments in the United States. Therefore, they have changed to accommodate the American culture.

Some American practitioners commented about the number of Latino people who attend the exams, a point that the literature review supported. I did not find this evidence in my research. No family members were present except for the husband interpreter. However, the participants' families do not live in this area.

The impact of the interpreter. The third party, the interpreter, added another level to the communication structure. At times, the presence of the interpreter added an atmosphere of security much like a life raft in a sea of uncharted waters. However, many times that presence added to the awkwardness, tenseness, and inaccuracy of information
shared. The personality of the interpreter can enhance the situation or impede progress. In this type of situation trust needs to be built for a free flow of communication.

During this study, frequently the nurse did not know if an interpreter would be available nor who that interpreter might be. The patient holds the responsibility of arranging for an interpreter. However, the Latinos who took part in this study in Daviess County knew that Sister Fran could usually help arrange for an interpreter. Most of the time the nurses did not know whether the patient could speak English. The interpreters volunteer their time, which may lend to the scarcity of interpreters. One interpreter did not work outside the home, one was the husband of the patient, and the third worked part-time for the Centro Latino. The majority of medical appointments take place during the day when most people work, which decreases the potential pool of interpreters.

One of the interpreters used in the study has built rapport with some of the staff at the health department; this relationship seemed to aid in the interaction. The interpreter seemed more aware of the process and types of questions. However, such a history could lead to potential problems if the interpreter becomes lax on presentation of facts to the patient or to the nurse. Also, the communication between the staff and the interpreter did not necessarily facilitate communication for the patient. All of the interpreters expressed their opinions both to the nurses and to the patients. They would draw conclusions for the nurse or give the patient their advice or opinions about the questions. Since I do not have a comparison, I am not sure if their contributions helped or hindered the communication atmosphere. The interaction may lend to rapport building with the patient but may also skew the information for both parties.
In general, at least once throughout each interview, the interpreter did not translate the nurse's information completely to the patient. In some cases, no problem resulted; however, some of the information may impact the health of the patient or baby in the future. The nurse may not receive valuable medical information about the patient. For instance, the interpreter did not realize that the exposure to TB holds as much relevance to that individual’s health as does the infection of the disease. In one case, she omitted that part of the translation. A cultural-based assumption occurred when the interpreter presumed that during a person’s youth he or she received immunizations that included Rubella.

Final Conclusions

None of the patients completed the questionnaire without questions or looks of confusion. Some of the participants, mostly the Latinos, gave contradictory responses. I am not sure if that result reflects problems with the questions or with the entire tool. In my opinion questionnaires reflect a predominantly American measurement device. None of the Latino participants seemed comfortable with responding to a questionnaire. They appeared eager to help me achieve my personal goal, but they were not comfortable with the task. It appears from this study that for this population a written questionnaire is not the most appropriate method for gathering information about the interaction. Therefore, I conclude that conducting personal interviews would produce more information from the patients.

Since the Latin culture tends to value relationships over the tasks, I recommend that future studies should involve relationship building between the researcher and the Latin participants to stimulate more responses. In my opinion the best option would
include a bilingual researcher. While my meager knowledge of Spanish helped me gather important data that would go unnoticed by a non-Spanish speaking researcher, a researcher fluent in Spanish could gain even greater amounts of data. I would also suggest conducting this study in an area where a larger Latino culture resides, thereby providing a greater number of interactions for evaluation. Future studies may include observing the interaction of an American patient in the same situations as the Latino patients to determine whether any communication variations occur as regards to cultural factors. I would also be interested in viewing the interactions in emergency situations to see if the new cultural factors appear or if the same factors receive additional verification. The comparison of American and Latino bereavement practices would be another culturally impacted area to study.

Future research may help to answer multiple questions that arise regarding the role of the interpreter in the communication dynamics. For instance, how can an interpreter build rapport for information sharing if he or she does not develop prior relationship-building experiences? Another question concerns whether the interpreter should only translate or if he or she should facilitate the interaction. To what extent does important information become lost through translation alone? If an interpreter does not know the skills involved in facilitation, can he or she adequately interact in the situation? Is a situation of culture brokering instead of straight translation even plausible when only volunteers interpret for the Latinos? Would more culturally based factors arise in emergency situations and/or bereavement situations? How significant a role does communication play in American medical care, in general? How much of the American
medical care received is based on diagnostic testing in comparison with the patient interview?

I recommend that the Health Department research the availability of grant monies to fund an interpreter or hire some bilingual nurses. By accomplishing either of these tasks, the issue of the availability of an interpreter disappears. I also believe that the Health Department and other facilities that provide medical care to Latino patients could elevate the level of care and patient compliance by providing patient education materials in Spanish. By providing forms in Spanish, especially the governmental forms, understanding and possibly trust could develop among Latino patients and health care providers. If the U.S. government does not provide the necessary forms, an interpreter or college-level Spanish instructor may translate for a nominal fee or as a volunteer service.

Overcoming the language barrier should be the first step in approaching the communication gap. Unfortunately, the media focuses only on this aspect of cultural competence. Other cultural aspects of communication need addressing to achieve intercultural communication success. All nurses must complete an established number of continuing education units annually to maintain a license. I recommend that those nurses who administer care to Latino patients take a minimum of one cultural competence course yearly.

Also, I think that those health care providers should at least know how to use basic medical terminology in Spanish. For example, a Spanish medical terminology course is offered at Owensboro Community College for health care providers. In my opinion, learning Spanish to be able to provide effective care does not differ from an information technologist needing to learn a new programming language to write
necessary documentation to accomplish his or her job. Our world changes and so must we. The knowledge of some Spanish may help to establish personalismo between patient and health care worker. By establishing personalismo, a relationship between patient and care giver, the communication interaction may produce more and better information which will increase the level of care the patient receives. The continuing education units should also include a personal awareness course. The first stride in understanding others is to understand oneself. An individual should look closely at his or her worldview and culturally driven behaviors prior to trying to evaluate someone else's culture.

I think that the communication would be enhanced from a partnership between the interpreter and the health care provider. The interpreter should understand the goal of each appointment and try to work with the health care provider in achieving the goal. Although managed health care eats away at the last morsels of relationship building that exists in providing health care to patients, the ideal situation would be for the interpreter to meet with the health care provider before the appointment to establish the objectives of the visit. I also think that accepting interpreters should be based upon a set of approved guidelines. A certain level of language competency needs to be established, perhaps a test of basic medical terminology prior to the interpreter being utilized.

Through this research I provided and applied communication theory to help advance the interpersonal level in health communication. Traditionally, health communication research used medical, psychological and sociological disciplines as a basis for theories and evaluation. In my research I took a fairly typical communication process, patients’ and nurses’ interactions, and applied another variable, Latino culture and American culture. I melded two paradigms and added another component,
acculturation, to evaluate my data. From this type of research I was able to draw a third perspective, the interpreter, from the interaction. The research unearthed areas of improvement in communication among Latino patients and American nurses in hopes that the level of care accelerates. My research also reveals ideas for new venues for research in the field of communication, especially intercultural communication. My hope is that this research will lead to additional studies in the field of medicine, based on communication theory and frameworks. I would like to see more data that combines the disciplines to develop a better product for all—a synergistic approach to health care communication.

Communication presents a paradoxical situation. Communication remains the distinguishing factor that separates humankind from the rest of nature. However, communication can also divide us. With the world operating more as a global society each day, the study of intercultural communication will continue to gain strength. The study of cultures breathes excitement into the field of communication. We face the challenges of intercultural communication as professionals, but more important as individuals trying to make sense of the world we have created for ourselves. With each new intercultural contact we make, another door opens toward the meaning of our cultural selves. At times these contacts reaffirm us and at other times challenge our belief systems. Intercultural contact affects every aspect of the community, including the health care arena. Barnes (1996) states, “In a multicultural environment, both within the United States and internationally, health care practice and research increasingly acknowledges the importance of culture as an organizing construct. To describe, explain, and predict
behavior associated with health phenomena, health beliefs and behavior must be studied in relation to culture” (p. 439).
References


